Theorising community engagement in sexual and reproductive health promotion in South Africa

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B.A., B. Health Sc., MPH.

A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Philosophy

Deakin University
May 2019
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**Dedication**

To my family, especially Phil, Leela and Ellie.

Wherever I may be, or wherever I may go, home is where my heart is.
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<td>Abstain, Be Faithful, Condomise</td>
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<td>Women who have Sex with Women</td>
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ABSTRACT

Background

South Africa experiences the highest burden from sexual and reproductive health (SRHR) issues globally, and the greatest burden from HIV and AIDS of any country. Various initiatives have been undertaken over successive decades to address this burden, including community-based prevention and health promotion programs. Community engagement is important for the effectiveness and sustainability of community-based interventions. However, community engagement is highly contextual and can be challenging, particularly regarding sensitive health issues such as SRHR. Given the plethora of community-based SRHR-promotion interventions operating in South Africa, this research aimed to theorise about community engagement in this context. Specifically, the research sought to understand:

1. What does the concept ‘community engagement’ mean in the context of communities in South Africa?
2. What factors influence community engagement in community-based SRHR promotion either positively or negatively in communities in South Africa?

Methods

A social constructivist approach, informed by symbolic interactionism and intersectionality, was adopted to explore how individuals’ experiences of community engagement are formed in relation to culture, class, gender, historical and political context, and social norms. A qualitative ethnographic and participatory methodological approach was applied.

Data were collected from January to December 2012, in five communities of the Eastern Cape with the support of a local field assistant in each setting. Purposive, snowball, convenience and opportunistic recruitment methods were used to recruit community members aged 13 years and over, and with a range of experiences of engagement in community-based SRHR promotion. A total of 78 participants contributed data through various means including semi-structured interviews, focus group discussions, opportunistic
discussions, and other ways determined by participants themselves such as poetry and practical demonstrations of SRHR promotion work. Data collection was undertaken in English language and isiXhosa. Immersion, observation and a reflective diary were also used by the researcher. Data were analysed using inductive thematic approach with grounded theory methods, and semiotic analysis.

Findings

The meaning of ‘community engagement’ was multi-faceted and contextual. Local meanings emphasised a focus on whole-of-community wellbeing, inclusiveness and connectedness, and were linked to the widely held cultural concept of *Ubuntu*.

Findings revealed four key multi-faceted factors influencing community engagement in SRHR promotion: knowledges, stigma, connectedness, and acceptance/denial. These factors operated both independently and interactively, and at both the individual and community levels, to influence community engagement. The interactions of these four factors contributed to the emergence of three superordinate themes which influenced community engagement in SRHR promotion: i). representations of SRHR issues, ii). the perceived relevance of SRHR issues and SRHR promotion among the community, and iii). the relational environment in which SRHR promotion occurs. These themes also operated independently and interactively, and at individual and community levels. The four key factors and three superordinate themes could act as either facilitators or barriers to community engagement in SRHR promotion depending on the context. These factors and themes were conceptualised into a model for understanding influences on community engagement in SRHR promotion in South Africa.

Conclusions

Community engagement in SRHR promotion in South Africa can be understood in relation to Bourdieu’s concepts of habitus, fields and capitals. Multiple contextual influences interact to inform community understandings of engagement, and individuals’ experiences of community engagement in SRHR-promotion. This research is the first to specifically draw the concepts of community engagement and SRHR promotion together in a conceptual
model, and with specific application to the cultural context of Xhosa communities in South Africa. This model can be used as a resource for health promotion practitioners to help inform the design and implementation of future health promotion interventions.
CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE RESEARCH
1.1 Introduction

This thesis presents the findings of research undertaken to explore community members’ perspectives on community engagement, and the factors that influence community engagement, in community-based sexual and reproductive health and rights (SRHR) promotion initiatives in South Africa. The thesis begins with an introduction to the research including a brief discussion of how the idea for the research was conceived, leading to the research aim and research questions. Details about the research setting, research team, and research governance are also provided in this chapter. The chapter concludes with an overview of the structure of the remainder of the thesis.

1.2 Background to the research

1.2.1 Origins of the research

South Africa experiences the highest burden from SRHR issues globally, largely constituted by the greatest HIV and AIDS burden of any country (Shisana et al. 2009, UNAIDS 2018). Various government and community-based initiatives have been undertaken over the past two decades to address this burden, including policy initiatives and community-based prevention and health promotion programs. Community engagement in community-based health promotion interventions has been shown internationally to be important for the effectiveness and sustainability of the interventions (International HIV/AIDS Alliance 2010; Orza 2011). However, community engagement can also be challenging, particularly regarding sensitive health issues such as SRHR, or with populations identified as hard-to-reach or hard-to-engage including gay, lesbian, bisexual, transgender populations (Flanagan and Handcock 2010). Reasons for difficulties reaching and engaging these populations include inappropriate or exclusionary service and/or program design (Flanagan and Handcock 2010). Men and boys have also commonly been identified as a difficult-to-engage group in SRHR issues in diverse global settings, due to reasons such as socio-cultural norms of hegemonic masculinities and perceptions of SRHR issues as feminised or women’s issues (United Nations Fund for Population Activities [UNFPA] 2013, New Zealand Parliamentarians’ Group on Population and Development 2015, Stern et al. 2015). Much of the evidence that does exist about community engagement in SRHR promotion presents
practitioners’ perspectives about what works, but there is little understanding of community members’ experiences of engagement in SRHR promotion. In particular, there is very little understanding about what ‘community engagement’ means for community members. A more comprehensive discussion of the literature is contained in chapter two (Literature Review). It is important to develop an understanding of what community engagement means to community members, and the factors which influence community engagement, so future interventions can enhance the potential for community engagement and thereby the potential for effective and sustainable programs.

My interest in understanding how communities in South Africa come to engage, or not, in community-based health promotion programs around sensitive topics like SRHR, in particular HIV and AIDS, began several years before this study. I had completed my undergraduate degree in Arts (International Development Studies) and Health Sciences (Health Promotion) and commenced a Masters of Public Health with a focus on international health. Part-way through the Masters degree I intermitted my studies and journeyed to South Africa to do one year of voluntary work in community-based health promotion. I had hoped to develop my applied understanding and skills in health promotion and community development in a low resource context, and in a cultural context different to my own. At the outset of my journey I had several objectives that I hoped to achieve; broadly speaking, these were to apply my skills to contribute to the community, and to learn from the community about their ways of understanding the world and of practicing health and community development. Admittedly, I had not initially contemplated the potential for longer-term engagement for more ethical and sustainable community development work. Thus, I commenced my volunteer placement with somewhat of a blank canvas with regards to where the journey would take me, literally as well as personally and professionally. As the journey unfolded over the course of the year, I began to realise that my journey would not be constrained by the limited duration or context of the volunteer program. Indeed, the journey has continued both literally and metaphorically to this day.

From that initial visit I developed a deep sense of connection to the community, and came to feel I was both accepted as an outsider, but also embraced and welcomed as part of the community. So, the relationships and community-based health promotion work which
commenced then has continued. Since that first visit, I have undertaken several more visits and travelled widely through the Eastern Cape and other parts of South Africa for varying amounts of time, and each time I return to Australia; but the journey has never ended.

Throughout my initial visit in 2007, I was intrigued and somewhat puzzled by the social context surrounding SRHR issues in the communities in which I lived and worked. I was involved in delivering a community-empowerment program that adopted a predominantly education-based approach to health promotion (Naidoo and Wills 2016) focusing largely on HIV and AIDS awareness and prevention, and the promotion of gender rights and respectful relationships. A range of other community-based organisations were also operating in the area, delivering SRHR programs spanning prevention, awareness and education, and management and support programs for those affected by SRHR issues. The puzzlement I felt related to why and how the community, or particular groups in the community, engaged with programs about sensitive issues. Topics related to SRHR, and in particular HIV and AIDS, were highly stigmatised and widely considered taboo in the community; people could experience stigma simply through association with the programs even if they were not infected with such illnesses themselves (McNeill 2009). Thus, I became curious about why people (and particularly those not directly affected or infected) engaged with these programs given this social context. I also observed some loose patterns in terms of who engaged – predominantly ‘mamas’ (adult women, generally married and with children and/or grandchildren), and to a lesser extent teen-aged girls. There appeared to be a mix of people directly affected by SRHR issues and people not directly affected. There were also some groups notable in their absence. These were, generally speaking, men of all ages, and young adult women. I became curious about why people, or seemingly particular groups, tended to engage with the programs while others did not. Simultaneously, I observed somewhat of a social juxtaposition; while association with taboo issues like HIV and AIDS and other SRHR issues could contribute to social stigma and isolation, many of the programs seemed to offer opportunities for people to connect with one another and contribute to the community. That is, SRHR promotion programs simultaneously provided spaces for potential social exclusion, but also social inclusion and connectedness. I have written about this elsewhere (Lamaro 2009).
Thus, I developed curiosity about the reasons and motivations for peoples’ engagement in these kinds of programs, the perceived or experienced benefits they gained from their engagement, the challenges to engagement they faced and how these were managed or perhaps mitigated by the gains, and how other community members could potentially be engaged. I was also cognisant that many of the community-based SRHR promotion programs focused predominantly on HIV and AIDS, unplanned pregnancy and to a lesser extent issues of gender, sexuality and sexual and reproductive rights. However, there exist high burdens from other SRHR issues in South Africa; of great significance is cervical cancer. Cervical cancer is the leading cause of cancer death among women aged 15-44 years in South Africa (Bruni et al. 2017). The crude mortality rate for cervical cancer is more than double the global rate (16.6/100,000 women compared to 7.6/100,000 women respectively), and the age-adjusted rate for South Africa is nearly three times the global rate (18.0/100,000 and 6.8/100,000 respectively) (Bruni et al. 2017). Factors influencing the burden of cervical cancer include the presence of the human papilloma virus (HPV) which is predominantly sexually transmitted, factors related to sexual practices including age of sexual debut and oral contraceptive use, a HIV positive status, and engagement in screening and health promotion services (Bruni et al. 2017). Thus, parallels can be seen between the determinants and social context of HIV and cervical cancer in South Africa. However, throughout my entire time spent in South Africa over multiple visits, I observed extremely limited community-based health promotion activity related to cervical cancer. I wondered what could be learned from the plethora of community-based HIV and AIDS initiatives about community engagement in SRHR promotion that could potentially inform future SRHR program planning. Thus, a desire to better understand various aspects of the processes and experiences of community engagement in SRHR promotion programs in South Africa was born.

1.2.2 The socio-economic context of South Africa and the Eastern Cape

South Africa has a population of approximately 55 million people, and is ranked as an upper-middle income country by the World Bank based on the country’s Gross National Income (GNI) per capita (World Bank 2017). Despite this overall classification, South Africa has a wide socio-economic gradient, and vast social and health inequalities. For
instance, the most recent community survey conducted by the national statistics agency found that 13% of households live in an informal dwelling and 23% of households live in government-subsidised housing (Statistics South Africa 2016). Ten percent of households nationally do not have access to piped water; this figure ranges from one percent of households in the Western Cape Province to 25% of households in the Eastern Cape Province, indicating the vast inequalities across the nation (Statistics South Africa 2016). A lack of a safe and reliable water supply was ranked as the highest perceived challenge among households in seven of the nine provinces (and by as many as 43% of households in some provinces) (Statistics South Africa 2016). Predominant factors influencing the socio-economic state of South Africa include the historical context and legacy of apartheid, and the impact of social and economic burdens from HIV and AIDS which have contributed to a declining life expectancy and widespread structural and intergenerational poverty (Eastern Cape Socioeconomic Consultative Council [ECSECC] 2012).

This research was conducted in the Eastern Cape Province of South Africa (Figure 1.1). The Eastern Cape is the second largest of the nine provinces of South Africa in terms of area, and the third largest in terms of population; approximately seven million people, or nearly 13% of the national population, live in the Eastern Cape (Statistics South Africa 2016). The vast majority of the population of the Eastern Cape identify as Black (approximately 87%), with the next most common identity being Coloured (mixed race; approximately 8%), followed by White (just under 5%). Indian, Asian and other groups comprise less than 1% of the province’s population (Lehohla 2014). The main language spoken in the province is isiXhosa (77.6% of the population), followed by Afrikaans (10.4%) and English (5.5%) (Lehohla 2014). The population is a predominantly young one; the proportion of young adults aged 15-34 increased from 33% in 2011 to 37.5% in 2016 (Lehohla 2016), and while

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1 These racial categories refer to legal classifications established during the apartheid era. In particular, the term ‘Black’ is used to refer to those of the majority indigenous African populations; ‘White’ refers to those of colonial European descent (primarily Dutch or English); and ‘Coloured’ refers to those of mixed race (Black-White, Black-Asian, White-Asian, and Black-Coloured) and their descendants (Brown, 2000). These classifications were used as the basis for the establishment of status and rights, with the minority White population considered supreme, the majority Black population as inferior, and the Coloured population as a distinct intermediary (Brown, 2000). Despite the abolishment of apartheid, these racial classifications have remained largely in use as some argue they continue to have a role in cultural and social identities (Adhikari, 2005). However, their use remains contentious as some argue they fail to recognise the diversity of multiple races and ethnicities within these classifications (Adhikari, 2005).
the proportion aged under 15 years has been showing a decline, they still constitute a further 25% of the provincial population (Makiwane and Chimere-Dan 2010). There are more females than males living in the province (53% compared to 47% respectively) (ECSECC 2012), reflecting labour force migration and gender-based mortality differences which negatively impact more on men (Makiwane and Chimere-Dan 2010). People who are intersex, non-cisgender or of a non-specific gender are not specifically identified in this data.

**Figure 1.1: Map of the nine provinces of South Africa**

Source: ECSECC (2012)

The Eastern Cape is comprised of eight district municipalities; six of which are further divided into a number of local municipalities, and two metropolitan municipalities which are not sub-divided (Buffalo City and Nelson Mandela Bay) (Figure 1.2). The manufacturing sector makes the largest contribution to the economy of the province (Trade and Industrial Policy Strategies [TIPS] 2016). The two metropolitan municipalities are built around large ports which provide a basis for shipping and economic trade. These two
municipalities in particular are home to large industrial and manufacturing sectors. Key industries include automotive, forestry and timber, and petrochemicals. Thus, these two metropolitan municipalities are considerably more economically developed relative to the other municipalities of the province (ECSECC 2012), but overall the province performs weakly on the national economic scale (TIPS 2016).

Figure 1.2: Map of the eight district municipalities of the Eastern Cape Province

Source: ECSECC (2012)

The Eastern Cape is relatively socio-economically disadvantaged overall compared to the other provinces of South Africa. The level of economic participation among the population in the Eastern Cape is lower than the South African average (27% of the population of the Eastern Cape compared to 33% nationally) and is declining (ECSECC 2012). The level of human development (indicated by the Human Development Index\(^2\)) is also lower than the South African average and has a declining trend. Inequality in the Eastern Cape (as

\(^2\) The Human Development Index (HDI) is a statistical ranking of level of population achievement in key areas of human development, used for comparative purposes across countries and/or regions. It is derived composition of key measures of standard of living including life expectancy at birth, expected years of schooling, mean years of schooling, and gross national income per capita (United Nations Development Programme [UNDP] 2015).
measured by the Gini Index\(^3\)) continues to increase (ECSECC 2012). Over half of the population of the Eastern Cape (57%) are living below the poverty line (a measure of income considered necessary to meet basic needs), which is higher than for the country overall (44%) (ECSECC 2012). While literacy levels and rates of educational attainment have been continually improving since the end of apartheid, illiteracy is still relatively high throughout the province (20%) (ECSECC 2012, Statistics South Africa 2016).

### 1.2.3 The health context of South Africa and the Eastern Cape

In addition to socio-economic disadvantage, the Eastern Cape also experiences disadvantage and inequities in health indicators and outcomes. Overall health status and indicators are generally poor. In 2017, the average life expectancy at birth in the Eastern Cape was estimated to be 58.0 years for males and 63.9 years for females, lower than the national averages (61.2 and 66.7 years respectively) (Statistics South Africa 2017). The leading causes of death are HIV-related illnesses and Tuberculosis (TB) which together account for one third of all deaths in the province. Cardiovascular illnesses, injuries and infectious or parasitic diseases are other major causes of death (Msemburi et al. 2016). The infant mortality rate and under-5 child mortality rate showed a concerning increasing trend at the start of the century, but both rates have decreased again since around 2005. It is anticipated the trajectory was influenced by a high number of infant and child deaths from HIV-related illnesses before programmatic efforts to address this illness began to take effect (Makiwane and Chimere-Dan 2010, Msemburi et al. 2016). In 2017, the infant mortality rate in the Eastern Cape had decreased to 29.2/1,000 live births but remained higher than the national rate of 26.1/1,000 live births, while the under-5 mortality rate was 45.0/1,000 in the province, compared to 40.2 nationally (Msemburi et al. 2016).

With regards to SRHR issues, HIV remains the primary concern of South Africa and the Eastern Cape. South Africa has the greatest HIV epidemic of any country, accounting for one-fifth of the global population of people living with HIV, and 15% of all new infections globally (UNAIDS 2018). The national incidence rate for HIV infection has consistently

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\(^3\) The Gini Coefficient is a measure of income equality or inequality. It measures the distribution of income across households or individuals in a population, and the extent to which the distribution deviates from the hypothetical, ideal equal distribution (IndexMundi n.d.).
decreased over the past decade, but the national population prevalence of people living with HIV remains high at just over 12% (Statistics South Africa 2017). In the Eastern Cape, HIV-related causes are the leading cause of death for all age groups up to the age of 60 years. A gender disparity in deaths from HIV-related illnesses is evident for the age group of 15-44 years, with 32.0% of deaths of males in this age group attributed to such illnesses compared to 56.7% of deaths of females in the same age group (Msemburi et al. 2016). The incident rate for new infections follows the decreasing national trend. Concurrently, the use of barrier contraceptives has continued to increase over time; about 70% of the population aged over 15 years reported using a barrier method in their last sexual encounter (Makiwane and Chimere-Dan 2010), but how consistently such methods are used was not reported. Sexual intercourse with multiple and/or concurrent partners, a risk factor for HIV infection, remains relatively common among young people aged 15-19 years in the province, at about 13% among both males and females (Makiwane and Chimere-Dan 2010). Among women aged eighteen years and older in the Eastern Cape, 6.7% reported ever having experienced sexual violence from a partner, which is close to the national average of 6.3% (Lehohla 2017).

Fertility and teenage pregnancy rates are declining in the Eastern Cape, but remain higher among women in rural areas, women of low educational status, and women of African ethnicity (Makiwane and Chimere-Dan 2010). Factors which have possibly contributed to the overall declines in fertility and childbearing include a decreased prevalence of marriage and increasing contraceptive use, possibly resulting from the high HIV prevalence which has contributed to greater awareness and use of barrier methods of contraception (Makiwane and Chimere-Dan 2010). The total fertility rate for the province in 2017 was estimated to be 2.77, slightly higher than the national rate of 2.41, and the highest of any province (Statistics South Africa 2017). Makiwane and Chimere-Dan (2010) note that regional variations in fertility rates exist across municipalities within the province, which reflect broader socio-economic patterns between municipalities. The rate was highest in the O.R. Tambo district municipality and the Nyandeni local municipality – settings in which this research was conducted (the study settings are discussed further in section 1.3 below). The proportion of females aged 15-19 in the Eastern Cape who had begun childbearing in 2016 was 17.9%, ranking the province fifth out of the nine provinces in terms of teenage pregnancies;
provincial rates ranged from 8.1% in the Western Cape to 20.1% in the Northern Cape (Lehohla 2017). The Eastern Cape Department of Social Development make the observation that while the responsibility and any burdens of reproduction and childbearing has traditionally befallen women, there is increasing involvement of males in fertility, reproductive and family matters (Makiwane and Chimere-Dan 2010).

SRHR issues affect the population broadly regardless of gender, ethnicity, location or other socio-economic characteristics (South African National AIDS Council [SANAC] 2011). However, the epidemiological and social burdens impact most on certain sub-populations. These groups include the black population, women and young girls, non-schooling youth, those living in peri-urban settlements or close to major transport routes, sex workers, transgender people, men who have sex with men, people with substance abuse disorders, people with physical or mental disabilities, and those who experience additional oppressions such as low socio-economic status and poverty, gender-inequality or other forms of social exclusion (SANAC 2011).

Previous research has identified a wide range of factors that contribute to morbidity and mortality from SRHR issues in South Africa (Johnson and Budlender 2002, Skinner and Mfecane 2004, Campbell et al. 2006, SANAC 2007, Harrison 2009, Phaswana-Mafuya et al. 2009, Shisana et al. 2009, SANAC 2011). Factors that contribute to the development and proliferation of SRHR problems in South Africa are multiple and often interactive, and include individual/behavioural, socio-cultural and structural factors. Individual and behavioural factors include individuals’ sexual behaviours and practices such as contraceptive practices and the number of sexual partners, and other health behaviours such as alcohol and other drug consumption (Johnson and Budlender 2002, Skinner and Mfecane 2004, Campbell et al. 2006, SANAC 2007, Harrison 2009, Phaswana-Mafuya et al. 2009, Shisana et al. 2009, SANAC 2011). Socio-cultural determinants include traditional beliefs and practices, gender-based norms and inequalities, service provider attitudes, service and client interactions and power-relationships, and religious factors. Structural determinants include factors such as health system factors, and widespread inequality, poverty and social exclusion (World Health Organization [WHO] 2010a). These factors have been linked to a legacy of apartheid (Khalema et al. 2015). Phillips and Pirkle (2011) argue that it is
upstream socio-cultural and structural factors which influence greater numbers of individuals compared to more downstream individual-level factors. The context of sexual and reproductive health in South Africa is discussed further in chapter two (Literature Review).

1.3 The research settings

This study was carried out in five settings: three communities in the Buffalo City Metropolitan Municipality (research settings one, two and three), and two communities in the OR Tambo District Municipality (spanning two local municipalities; research settings four and five) (Figure 1.2). The sites encompassed diverse social and geographical characteristics. In the Buffalo City Metropolitan Municipality, research setting one and research setting two were urban settings. These two urban settings (research settings one and two) each contained a bustling city centre including a central business district, local government buildings and civic services, healthcare services and transport networks. There were multiple shopping centres with major chain stores, as well as a large number of independent stores, market-type stores, and individual street-based traders selling all sorts of wares that could be expected to be sourced in a major city (such as food, clothes and textiles, electronics, and entertainment). Government and private schools, universities and training colleges were present in both cities. Research setting one in particular was a geographically and demographically large city in the province; the central business district was surrounded by suburbs of varying affluence or disadvantage, and many of the suburbs had their own suburban shopping centres, schools, and other services and amenities. A range of residential housing types of varying size and standards were present in the city centres and surrounding suburbs, including free-standing houses, apartment blocks, and informal housing.

Research setting three was located within approximately a thirty minute drive of research setting one, and so was considered for this research to be peri-urban. This community was comprised predominantly of housing, as well as a community centre, school and church. The housing structure and availability of amenities (electricity, water, sanitation systems) were more similar to those which would be found in the informal settlements or rural areas (described below) than an urban area; however, this community was considered peri-urban
due to its location in a metropolitan municipality, and geographic proximity and access to other major social and economic services and infrastructure in the nearby city.

Research setting four, located in the O.R. Tambo District Municipality, was an informal settlement or ‘township’ in close proximity to a regional town centre. The township was comprised of dense housing, often with small businesses operating out of some houses (such as a local stores selling bread, drinks and sweets). The nearby regional town serviced the local economy, with access to larger wholesale stores, hardware stores and supermarkets, chain stores, a medical centre, town hall, schools and municipal offices. The township was organised in rows of equal sized blocks, individually fenced off, each containing a house of concrete and tin construction, and a small yard. Houses were connected to electricity and had an outdoor tap for clean water, and an outdoor toilet (non-flushing, not connected to a sewage system).

The final setting was a rural community in the O.R. Tambo District. The rural community was comprised of traditional housing situated on a larger plot of land. Families/residents typically live on a plot of land which is often (but not always) fenced off to demarcate boundaries. A plot often contained several buildings of mud-brick construction; some buildings had thatched roofs and some had tin roofs. Some had an electricity connection, but there was no piped water; water was gathered from rainwater tanks when available, or the nearby river. There was a medical clinic, a secondary school, two primary schools, two general stores, several churches and a religious mission in the community. Further details of the research settings are provided in Table 1.1.
<table>
<thead>
<tr>
<th>Research setting</th>
<th>Setting</th>
<th>Demographic and geographic information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A major provincial city; Buffalo City Metropolitan Municipality</td>
<td>Large port city with substantial economic industries based there. Population totals approximately 400,000 people in the city, and approximately 700,000 in the broader metropolitan region. Predominantly Black population (70%), followed by White (16%), Coloured (12%), and 2% other ethnicities. Has all the amenities of a major city, including access to schools, further education and training institutes, and health and medical facilities.</td>
</tr>
<tr>
<td>2</td>
<td>Regional city; Buffalo City Metropolitan Municipality</td>
<td>Inland city in a metropolitan municipality, with a population of approximately 34,000 people in the immediate city (9,900 households), and 80,000 people in the surrounding region. Comprised predominantly of the Black population (65%), with smaller populations of other ethnic groups (Coloured 25%, White 5%, other 5%). Predominantly Xhosa speaking (55%). Has all the amenities of a major city, including access to schools, further education and training institutes, and health and medical facilities.</td>
</tr>
<tr>
<td>3</td>
<td>Peri-urban community; Buffalo City Metropolitan Municipality</td>
<td>Xhosa community of approximately 1000 people, located approximately 30 minutes by vehicle from setting one with frequent public taxis to setting one. Housing is traditional mud brick with tin roofs. Homes have no running water supply or sewage, and limited electricity. The community has a number of small local shops and sellers for basic goods, but travel to the nearby city is common for shopping and schooling.</td>
</tr>
<tr>
<td>4</td>
<td>Informal Settlement community; O.R. Tambo District Municipality</td>
<td>Informal settlement community situated within a broader regional community totalling approximately 5000 people. The population is almost entirely Black (99%) and Xhosa speaking (92%). Houses in the settlement community are made of mud brick and cement, with tin roofs. Houses are organised into orderly rows, with each plot demarcated by fencing. Each plot has a tap with running water, but no sewage system. The settlement community and surrounding regional community contains several schools (primary and secondary), churches, health clinic facilities, shops and warehouses, and transport interchange.</td>
</tr>
<tr>
<td>5</td>
<td>Rural community; O.R. Tambo District Municipality</td>
<td>Traditional Xhosa community of approximately 1500 people, predominantly Black population, but two Coloured families and two Indian families live in the community. Located approximately forty minutes by vehicle from the nearest local municipal town centre (population approximately 3000, comprised of 97% Black population), and one hour by vehicle from the nearest regional city. Housing is traditional mud-brick constructions with no running water or sewage system, and limited reliable electricity. The small local community has a medical clinic, two primary schools and a secondary school, several churches and Christian missions, and several small shops for buying basic groceries. Hospitals, larger shops, and emergency services are located in nearby towns and centres.</td>
</tr>
</tbody>
</table>

1.4 Research team and governance

The research team comprised of the lead researcher and a team of five field assistants. The lead researcher was etic to the communities and cultures of the research context and settings. Five local community members were engaged as field assistants to work on the project (one in each research site) to enhance the cultural appropriateness and meaningfulness of this research (discussed further below). This strategy also supported the participatory and collaborative methodology guiding the research (further discussion of this is contained in chapter three, methods).

The researcher sought to work collaboratively with organisations engaged in SRHR promotion in the Eastern Cape to assist with recruitment of field assistants, participant recruitment, and entry into communities. Relevant organisations were identified based on the researcher’s knowledge and through an internet search. A key contact within each organisation (such as an Executive Officer or SRHR program manager) was contacted via email and invited to collaborate on the project. Three organisations responded positively. The three organisations varied in location and the nature of their work (Table 1.2). Organisation one and organisation two were based in the same city (research setting one), and both ran community-based and peer-based SRHR education and empowerment programs in communities surrounding the city and throughout the broader rural areas of the province. Organisation one also ran programs within the city for urban-based populations, while organisation two did not. Organisation one had an additional office located in research setting two. The researcher subsequently collaborated with employees and volunteers in that office also. Organisation three was located in a rural area approximately five hours drive from organisations one and two. This organisation ran community-based and peer-based SRHR-related programs for local communities in that rural area.

Key contacts in each organisation were asked to identify communities in which the research could be carried out, and to identify and recruit a field assistant from those communities (see details of field assistants in the final column of Table 1.2). Desired characteristics of field assistants included involvement with the organisation’s program, have written literacy competency, of any gender, and aged 13 years or older (a discussion of the appropriateness of engaging young people in this research is presented in section 3.7 – Ethical
Considerations). Subsequently, five field work sites and a local person to work as the field assistant within each site were identified.

The lead researcher provided training to the field assistants about the purpose of the research, ethical conduct, participant recruitment (including informed consent procedures), conducting interviews and focus group discussions, data collection and management, and secure data storage. The training was based on that provided in other cross-cultural participatory ethnographic research (see Firebrace et al. 2010). Field assistants were each provided with necessary equipment to conduct the research including a digital voice recorder, small hand-held video recorder, USB stick for file electronic file storage, access to a computer, large sheets of paper and white-board markers, and a notebook and pens. Field assistants were paid R800 (800 rand – the local currency) each to complete the equivalent of ten days work each on the project, including training, participant recruitment and data collection. The amount paid was based on advice from key contacts in the partner organisations about a suitable local daily rate for the nature of such work.
Table 1.2. Characteristics of partner organisations and field sites

<table>
<thead>
<tr>
<th>Organisation number</th>
<th>Organisation location</th>
<th>Key population groups of interest/service users</th>
<th>Key program initiatives</th>
<th>Research setting and field assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has offices based in research setting one and research setting two. Conducts work in those cities and surrounding regional/municipal communities.</td>
<td>Whole of community; predominant focus on women and young people</td>
<td>Community-based SRHR education, awareness-raising and activism; school-based engagement and SRHR education, awareness-raising and activism; case work and support.</td>
<td>Research setting one: Field assistant: Qaqamba, female youth; limited past involvement with the organisation. Research setting two: Field assistant: Nokwanda, female youth; some past participation with the organisation and peer-educator with another organisation.</td>
</tr>
<tr>
<td>2</td>
<td>Based in research setting one with operations widespread through several district and local municipalities in the Eastern Cape.</td>
<td>Youth</td>
<td>Youth empowerment, life skills development, leadership development; SRHR promotion (education, awareness-raising and activism) integrated with/embedded in broader empowerment-based initiatives.</td>
<td>Research setting three: Field assistant: Paki, male youth; past program participant with the organisation. Research setting four: Field assistant: Thandiwe, adult female; past program participant with the organisation.</td>
</tr>
<tr>
<td>3</td>
<td>Based in research setting five</td>
<td>Whole of community; people living with HIV or AIDS; own community and nearby rural communities and regional communities.</td>
<td>Home-based care for people living with HIV or AIDS; SRHR education, awareness-raising and activism; microfinance.</td>
<td>Research setting five: Field assistant: Ivy, female youth; member of the community; qualified auxiliary social worker. Limited involvement with work of this organisation and some familiarity with work of organisation two in this research setting previously.</td>
</tr>
</tbody>
</table>

*Names of field assistants in Table 1.2 are pseudonyms.*
1.5 Structure of the thesis

In response to the high burden of SRHR issues affecting the South African population, a range of interventions have been implemented over many years (discussed further in chapter two – Literature Review). This research, undertaken in five areas in the Eastern Cape as described above, sought to develop understanding about community engagement in SRHR promotion in South Africa in order to inform future program design. The following chapter (chapter two) provides a review of the current literature pertaining to community engagement in SRHR promotion in South Africa to provide further context and rationale for the research.

Chapter three provides a detailed description and justification of the methods used to conduct the research, including the theoretical approaches, methodological approaches, data collection and analysis procedures, and discussion of ethical considerations.

The findings of the research are presented in chapters four to eight. Each of the chapters four to seven focuses on one key factor which emerged in the research as a key influence on community engagement. The first factor to be discussed, in chapter four, is the role of community understandings of community engagement, and the multiple forms of knowledge which inform community understandings of community engagement. The chapter begins with a discussion about community members’ perspectives of what community engagement means to them. This provides important context for the ensuing discussions. It then unpacks the various forms of knowledge that were revealed as being present in communities, and which influence community engagement in SRHR promotion either positively or negatively. The chapter also discusses how these different forms of knowledge interact with a range of other factors to influence community engagement.

Chapter five focuses on the role of stigma in community engagement in SRHR promotion. The related concept of fatalism is also discussed. Throughout the discussion, links with community knowledges (discussed previously in chapter four) are made to highlight the interactive and dynamic nature of community engagement.
Chapter six discusses ‘connectedness’ with regards to community engagement in SRHR promotion. Two main facets of connectedness are discussed: social connectedness – interpersonal relationships; and issue-connectedness - close experiences or connection with SRHR issues. The influences of these factors could be positive or negative for engagement, and both these aspects are discussed.

The influence of acceptance and/or denial on community engagement in SRHR issues is discussed in chapter seven. Multiple aspects of acceptance and denial are discussed including acceptance of oneself and one’s own SRHR-related experiences, acceptance of others in the community, and acceptance of the reality of the lived experiences of SRHR issues in everyday community life. This chapter highlights how acceptance and denial are dynamic processes, and interactive with the other key factors discussed in previous chapters.

The research findings also reveal how multiple interactions of the key factors provides an added layer of complexity to understanding community engagement in SRHR promotion. These interactions led to the identification of three superordinate themes which influence community engagement in SRHR promotion in the South Africa; i) representations of SRHR issues in the community; (ii) community perspectives about the reality of SRHR issues; and (iii) the broader relational environment in which community-based SRHR promotion is undertaken. These themes are discussed in the final findings chapters (chapter eight). Chapter eight also draws together the four key factors (presented in chapters four to seven) and three superordinate themes, and presents a conceptual model for understanding influences on community engagement in SRHR promotion in the South Africa. In this chapter, the findings are discussed in relation to Bourdieu’s theory of habitus to understand how factors influencing community engagement are constructed and operate.

The final chapter in the thesis, chapter nine, presents the conclusions of the research in relation to current public health and health promotion research and practice, and discusses implications for future research and practice.
1.6 Chapter summary

Sexual and reproductive health and rights matters are a significant issue in South Africa. The research presented herein was conceptualised and undertaken to develop an ethnographic, culturally contextual understanding of factors influencing community engagement in SRHR promotion in the Eastern Cape of South Africa, to inform future research and practice which may help to enhance SRHR for the population in future. This introductory chapter has described the origins of the research, and the social context in which the research was set.

This thesis theorises that community engagement in SRHR promotion in South Africa is influenced by multiple complex and interactive factors operating at the individual and community levels. These factors, and their interactions, influence community engagement contextually, and in both positive and negative ways. These arguments are presented in the ensuing chapters. The following chapter will present a review of the literature relevant to this research topic to further develop the rationale for the research.
CHAPTER TWO

LITERATURE REVIEW
2.1 Introduction

This chapter provides a review of the literature covering a range of topics related to community engagement in SRHR promotion. It first defines key concepts relevant to SRHR, and discusses current strategic and programmatic responses to SRHR promotion in South Africa. The discussion then outlines theoretical concepts of community engagement. In doing so, it becomes clear that there is little literature which brings together theories about community engagement and sexual and reproductive health promotion, and even less so which is specific to the South African context. Further gaps are highlighted regarding this focus. The literature review provides the rationale for the research conducted.

2.2 Defining sexual and reproductive health and rights (SRHR)

‘Sexual and reproductive health and rights’ (SRHR) encompasses the concepts of sexual health, sexual rights, reproductive health and reproductive rights. Sexual health is defined by the World Health Organization (WHO) as:

“a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (WHO, 2006: 5).

The achievement of sexual health is influenced by multiple determinants including downstream and individual factors such as an individual’s sexual behaviours and knowledge about the sexual health risks they face and their vulnerability to the adverse consequences of sexual activity; and social and structural factors including access to comprehensive good-quality information about sex and sexuality, access to sexual health care, and an environment that affirms and promotes sexual health (WHO 2010b, 2015).
Implicit in this definition of sexual health is sexuality, which is a discrete concept in itself but also core to sexual health. WHO asserts sexual health cannot be understood or addressed without consideration of sexuality (WHO 2015). Sexuality is defined by WHO as:

“a central aspect of being human throughout life encompass[ing] sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors” (WHO, 2006: 5).

Also embedded in the definition and operationalisation of sexual health are sexual rights. WHO (2006) defines sexual rights as human rights which are explicitly related to individuals’ ability to achieve and experience sexual health (including the ability to express sexuality), attainable by individuals free from coercion, discrimination and violence. For instance, sexual rights include the human rights to life, liberty, autonomy and security of the person; to equality and non-discrimination; to freedom from torture or cruel, inhumane or degrading treatment or punishment; to privacy; to the highest attainable standard of health (including sexual health) and social security, with specific regards to the context of sexual health and sexuality (WHO 2006, 2010b). The statement about freedom from coercion, discrimination and violence is explicitly included in the definition of sexual health, thus intricately linking sexual health and sexual rights. Sexual rights reflect basic human rights, but explicate human rights with respect to the realm of sexual health and sexuality specifically.

A distinct but related concept to sexual health is reproductive health. WHO (2006) states that:
“reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so” (p.4).

As with the concept of sexual health described above, individuals’ capacity to attain reproductive health is influenced by several factors including access to safe, affordable and appropriate reproductive health care, which itself is influenced by multiple, multilevel determinants. Reproductive rights refer to those rights directly related to experiences and outcomes of reproductive health, including the right to freedom of decision with regards to family planning (that is, decisions about the number, spacing and timing of child bearing), and access to appropriate and high quality reproductive health information.

Sexual health, sexual rights, reproductive health and reproductive rights are intricately linked. For instance, WHO (2010b) postulates that in order for individuals to achieve reproductive health, a level of determination and control over their sexuality and sexual health needs to be able to be exercised. This implicitly involves the operationalisation of sexual rights and reproductive rights. Throughout this study, the multiple and related concepts of sexual health, sexual rights, reproductive health and reproductive rights are considered and encapsulated within the encompassing term, sexual and reproductive health and rights (SRHR). However, occasionally, the term sexual and reproductive health (SRH) is used when referring to situations (such as literature, programs or contexts) in which the aspect of rights was not explicitly or implicitly referred to or incorporated, or was specifically excluded, or this was not clear. For instance, this may include situations in which only the biological aspects of sexual and reproductive health have been referred to, or literature in which the researchers or authors have referred to SRH without attention to a rights component.

The burden of prominent SRHR issues and their determinants in South Africa has already been introduced in section 1.2.2 in the previous chapter. The following section will thus discuss responses for SRHR promotion in South Africa.
2.3 SRHR promotion in South Africa

2.3.1 Global response frameworks

Sexual and reproductive health and rights are enshrined in South Africa’s democratic, human-rights-based constitution (Cooper et al. 2016). Thus, South Africa’s legislative and policy responses have tended to parallel and support several key global strategic responses addressing SRHR. These include the WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programs (WHO 2007), and the United Nations’ Sexual and Reproductive Health Framework (UNFPA 2008). However, both of these peak-body strategies were developed within the context of the United Nation’s Millennium Development Goals (MDGs), a series of goals and targets for global development to be achieved by the end of 2015. The MDGs have, however, been superseded by the more contemporary Sustainable Development Goals (SDGs). SRHR has been recognised as critical for sustainable development (Brolan and Hill 2014, Hermann 2014), yet an explicit goal about SRHR is not contained in the SDGs. Rather, facets of SRHR are incorporated within other priority areas such as Goal 3 – Good health and wellbeing; and Goal 5 – Gender equality. The rights-based issues could also potentially be partly addressed through Goal 10 – Reduce inequalities; and Goal 16 – Peace, justice and strong institutions. These goals include targets which focus on increasing empowerment and inclusion irrespective of gender or sex (Goal 10), and reducing violence, abuse, exploitation and trafficking (Goal 16) which could include sexually-related forms of these activities. There do exist a range of other strategies from the WHO and United Nations Population Fund (UNFPA) which focus on specific SRHR issues (such as HIV, STIs, contraceptive use and unintended pregnancies, among others), or specific population groups (such as adolescents, transgender people, or men who have sex with men), but there is no current comprehensive SRHR strategy.

2.3.2 South African responses

The range of responses to address SRHR issues within South Africa span policies and strategic frameworks, service provision, prevention and awareness-raising campaigns, media campaigns and peer-education (Beksinska et al. 2014). The responses involve
government, non-government, community and private sectors, and overwhelmingly focus on addressing HIV (SANAC 2007; Department of Health [DoH] 2010; SANAC 2011) which is a current national health priority of the South African Government (DoH 2010; SANAC 2011). However, other emergent or concerning SRHR issues, such as other STIs, cervical cancer, unplanned pregnancies, and sexual and gender-based violence, receive relatively little strategic attention compared to HIV in current national SRHR strategies. For instance, South Africa has had sequential integrated National Strategic Plans on HIV, STIs and TB (known as the National Strategic Plan; herein NSP or the Plan) in recognition of the high rate of co-infection of HIV and other STIs (SANAC 2007, 2011, 2017a), but the Plans to date have focused predominantly on HIV with very little focus on issues of co-infection. The objectives of earlier versions of the Plan (2007 and 2011) comprehensively addressed HIV prevention, care, treatment, support, monitoring and surveillance, but in those iterations no other STIs were highlighted for specific attention or action.

Similarly, in relation to gender-based violence, while the last Plan [2012-2016] (SANAC 2011) did appear to incorporate some recognition of gender-based violence and inequities, it did so only in relation to this issue as a social determinant of HIV and STIs rather than being considered a priority issue in itself. Furthermore, Waldman and Stevens (2015) contend that a focus on sexual rights is lacking in the NSPs. This has led them to assert that “South Africa’s health policies are…characterised by a conceptualisation of sexual and reproductive health programming through HIV prevention activities, with less focus on rights” (p. 98). Cooper et al. (2016) also contend that while there have been substantial advancements in SRHR matters since the democratic transition of 1994, such as Choice of Termination of Pregnancy (CTOP) and LGBTI⁴ rights, progress on social justice issues related to SRHR has been mixed. This highlights areas that remain to be comprehensively addressed through national strategic plans.

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⁴ Various versions of this acronym exist, including LGBTIQ and LGBTIQA in which the ‘Q’ has been used variably to represent different characteristics or identities, including ‘questioning’ (meaning gender questioning) and queer, and the ‘A’ stands for asexual. Here, the acronym LGBTI is used as this was the scope and acronym adopted by Cooper et al. (2016) in the cited study.
The current Plan [2017-2022] (SANAC 2017a) does seem to be somewhat more comprehensive and encompassing of a broader range of SRHR issues compared with previous Plans. The current Plan does specifically list STIs among the strategic objectives, and has also stated objectives specifically related to rights-based action and outcomes. This is directly reflected in goal 5 of the Plan, which is to “Ground the response to HIV, TB and STIs in human rights principles and approaches” (p. xvii). The Plan reiterates a focus on addressing the social and structural drivers of HIV and STI infection, and addressing SRHR issues in a holistic way, and in a person-centred way. Thus, the current Plan in theory offers promise for addressing some of the gaps in previous plans.

Strategic responses at the national level highlight several priority groups for SRHR promotion, and also reveal gaps with regards to meeting the needs of several vulnerable or at-risk groups. Priority groups highlighted by national strategies include teenagers, with the specific National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019 (Department of Social Development 2015a) developed to address the needs of this group. Within the current NSP, key population groups identified include sex workers, transgender people, people who use drugs, people in incarceration, and men who have sex with men (MSM).

Somewhat contentiously, women who have sex with women (WSW) are not included as a priority population in the current plan. Daly et al. (2016) highlight the unmet need of lesbians, bisexual women, and women who have sex with women (WSW) in the current Plan, and advocate for their recognition as a priority population. This group was previously a priority in the 2007-2011 NSP, but was rescinded in the 2012-2016 Plan and the current Plan for 2017-2022. A policy analysis conducted by Rispel and Metcalf (2009) found a considerable factor influencing the inclusion of WSW as a priority group in the 2007-2011 plan was the high level of ‘actor power’ and engagement of key stakeholders in policy consultations, including WSW and the national advocacy group, the Treatment Action Campaign (TAC). The consultation process involved actors from the health sector, public sector, private sector and civil society, and was widely heralded as a success (Rispel and Metcalf 2009). Additionally, a broader social movement of civil society organisations
mobilising together around WSW sexual health and wellbeing helped influence the policy process and outcomes. However, the broader political and social context around WSW’s sexual health and wellbeing had changed by the time the subsequent plan for 2012-2016 was developed, contributing to the exclusion of this group as a priority population (Daly et al. 2016). This highlights the important influence community engagement can have on SRHR advocacy.

A key feature of national government responses has been national schools-based education initiatives (Gacoin 2016). Compulsory sexual health and sexuality education is delivered to all schooling youth through the national government’s Life Orientation (LO) program. The LO program is broader in scope than just HIV or SRHR education however, and includes education on life skills, and civic rights and responsibilities. A criticism levelled at the program is that the scope of the sexual health and sexuality components are limited as they focus on an abstinence-only discourse regarding STI prevention (Ngabaza et al. 2016). Also, while the program does address topics such as gender-based power, violence, sexual abuse, and sexual health outcomes (such as HIV and other STIs), matters of sexuality, sexual diversity, and LGBTIQ health and wellbeing are limited (Ngabaza et al. 2016). Other criticism include a shortage of trained educators to deliver the program in schools, and inadequate integration of the program into broader school policies to support program efficacy (Beksinska et al. 2014).

A range of other education-based interventions are delivered through the national non-government organisation, ‘loveLife’. However, a national evaluation of loveLife programs conducted three years after initiation revealed no significant difference in HIV and STI rates among young people in communities which received the program and those which did not. This led to conclusions that the awareness-raising generated through the intervention did not necessarily lead to positive health behaviour change (Beksinska et al. 2014). Furthermore, Gacoin (2016) argues that the nature of knowledge and education delivered through such interventions provide only a particular, narrow conceptualisation of sexuality (and youth sexuality in particular), and perpetuates normative stereotypes.
2.3.3 Community-based responses to SRHR

In addition to strategic frameworks, there have been a great deal of community-based programs implemented throughout South Africa to address SRHR issues. However as with – and in the context of – the strategic agendas, these have focused predominantly on HIV. Campbell and Cornish (2010) argue that the nature of community-based responses to SRHR issues in South Africa, and particularly those related to HIV, has evolved over the years. They developed a framework for conceptualising the various types of responses. Their work looked at HIV and AIDS responses specifically, but it could be reasonable to expand this conceptualisation to responses to SRHR more broadly. The framework theorises that programmatic responses (as distinct from policy responses) have developed from an initial period focusing on awareness-raising interventions, to peer-education-based interventions, to a present focus on community mobilisation. However, they contend that approaches to date have largely failed to take account of the contextual factors influencing program outcomes. This has led them to advocate for a new “fourth generation” (p. 1575) of approaches to enhance community mobilisation in HIV and AIDS interventions – one which considers the context of interventions. This framework is only one way of conceptualising the vast array of response types which have been implemented in South Africa, however. Other terms used in literature to describe the various types of responses include education, information-education-communication (IEC) campaigns, behaviour change, peer-led, participatory, empowerment-based, communication campaigns, social and behavioural communication campaigns, and mass-media campaigns, among others. Some of these terms are fluid or may be used interchangeably, or may be subsumed within others (for instance, mass-media may form one part of communication campaigns). For the purposes of the discussion below, Campbell and Cornish’s (2010) conceptualisations will be used to provide a broad structure for considering some of the literature about different community-based SRHR interventions in South Africa.

Communication and Awareness-raising approaches

Community-based communication and awareness-raising approaches have been popular in South Africa, and have taken various forms including population-based, mass-media based, IEC campaigns and other forms of communication campaigns. They are not necessarily
distinct from other categories of responses; for instance, awareness-raising is often a cornerstone of peer-education and community mobilisation initiatives. For the purposes of this discussion, the term is used to refer to responses where the primary purpose of the approach is information delivery in a didactic manner, received by an audience in a passive fashion.

Despite a plethora of communication and awareness-raising campaigns having been delivered at national and local-community levels by various levels of government, non-government organisations (NGOs) and other sectors (including the health care sector and media/‘edutainment’ sector), published evaluations of such initiatives are relatively scarce. The evidence available tends to show that communication and awareness-raising initiatives have had some good effect in terms of reach and impacts on SRHR behaviours. A review of communication strategies conducted by Scalway (2010) found that over 90% of the South African population has been reached by an SRHR awareness program. However, there is some variability in reach across regions. For instance, the most recent national evaluation of communication programs found that in the Eastern Cape, reach was as low as 67% of the population (Johnson et al. 2013). Exposure was also lower among those of lower educational status, and living in peri-urban areas compared to those of higher educational attainment and living in urban areas (Johnson et al. 2013). In relation to impacts on SRHR-related behaviours, results for two major national mass-media awareness-raising campaigns, Siyayinqoba and Soul City, revealed a higher rate of condom use or likely condom use among those who had been exposed to the campaigns (23% and 17% higher for Siyayinqoba and Soul City respectively) compared to those who had not been exposed (Scalway 2010).

The method of communication in this type of intervention has also been found to influence program outcomes. There are mixed findings about the effectiveness of multimedia and interpersonal communication methods (Peltzer et al. 2012, Beksinska et al. 2014), while Johnson et al. (2013) contend that interpersonal communication could be more effective to reach populations of a low socio-economic status.
It is possible that some of the variability in findings about the effectiveness of communication and awareness-raising initiatives could be in part due to how ‘effectiveness’ is defined and measured. For instance, Scalway (2010) and Johnson et al. (2013) both posit that the efficacy and effectiveness of communication and awareness-raising interventions should not be measured in terms of the direct impact on incidence or prevalence of health conditions (such as HIV rates). Rather, these types of interventions seek to change the mediating factors. Thus, the range of outcomes measured and reported in the literature is vast, and includes knowledge, attitudes (including stigma), and behaviours (such as contraception use and HIV testing and counselling), so meanings of ‘effectiveness’ are variable and comparability of ‘effectiveness’ is challenging. Also, definitions of an ‘awareness-raising’ intervention may vary, thus influencing which interventions and/or components of interventions are evaluated. It may also be difficult to attribute any outcome to one particular awareness-raising intervention, as interventions often do not occur in isolation from other interventions occurring simultaneously in communities. The most recent National HIV Communication Survey found that individuals were exposed to an average of four awareness-raising communication programs in the twelve months prior to the survey (Johnson et al. 2013).

While awareness-raising is an important facet of health promotion, contemporary health promotion theory posits that effective and sustained health promotion requires a multi-faceted approach (WHO 1986, Naidoo and Wills 2016). Thus, community-based responses to SRHR promotion tend to have evolved beyond awareness-raising to be more comprehensive, and encompass other facets. Peer-education and empowerment approaches extend on awareness-raising by incorporating aspects of the social environment and skill development to support health changes.

Peer-education
Peer-education approaches have been particularly popular in community-based interventions globally and in South Africa (Campbell and Cornish 2010), especially for interventions aimed at youth (Harrison et al. 2010). Kelly et al. (2006) reported that at one stage peer-based approaches were used by more than 60% of HIV prevention interventions in Africa,
which was more than double the rate for other regions across the world. This type of intervention seeks to provide information and awareness, as well facilitate positive behaviour change through skills development and capacity building. It also seeks to positively influence peer-based social norms and attitudes which subsequently influence SRHR behaviours and outcomes (Swartz et al. 2012). However, the international evidence on the effectiveness of peer-education interventions suggests that overall they are ineffective in improving SRHR outcomes, including knowledge, attitudes and behaviours (Chandra-Mouli et al. 2015). In South Africa, they have demonstrated varying success (Harrison et al. 2010), with inconsistent evidence regarding achieving a breadth of program goals such as increasing safe sexual behaviours, decreasing STI transmission, or increasing community empowerment outcomes. The evidence also shows mixed experiences regarding engaging community members (Cornish and Campbell 2009). Reasons for program failure include technical program factors such as inappropriate content of programs, inappropriate format or methods of delivery, and/or inappropriate selection and training of peer-educators (Cornish and Campbell 2009, Chandra-Mouli et al. 2015).

Community mobilisation
Community mobilisation is an approach based on principles of community engagement, agency, capacity building and empowerment, designed to have radical transformative impacts on the community (Campbell 2014). The concept is not universally defined, and has been used to mean the same thing as other like concepts such as community participation or community engagement (Cornish et al. 2014). Community mobilisation can be externally driven by organisations or internally generated at the grass roots of the community (Cornish et al. 2014), and can take different forms. For instance, an instrumental form positions the community as a channel through which external or donor agency programs can be delivered (Campbell 2014). Thus, an instrumental form of community mobilisation could be considered a relatively passive form. In contrast, a critical form of community mobilisation views the community as empowered and active agents in seeking social, political and structural changes to take control of, and improve, their health (Campbell 2014).
Community mobilisation approaches have been increasingly applied to SRHR promotion, in particular HIV interventions (Lippman et al. 2013, Cornish et al. 2014). Cornish et al. (2014) undertook a systematic review of twenty studies to determine the effectiveness of mobilisation approaches on a range of outcomes including biomedical, social and behavioural outcomes. The review found some consistent evidence of effectiveness on social and behavioural outcomes for some vulnerable population groups such as sex workers and MSM. The review also sought to identify the conditions under which mobilisation approaches are most effective. It revealed effectiveness was enhanced if the socio-political context was addressed and if mobilisation strategies were accompanied by structural interventions. Thus, community mobilisation and the community context are intricately linked. However, the findings need to be considered with some caution given that the definition of community mobilisation is not universal; the authors placed parameters around the definition of the concept for their review for practical reasons, thus some potentially relevant studies may have been omitted from their review. The systematic review included studies from multiple countries, so some findings may not have contextual relevance to South Africa. Also, the findings revealed inconsistent and overall inconclusive evidence of effectiveness of mobilisation approaches for some populations such as youth, as well as the general population. The authors considered this was likely due to limitations of the studies rather than the mobilisation approaches. Thus, more exploration of mobilisation strategies in a contextually specific way and with certain populations is needed.

Community context

The need to consider SRHR promotion interventions within the broader community context is an emergent focus of responses. It is now widely recognised that a range of factors beyond individuals’ control influence sexual health risk behaviours and SRHR outcomes (WHO 2010a, Phillips and Pirkle 2011, Khalema et al. 2015, Sommer and Mmari 2015, SANAC 2017a, UNFPA 2017, 2018). These factors include social factors such as the influence of family and friends; environmental and community factors such as safe and secure housing and other safe places, access to health services, societal attitudes regarding sexuality, and gender-based norms and inequalities; and economic and structural factors such as poverty, access to employment, and access to educational opportunities (Scalway
Early work by Campbell (2003) identified a key reason interventions failed was that they did not take into account community needs and context. Campbell found that despite many programs endeavouring to be community-based and involve the community, many remained top-down and were imposed on communities by external organisations. Later work by Cornish and Campbell (2009) supported that earlier work, reinforcing that community context is important to consider, yet Sommer and Mmari (2015) contend many interventions still fail to consider the broader contexts which influence SRHR determinants and outcomes.

The need to consider the community context in responses is demonstrated by an evaluation of the PREPARE intervention in the Western Cape of South Africa. The PREPARE intervention was a school-based intervention aimed at decreasing HIV risk through sexual risk behaviour change and the reduction of intimate partner violence (IPV) (Mathews et al. 2016). This initiative was multi-faceted, including an education-based component, delivery of a school health service, and a school-based safety program. The evaluation found that while the intervention did have positive effects on HIV knowledge and reduced self-reported incidents of IPV among the school-going participants, it had no effect on sexual risk behaviours. The researchers suggested this may have been due to social and environmental factors which constrained and undermined the impacts of the intervention. For instance, while the intervention focused on creating a safe school environment, it did not address safety in home environments or other social protections, or secure livelihoods, which influence risk behaviours (Mathews et al. 2016).

Cornish and Campbell (2009) identified some of the contextual factors influencing program outcomes include the social organisation of a community, the level of community resources, the level of community social and/or economic marginalisation, the position of the peer-educators as ‘insider’ or ‘outsider’ to the community, and social context which may influence the capacity of community members to enact program messages (such as a limited capacity for individuals to exercise control over their own sexual encounters). Their further work highlighted three dimensions of the social context as particularly critical to consider:
the material context (community and program resources available), the symbolic context (the meanings, ideologies and world views dominant in a society), and the relational context (the nature of group dynamics and leadership structures, including gender relations) (Campbell and Cornish 2010). Gacoin’s (2010, 2016) work evaluating loveLife initiatives further supports the need for the unique context of any situation to be considered in the design and delivery of community-based initiatives. Gacoin (2010) argued that many South African SRHR interventions addressing sexuality and HIV have presented “easily packaged ‘norms’ for [HIV] prevention” (p. 430), and the contextual meanings of gender, sexuality and sexual identity have not been critically interrogated in many cases. This suggests the many interventions are de-contextualised from their symbolic and relational contexts, and greater attention needs to be given to these areas.

A significant example of this kind of contextual approach is provided by the South African non-government organisation, the Soul City Institute for Social Justice (herein referred to as Soul City). Soul City is a social and behaviour change communication project delivered nationally throughout South Africa. The program is multi-faceted and includes several ‘edutainment’ television series’, peer-training, and awareness-raising campaigns. The program adopts a socio-ecological model to address the individual, social and structural influences on health behaviours. This model recognises that multiple contextual factors - including individual, socio-economic, cultural and political factors - interact to shape health behaviours and outcomes at the individual, community and societal levels. Strategies seek to address and positively change individuals’ knowledge and behaviours, as well as community and societal norms (Perlman et al. 2013). However, organisational evaluations of the efficacy of the interventions are done based on individual series’ or campaigns, with several gaps existing. For instance, the most recent evaluation report for their flagship edutainment series, Soul City (Series 12) was undertaken in 2015 (Soul City Institute 2015). This evaluation was of audience reception of the program, but did not evaluate the impacts on health outcomes or people’s engagement in health behaviour change. Prior to that evaluation, the last published evaluation able to be obtained from the organisation was of series number seven (Health and Development Africa and Markdata 2007). This reveals gaps in the body of evidence of comprehensive, community-based interventions.
Consideration of the social and relational contexts of interventions highlights the role of habitus (Bourdieu 1977) in shaping individuals’ experiences of their worlds. Habitus refers to the objective structures that exist in society, and one’s subjective interpretations of those, which shape everyday thoughts, behaviours and experiences within one’s social context (Bourdieu 1989). Entwined with experiences of habitus are the various forms of capital one has access to including economic, cultural, symbolic and social capital (Bourdieu 1989). This is discussed further in chapter eight. It is relevant to introduce these concepts here, however, as Campbell and Cornish (2010) argued that the relational social context and social capital are important aspects to consider in contemporary SRHR promotion work.

Social capital is the constitution of norms, values, trust, relationships and resources in society (Putnam 1995). Szreter and Woolcock (2004) identified three forms of social capital – bonding, bridging and linking capital. Bonding social capital refers to norms, relationships, trust and reciprocity existing between groups on a horizontal plane; that is, groups who consider themselves similar on the bases of social identity. Bridging social capital refers to these types of cooperative and reciprocal relationships occurring between social groups across a vertical plane; that is, between groups distinguished by social hierarchies. Thus, bonding and bridging capital are highly contextual and based on socially constructed group identities. Linking social capital is that which connects groups to more institutional or formalised divisions of power and authority (Szreter and Woolcock 2004). However, Bourdieu (1986, 1989) also contended that social capital can also serve an exclusionary function by reinforcing social class inequalities.

Social capital has been linked to social support and social equality or inequalities, and to political, economic and cultural factors which can influence SRHR issues and interventions (Chen and Meng 2015). The form(s) and extent of social capital present in a community contribute to the social conditions in which programs occur, and subsequently influence the program success (Campbell and Cornish 2010). Thus, understanding the social context of communities, including group identities, relationships and interactions, and communities’ access to opportunities and resources for making and sustaining positive health changes,
could further understanding of how and why groups in society engage or not with SRHR promotion.

While social capital can contribute to the success of community-based SRHR interventions, a range of other factors are also crucial for the success and sustainability of interventions. One key factor is the level of community engagement in a program (Popay et al. 2007; International HIV/AIDS Alliance 2010; Orza 2011; WHO 2011a). The following section provides a more detailed discussion of the literature pertaining to community engagement in SRHR promotion.

2.4 Theory and concepts of community engagement

2.4.1 Conceptualisations of ‘community’: a contextual construct

Community engagement is important for the success and sustainability of community-based health interventions. It is a central tenet of policy and practice of governments and organisations globally, including the World Health Organization (Commission on the Social Determinants of Health [CSDoH] 2008; Attree et al. 2011). However, community engagement is challenging. One key challenge is identifying ‘community’. ‘Community’ is a multifaceted and complex concept, and both plural and changing in nature; that is, no one type of community exists, but rather multiple types of communities have evolved and existed over time (Krause and Montenegro 2017). Communities can be place-based (with an emphasis on geographic boundaries), non-place based (with an emphasis on relational and emotional ties, collectivism and solidarity), or established on a combination of these things (Krause and Montenegro 2017). Cohen (1985), in foundational work on the construction of community, diverged from the traditional notion that ‘community’ was based on structural or categorical aspects, and posited instead that communities are interpretive, and define themselves on the basis of symbolic constructions such as a shared language or behaviour. Similarly, more recently Chiu (2008) contended that ‘community’ is a socially constructed concept, influenced by the combination of multiple factors including language, socio-political and cultural factors. Chiu argued that defining communities by categorical variables like ethnicity can be problematic as doing so ignores diversity within groups, such
as cultural, linguistic, socio-political and historical migration diversities. For instance, through participatory community health interventions, Chiu found that some people who shared a common language did not necessarily share other aspects of identity or group membership; rather, they sought to assert symbolic points of difference in other characteristics and self-identify as ‘other’. Additionally, different views about community identity existed within language and ethnic groups. This highlights that ‘community’ is constructed in varying ways and needs to be understood contextually in any given situation.

In the South African context, an important concept to consider in relation to community is *Ubuntu*. *Ubuntu* is a social and cultural philosophy which emphasises collectivism, and a shared humanity and existence, over individual interests and needs (Mangena 2016). The concept also emphasises the role of human interdependency in the construction of identity and outcomes of wellbeing (Murove 2014). A common colloquial understanding of the concept is encapsulated by the phrase, “people are people thru [sic] other people” (South African Ubuntu Foundation 2011). In their White Paper for Social Welfare, the South African Department of Social Development (1997), explained *Ubuntu* as: “the principle of caring for each other’s well-being and as a spirit of mutual support. Each individual’s humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual’s humanity. ... It also acknowledges both the right and responsibilities of every citizen in promoting individual and societal well-being” (p. 12).

*Ubuntu* is embedded within many African societies and cultures and thus often termed an ‘African’ philosophy, and perceived as differing from Western values (Mangena 2016). However, Mangena (2016) provides a critical, post-modern discussion of *Ubuntu*, positing that it should not, and cannot, be validated by comparing it with Western values or philosophies as there is no one truth, but rather multiple cultural experiences and subjective truths. Likewise, Tomaselli (2016) also cautioned against labelling *Ubuntu* as a common ‘African’ philosophy, arguing that doing so presents an essentialist view which homogenises the diverse African populations as one rather than acknowledging the immense diversity between and within various African populations.
Ubuntu has also been linked to notions of power and individual freedoms. Tomaselli (2016) took a critical perspective on Ubuntu, arguing that Ubuntu is linked to power, access to resources, communication networks, and meaning-making, and thus can be a form of either inclusion or exclusion. Chasi (2014) contended that the concept of Ubuntu could be misappropriated by those in power to limit individual freedoms of others, and contribute to immoral actions and consequences such as corruption and exploitation. However, Chasi himself argued that Ubuntu is not a form of collectivism which denies individual agency or expression. Rather, he posited Ubuntu is oriented toward individuals achieving their own potential for the benefit of the community, and thus freedom of expression to pursue and achieve those outcomes is necessarily part of Ubuntu, and contributes to governance of the community.

In relation to South Africa, Murove (2014) contended that Ubuntu is best understood in relation to experiences of dehumanisation under apartheid, and so represents the antithesis of such dehumanisation. That is, Ubuntu promotes the values that people are accountable to one another, and people experience this accountability through relationships with one another; this promotes consideration for the needs of others, rather than the values of elitism, self-interest and individualism which were fostered under apartheid (Murove 2014). Understandings of Ubuntu extend beyond inter-personal relationships and accountability, however, and also encompass relationships with the natural world and environment, and the spiritual world and ancestors (Murove 2014, Mangena 2016). Thus, while Ubuntu is not akin to a definition of ‘community’, it may be helpful in understanding the concepts and values underpinning ‘community’ in the South African context. It suggests that in this context, ‘community’ is based on numerous relationships, shared values and a sense of connectedness across multiple domains.

Ubuntu has been found to be an underpinning driver of community members’ engagement in health care-giving in South Africa (Schwartz 2013, Klemz et al. 2015). However, contentions about the continued strength and nature of Ubuntu among the South African population are reported. Schwartz (2013) undertook an ethnographic study of the way community-based health care workers construct their caregiving roles. Her findings revealed
a perceived fragmentation between older and younger generations of community health workers. Many community health workers considered to be of the older generation (being older in age, and/or professional experience by having experienced work under the apartheid government) perceived that the younger generation of community health workers had ‘lost’ the values of *Ubuntu* in their caring roles, and were instead motivated in their roles by upward economic and social mobility. However, Schwartz asserted that this was not simply a division of the generations; rather, it represents how community health workers construct legitimacy regarding their work in relation to each other and the social context (pre- and post-apartheid). That is, Schwartz argued that the older generation located their experiences of work in relation to *Ubuntu*, formed in the context of social and economic hardship during apartheid, in that, “an understanding and memory of ubuntu are mapped onto the community care work that older women provide today—they have what they describe as a “passion” for caring that stems out of a “cultural” inclination toward ubuntu, which younger CHWs [community health workers] are described as lacking.” (p.147). This highlights the complex and contextual role of *Ubuntu* in experiences of community, and community engagement in health, in South Africa.

### 2.4.2 Conceptualisations of ‘community engagement’: also a contextual construct

As with the concept of ‘community’, there is no standard definition of ‘community engagement’. A range of definitions of community engagement are presented in Table 2.1. The definitions highlight some commonalities in conceptualisations of community engagement, such as engagement being a process, and involving a range of undertakings from information provision through to capacity building. These concepts are discussed further below.

The term ‘community engagement’ is often conflated in the literature with several other similar concepts such as community involvement or participation, and the term ‘community engagement’ is often used interchangeably with involvement or participation. However, a critique of definitions presented in literature (see Table 2.1) reveals that that the concept of community engagement goes deeper than a statement about community participation, to consider the various forms of meaningful participation, the processes by which community participation occurs, and the outcomes of such meaningful participation. For instance, Popay
(2006) and Lambat and Lambat (2011) both refer to a continuum of actions involving the community, from ‘informing’ in which the community are passive recipients of information, through to co-production in which the community are creators and have a degree of self-determination. In terms of processes, community engagement emphasises communities’ self-determination in prioritising their own needs, and collaboration including the formation of partnerships, developing a shared vision, and undertaking collaborative action (Centre for Disease Control [CDC]/Agency for Toxic Substances and Disease Registry [ATSDR] Committee on Community Engagement 1997, Frew et al. 2008, Nakibinge et al. 2009). Thus, community engagement necessitates a decentralisation of power (Attree et al. 2011).

With regards to community outcomes, community engagement is oriented toward enhancing community capacity and empowerment (CDC/ATSDR Committee on Community Engagement 1997, Popay 2006, Chiu 2008, Attree et al. 2011), and developing strong and sustainable communities underpinned by strong relationships (Lambat and Lambat 2011).

Community engagement also considers the social and structural contexts. Lambat and Lambat (2011) consider that community engagement utilises and seeks to strengthen existing relationships of trust between communities and organisations, and between citizens; in this sense, bridging and bonding forms of social capital are highlighted as central to community engagement. Foundational principals stated by Logsdon (1978) include that community engagement should seek to involve local leaders, recognise local forms of governance and leadership, and importantly, should appeal to local social norms and values.
Box 2.1: Definitions of community engagement

Centre for Disease Control (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) Committee on Community Engagement (1997: xv): “…the process of working collaboratively with groups of people affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being”.

Popay (2006: 2): “An umbrella term encompassing a continuum of approaches to engaging communities of place and/or interest in activities aimed at improving population health and/or reducing health inequalities. The goals of community engagement can range from the provision and exchange of information and consultation at one end of a continuum to co-production of services/activities and communities control of activities to improve health”

Tindana et al. (2007: 1452): community engagement “goes beyond community participation; it is the process of working collaboratively with relevant partners who share common goals and interests”. This involves developing authentic partnerships with power sharing and mutual respect, and which are mutually beneficial.

Chiu (2008: 152): “… engagement means that members of the community are systematically involved … in all aspects of planning, implementation and evaluation of health promotion programs”, with an emphasis on capacity building for empowerment.

Lambat and Lambat (2011: 9): “Community engagement consists of informing, consulting, involving, listening and responding to communities through ongoing relationships ….Community engagement builds on relationships of trust between agencies and communities and allows communities to influence services and neighbourhood improvements. It also helps to build strong, resilient communities with active citizens and strong social networks”

Community engagement approaches are applied to a wide range of public health interventions that have diverse goals. Thus, there is no single value base underpinning community engagement, and no one approach to community engagement (Popay 2006). Rather, the practice of community engagement is contextual. Given this, there is no singular model conceptualising community engagement which can be used by program planners and practitioners to guide them in their practice; rather, an array of models abounds. One widely accepted model (see Milton et al. 2011) is Popay’s (2006) conceptual framework for community engagement (Figure 2.1). This framework presents community engagement as a continuum of approaches, depending on the desired outcome, from information provision through to full community control. The framework depicted in Figure 2.1 does not articulate the methods for practicing community engagement; rather, this is left generalised, reflecting the vast range of methods which may be applied, depending on the approach or desired outcome, and the context of a project (including the scope and scale of a project, financial
resources and human resources, among other factors). However, in a discussion of the framework, Popay (2006) does suggest examples of common methods such as community forums, community committees or panels, and participatory program research or evaluation, among other things.

**Figure 2.1: A conceptual framework for community engagement**

![Conceptual Framework for Community Engagement](image)

Source: Popay (2006: 6)

Popay then took the framework a step further to apply it to the context of health actions and outcomes. The resultant model of pathways from community engagement to health improvement (Popay 2006) is presented in Figure 2.2.
This model highlights four key pathways through which health improvements can occur when the various approaches to community engagement (depicted in Figure 2.1) are applied. These pathways are service improvements, enhancing social capital, improving social and material living conditions, and enhancing community empowerment, to contribute to improved health outcomes. The different approaches to community engagement correspond with particular mediating pathways; for example, an ‘informing’ or ‘consultation’ approach to community engagement can lead to improved health outcomes through the pathway of improved services, but does not correspond with increased social capital or community empowerment to contribute to better health outcomes.

These pathways also correspond with the outcomes of community engagement, ranging from short-term downstream outcomes such as service delivery experienced by individuals, through to longer term upstream outcomes experienced at the community or societal level,

Source: Popay (2006: 9)
such as improvements in socio-economic conditions and reductions in health inequalities. The model depicts that community engagement, participation and empowerment are related; as one moves along the continuum from rudimentary forms of engagement such as ‘informing’ to higher levels of engagement such as ‘community control’, the level of community participation increases, as does progression toward community empowerment. This model also suggests there is a relationship between community engagement and social capital; higher levels of community engagement contribute to greater social capital as an intermediate outcome. In this way, social capital and community engagement in interventions are interdependent. This suggests that community engagement processes and outcomes may be influenced by the broader context of various forms of capital present in a community or society.

However, several limitations of this model exist. The first is that it represents approaches and pathways to community engagement as discrete and linear, rather than capturing the dynamic and iterative nature of community engagement. While the model does not explicitly represent a temporal element, it does represent the actions from ‘informing’ through to ‘community control’ as being undertaken in a stepwise order alongside an also-linear trajectory of increasing community participation, empowerment and control. The model does not depict potential for moving back and forth between actions, or for multiple actions to be occurring either out of order or simultaneously. Second, while the model does highlight various domains of outcomes, it does not represent the factors influencing engagement, including individual, cultural, social or structural determinants. Thus, while this model and others like it do articulate common actions in community engagement, greater interrogation of the contextual influences on community engagement is needed to help understand and inform its practice.

Community engagement regarding SRHR promotion specifically is an increasing priority of peak health bodies. The WHO (2011a) identified community engagement as one of the core competencies of primary care for SRHR issues. Despite this acknowledgement, there is little theory to guide community engagement in SRHR promotion practice, and even less which is specific to the South African socio-cultural context. That which does exist is discussed in the following section. From the review of the literature to this point, it becomes apparent
that while there do exist frameworks to guide SRHR program responses, and models to conceptualise community engagement, there is no model which brings together community engagement and SRHR promotion, or influences on community engagement in SRHR promotion, to inform understanding and practice in this area.

2.5 Understanding and practicing community engagement in SRHR promotion in South Africa

2.5.1 Meanings of ‘community engagement’ with regards to SRHR promotion

As outlined above, ‘community engagement’ is a contextual concept. Therefore, the meaning of ‘engagement’ in any given community or situation needs to be understood contextually for successful community engagement. With regards to community engagement in SRHR promotion, very little literature provides insight into meanings of community engagement. That which is available reveals meanings of community engagement in relation to SRHR promotion are closely linked to broader community-level social capital and community-level outcomes rather than individual-level experiences and outcomes. For instance, Tucker et al. (2013) explored volunteer health workers’ experiences of community engagement among MSM in Cape Town, South Africa. They found the emphasis of community engagement for this group was on creating links between individuals and various groups which existed in society, which was akin to bridging social capital. Similarly, the emphasis of community engagement among this community was also on building links across different groups in society (such as the MSM and health workers), which reflects bridging social capital. It is important to note, however, that these perspectives were from the volunteer health workers rather than the MSM themselves. Nevertheless, the insights of these community insiders reveals that the meaning of community engagement in this context was linked to social capital (previously discussed in section 2.3.3 above).

A further aspect of the meaning of community engagement revealed through Tucker et al.’s (2013) research was a pre-eminent concern among some community members for the wellbeing of others and the broader community. For instance, the authors discussed their
own concern to avoid overburdening program volunteers with excessive training for the intervention they were delivering. However, the volunteer workers themselves refuted this concern, and expressed a desire for more training. The volunteer workers’ rationale for this was that they wanted to be better able to assist the MSM community, and were of the view that a greater amount of training would help them to do this. This desire superseded any concern for their own workload. From this, it could be inferred that in this situation, the meaning of community engagement for the volunteer health workers was centred on achieving community-level wellbeing rather than on their own experiences of their participation in the program. Thus, it seems that the meaning of community engagement in this context also has resonance with the philosophy of Ubuntu (discussed above in section 2.4.1). However, it is worth noting that this is an interpretation of the study findings, as the question about the meaning of community engagement was not explicitly asked by the researchers in this study. Also, the informants for the research were community volunteer health workers, rather than the population of interest for the SRHR intervention (the MSM population). Thus, further exploration of the meaning of community engagement among populations to whom SRHR interventions are aimed is still needed.

2.5.2 Influences on community engagement in SRHR promotion

There exists a body of literature about influences on, and processes of, community engagement in SRHR promotion initiatives in South Africa. However, much of the literature pertains to community engagement in clinical trials and interventions (Ellen et al. 2010, Ramjee et al. 2010, Essacka et al. 2012, Koen et al. 2013, Newman et al. 2015, Lippman et al. 2017, Baron et al. 2018, Lippman et al. 2018, MacQueen and Auerback 2018, Newman et al. 2018); there is much less about engagement in community-based health promotion interventions. There may some commonalities in the contexts and influences on engagement in clinical trials and community-based health promotion, such as a legacy of historical mistrust between researchers and the community, and the role of gatekeepers (Ellen et al. 2010, Newman et al. 2015, Newman et al. 2018). However, engagement in clinical trials and community-based health promotion also have distinct differences, with different models developed to guide engagement which are specific to each context (Lau et al. 2011, the Joint United Nations Programme on HIV/AIDS–AIDS Vaccine Advocacy Coalition’s 2011,
MacQueen et al. 2012, Community Partners 2014). Thus, more understanding about community engagement in community-based SRHR health promotion is needed to increase the relative scarcity of evidence specific to this context compared to the clinical trial context. The focus of this discussion is restricted to the smaller body of literature from both South African and international contexts about influences on community engagement in community-based SRHR promotion. Multiple factors have been found to influence community engagement in SRHR promotion interventions, and these may be broadly grouped as program factors and community factors. These two groups of factors are discussed below.

**Program factors**

A range of program factors were cited in the literature as factors influencing community engagement in SRHR promotion. Program factors include things such as the theoretical approach to the program (Mosavel et al. 2005, White 2006, Buthelezi et al. 2007, Simon et al. 2007, Kim and Free 2008, Pietrzyk 2009, Harrison et al. 2010, Nystrom et al. 2013, Lorway et al. 2014), the program aim and objectives (Wilbraham 2008, Nakibinge et al. 2009), and the program messages (Mosavel et al. 2005, Wilbraham 2008). It is noteworthy that the body of literature discussing program factors tended to present evidence from the viewpoint of program practitioners rather than community members perspectives or experiences of their engagement.

The theoretical approach of health promotion interventions was a key programmatic factor discussed by several authors as an important influence on community engagement in any intervention (Mosavel et al. 2005, White 2006, Buthelezi et al. 2007, Simon et al. 2007, Kim and Free 2008, Pietrzyk 2009, Harrison et al. 2010, Nystrom et al. 2013, Lorway et al. 2014). Literature from both South Africa and the broader international context discusses various types of programmatic approaches to community-based SRHR promotion with regards to community engagement, including peer-based approaches, community-based participatory (CBP) approaches or community-based participatory research (CBPR), and arts-based approaches. Some of these have been introduced previously in section 2.3.3 as
approaches to SRHR promotion generally, but here the discussion will focus on their utility with regards to community engagement.

CBP and CBPR approaches are widely advocated for engaging members of hidden or hard-to-reach populations, or when the issues concerned are sensitive or stigmatised. For example, a study in India (Lorway et al. 2014) found that using a CBPR approach was effective in engaging the hidden community of MSM and male sex workers (MSW). This kind of approach has been successfully used over a prolonged period of time, having also been successfully used for engaging communities in health promotion about cervical cancer in Cape Town, South Africa (Mosavel et al. 2005; see also Simon et al. 2007). Both Lorway et al. (2014) and Mosavel et al. (2005) provided a detailed account of how a CBPR approach was applied to engage the community in SRHR research and interventions. In both instances, the CBPR approach was found to promote a sense of empowerment and self-efficacy among community members by enabling them to take a leading role in determining the course and processes of conduct of the research. In the South African study (Mosavel et al. 2005), opportunities were provided for community control and capacity building through the establishment of a community advisory group to inform and guide the intervention processes; through the recruitment and training of local people as focus group facilitators and outreach workers; through community involvement in the designing and testing of data collection instruments; and through a shared division of labour between researchers and community participants in data collection and analysis. The researchers acknowledged, however, that they commenced with a pre-determined research question. This contrasts with popular theory about CBPR which contends the research question should be shaped by the community (Simon et al. 2007). However, through the process of CBPR, the research question was reshaped by the community members to better reflect their emergent concerns and priorities. Thus, the CBPR approach provided community members with opportunities for self-determination and control over the SRHR intervention as a method of community engagement. It is notable, however, that the literature in this context is now rather old and more contemporary evidence is needed, particularly given the developments and changes in approaches over time as described by Campbell and Cornish (2010).
The peer-based approaches which have been popular in SRHR program design both in South Africa (as previously discussed in section 2.3.3) and globally have also been found to be successful in facilitating community engagement in SRHR promotion in some situations. A peer-based approach was combined with the CBPR approach adopted by Mosavel et al. (2005) and Lorway et al. (2014) discussed above, as well as others (for example, Nystrom et al. 2013). International studies, such as that by Nystrom et al. (2013) conducted in the U.S., have found peer-based approaches facilitate a sense of trust and rapport between the community and the research team, and among the community members, and thus facilitates enhanced community engagement. In Lorway et al.’s (2014) study with MSM and MSW in India, a peer-based approach was found to be particularly effective as it was used concurrently with the strategy of disclosure by the peer-researchers of their own status as MSM and/or MSW. The researchers found this helped to build a sense of trust, safety and comfort among the community participants, as the participants were able to find commonalities and empathetic understanding in the researchers, and this enhanced their engagement. It also contributed to rich and open personal accounts being communicated by participants, and enabled stigma to be addressed and overcome.

However, while some studies have found a peer-based approach to community engagement in SRHR promotion to be beneficial, overall, the broader body of literature regarding the effectiveness and appropriateness of peer-based approaches for community engagement has been contested over time (Kim and Free 2008; Harrison et al. 2010). Some researchers found that with specific reference to sensitive SRHR issues, the effectiveness and appropriateness of the use of peers as program facilitators is itself mediated by the personal characteristics of the facilitator. For example, Elazan et al. (2016) highlighted that certain personal characteristics of peer-facilitators, such as gender, were influential factors in the Indian context. Elazan and colleagues found that engaging male health activists (MHAs) as community health workers alongside female community health workers around reproductive and maternal health issues in rural India had positive impacts for community engagement. This strategy was found to be effective in engaging more men from the community in family planning and antenatal care initiatives. The male health activists also assisted other female community health workers to be able to more effectively engage with hard-to-reach populations in rural communities in this traditionally patriarchal society, and increase
overall community engagement in outreach services. The authors highlighted the capacity for, and importance of, gendered community health worker roles in reproductive health promotion to enhance community engagement and subsequent program outcomes.

Similarly, in the South African context specifically, Francis and Hemson (2009) found that gender, age, race, social position and relationship to the community (as insider or outsider) were important potential mediating factors in the engagement between youth peer-researchers and youth participants, however the nature and direction of the relationships were not greatly detailed. They concluded that using peers as facilitators had both advantages and limitations for community engagement. This highlights the contextual nature of community engagement, and Campbell and Cornish’s (2010) contention discussed above (in section 2.3.3) that the broader context of the community (including the social, cultural and political contexts) needs to be closely considered. Thus, it is important that the potential role of facilitators in engaging community members in SRHR interventions in contemporary rural South African communities is investigated in a contextual way in order to better facilitate community engagement in interventions.

Arts-based approaches have also been widely and increasingly utilised over time and across diverse cultural settings, including in South Africa, to promote community engagement in health promotion interventions (White 2006; Buthelezi et al. 2007, Pietrzyk 2009). One of the most prominent and wide-reaching arts-based initiatives in South Africa is the ‘Soul City’ program (discussed previously in section 2.3.3). Arts-based approaches adopt a holistic approach to health, and to personal and community development more broadly (Buthelezi et al. 2007). Pietrzyk (2009), in conducting an ethnographic analysis of cultural activism related to HIV prevention in Zimbabwe, posited that arts-based approaches to health promotion acknowledge and legitimise diverse and multiple forms of knowledge, particularly regarding complex issues such as HIV. These approaches highlight the important role of informally structured activities and interventions, particularly in contexts in which formal structures and institutional knowledge are privileged (Pietrzyk 2009). Buthelezi et al. (2007) found that an arts-media based approach was effective in engaging youth in KwaZulu-Natal, South Africa, in discussions about sexual health and thus in developing understanding about youth perspectives on sexual health issues. It is possible
that such an approach could also be relevant to engaging youth in a range of broader SRHR promotion interventions, or the wider community in sexual health promotion. Pietrzyk (2009) contended that arts-based approaches could also be advantageous in facilitating wider civic engagement beyond the focus or intentions of an intervention.

However, one shortcoming of arts-based approaches cited in the literature is their inability to sustain community engagement in some contexts. White (2006) found that some arts-based interventions have not sustained community engagement over the longer term in South Africa compared to in other international settings, due to a lack of an appropriate model for long term engagement relevant to South Africa. However, there is great variability in the sustainability of arts-based programs, as evidenced by the duration of the ‘Soul City’ program which has been in operation for over two decades. This highlights that sustainable community engagement in SRHR promotion interventions is context-specific. White (2006) suggests that undertaking more process evaluation of arts-based interventions would help to develop understanding about the sustainability of arts-based programs in their diverse contexts.

The discussion above highlights that multiple approaches to community-based SRHR promotion can have both advantages as well as limitations for community engagement in different settings and with different populations. Thus, more specific and contextual exploration of the potential appropriateness, utility and success of various types of approach for engaging communities in SRHR promotion in South Africa is needed.

Another program factor which can influence community engagement in a program is the overall aim and objectives of the program. Literature suggests that program aims, and strategies to achieve the aims, need to relate to the broader social context in which programs are delivered in order to effectively engage the community. Nakibinge et al. (2009) argued that broader social and community development objectives are often a key motivator for community members to engage with interventions, and programs should take account of this and seek to address these broader objectives where possible. Furthermore, they contended that failure to take account of a community’s broader social development desires in program goals and objectives demonstrates little understanding of community priorities, and thus
may pose a barrier to community engagement. However, they acknowledged that bringing together primary program objectives related to SRHR promotion with broader social development objectives (for example, income generation) can be challenging due to reasons such as limited resources. The matter of understanding community context is further discussed below (under ‘Community factors’).

Health promotion messages should also be relevant and appropriate for the community context in order to enhance community engagement (Wilbraham 2008; also, see discussion of ‘Community factors’ below). One study with an urban middle-class population in South Africa found that health promotion messages need to be appropriately gendered, raced, cultured and classed according to the target community in order to engage the desired community in the diverse South African context (Wilbraham 2008). This is further explained in the section on ‘community factors’ below, where the importance of understanding the diverse group identities, and health promotion needs of those diverse groups, is discussed.

**Community factors**

Other than programmatic factors, a range of community-related factors have also been identified in the literature as influences on community engagement in SRHR promotion. Community factors include things such as the historical and contemporary social, economic, cultural and political contexts of a community, and community’s prior experiences with SRHR promotion (Mosavel et al. 2005, McNeil 2009); the context of socially constructed groups and identities (Cornish and Campbell 2009, Dodge et al. 2012, Tucker et al. 2013, Germanos et al. 2015); and the influence of community leaders or structures (Hendriks and Erasmus 2005, African Religious Health Assets Program [ARHAP] 2006, Eriksson et al. 2010, Campbell 2010, Campbell et al. 2011).

There is some literature to suggest that the historical and contemporary socio-cultural and political contexts of a community can influence community engagement in SRHR promotion. One example of good practice in community engagement in SRHR promotion in South Africa which sought to explicitly recognise and address these relevant broader context was provided by Mosavel et al. (2005). In their CBPR project related to cervical cancer
prevention, the researchers acknowledged the history of racial segregation and exclusion of the Black South African population from the White population in the design of their project. For instance, they sought to pair project workers from different ethnic backgrounds together (such as a Black participant with a member of the Coloured community) to promote positive inter-ethnic interaction. They also undertook to adopt ‘insider’ language and concepts, for example, using the term cervical health rather than cervical cancer. These strategies sought to strengthen the cohesiveness between their project and the local community context to enhance community engagement.

The community context regarding perceptions and experiences of SRHR issues may also influence engagement in SRHR promotion particularly regarding sensitive or taboo issues. In South Africa, this is particularly the case regarding HIV. McNeill (2009) contended that historical socio-political discourses of public denial and silence of HIV in South Africa, promulgated by a previous national government, have left a legacy of persisting fear and stigma which poses a barrier to community engagement in health promotion related to HIV. However, McNeill himself challenged this view, contending that rather than a collective denialism, the silence about the issue is actually underpinned by broader socio-cultural norms of silence associated with death generally. Thus, avoidance of discussing HIV-related issues (and thus limited engagement in HIV prevention and SRHR promotion) is due to a cultural desire of the population to create separation and distance from death, rather than HIV itself. The discussion about the cultural context of perceived HIV-related denialism, and the implications for community engagement in SRHR promotion, is discussed in further depth in chapter seven. It is briefly raised here, however, to highlight the influence of historical and contemporary socio-cultural contexts on community engagement in SRHR promotion, and that understanding this context has important implications for SRHR promotion design and delivery.

Another important aspect of the community context to consider is understanding the social construction of group identities in the community. A body of international and South African research exists which highlights the role of group identity constructions as an influence on community engagement in SRHR promotion. For instance, with regards to HIV interventions specifically, Cornish and Campbell (2009) contend that group identity
constructions are critical. They contrasted the experiences and outcomes of peer-based interventions with sex workers in South Africa and India. Their comparison revealed that in the South African intervention, the priority focus was the health and wellbeing of male mineworkers who used the services of sex workers. Thus, the female sex workers were constructed as the conduits of diseases in this context, and “a problem to be addressed rather than a partner to be engaged” (p. 132). Consequently, in that South African setting, sex workers were not involved in decision making about the intervention. This was in contrast to the program in India, where the sex workers were positioned as a central focus of the program. Thus their concerns were prioritised, and they were engaged in decision making about the intervention. This contributed to the Indian intervention more successfully achieving its program goals compared to the South African intervention.

Studies from South Africa and international contexts have also highlighted the need to recognise nuanced differences between population group identities rather than homogenising group identities, and to acknowledge these diverse identities in program planning in order to enhance community engagement (Dodge et al. 2012, Tucker et al. 2013, Germanos et al. 2015). Research has found that people from specific sexual identity minorities experience exclusion from SRHR health promotion. For instance, Tucker et al. (2013) highlighted Black South African MSM as a group who have been largely excluded or neglected from health promotion and preventive research, as distinct from men who identify as gay. Similar conclusions have been made in international research. For example, Germanos et al. (2015), in their research with lesbian, bisexual and queer women in Sydney, Australia, surveyed 379 women aged 17-30 about engagement with their sexual identity and with the broader LGBTIQ community. This information was gathered to understand needs for engaging lesbian, bisexual and queer (LBQ) women in health promotion, including the differences among this group (i.e. specific needs and engagement strategies for lesbian women, for bisexual women and queer-identifying women separately). The research found that bisexual women were a particularly invisible sexual minority and many experienced a sense of not belonging to either the lesbian or heterosexual communities, or other sexual minority communities. Germanos et al. (2015) concluded that the bisexual women in their study were likely to experience social exclusion, and exclusion from health promotion aimed at the collective LGBTIQ community. The research identified the need for unique
and specific health promotion strategies for bisexual women, and for each sexual identity group. A similar phenomenon was found among bisexual men in culturally diverse populations in the U.S. (Dodge et al. 2012). Overall, the research from South Africa and internationally consistently highlights the unique identities and health promotion needs of each identity group, and the need for population-specific and relevant strategies to meaningfully engage these groups in relevant and efficacious health promotion interventions.

Understanding who the potential community leaders, partners, facilitators and gatekeepers are in a community is also important to understanding the community context and thus facilitating engagement. Faith-based organisations repeatedly arose in the literature as a critical partner in SRHR promotion (African Religious Health Assets Program [ARHAP] 2006, Eriksson et al. 2010, Campbell et al. 2011). In South Africa, faith-based organisations could potentially have a significant role in SRHR promotion interventions due to their highly regarded status and role in community life in South Africa (Hendriks and Erasmus 2005, Eriksson et al. 2010). However, the church’s underpinning values regarding matters of sex and sexuality also pose a potential barrier to the full engagement of church leaders, and the church as an organisation, with SRHR issues such as HIV prevention (Eriksson et al. 2010). Campbell et al. (2011) concluded that the role of the church and faith leaders could be either help or hindrance in SRHR promotion (specifically, the reduction of stigma related to HIV), and more work is needed to understand the influence of the church in this context.

Some research has explored the role of other community leaders (such as community chiefs and headmen) in rural South African communities with regards to HIV prevention initiatives and has found that, like church leaders, they can be an important facilitator or potential barrier to community engagement and subsequent intervention outcomes. Campbell (2010) conducted a case study investigation of the influence of leadership style on HIV and AIDS programs in South Africa and found that, in this case, although the community Chief supported the HIV prevention intervention, his style of engagement in the program was contradictory to the program goals and this subsequently negatively influenced community engagement in the program. The investigation found that the Chief’s retention of traditional
attitudes regarding women, youth and issues of sexuality limited the effects of the program, and undermined efforts to engage women in capacity building and men in examining their own responsibility in preventing HIV and AIDS. This knowledge is based on one case study, however, so more research is needed to understand the influence of community leaders on community engagement in SRHR interventions.

2.6 Chapter summary

This chapter has provided an introduction to the current state of knowledge about community engagement in SRHR promotion in South Africa. The chapter began by providing definitions of key concepts and outlining the current context of SRHR promotion responses in South Africa as a platform to then explore community engagement in these responses. A critique of national responses to SRHR issues in South Africa to date highlights a predominant focus on HIV in key strategies, with a vast under-representation of the broader suite of SRHR issues other than HIV in those agendas. In the context of these national priorities and agendas, community-based responses to SRHR promotion have also been predominated by a focus on HIV. However, community-based responses have evolved over time and contemporary theory advocates the need for such responses to strongly consider community contextual factors in their design and implementation, in order to enhance community engagement and be relevant and efficacious. The discussion then discussed key theoretical concepts of community, and community engagement. This highlighted that the meaning and construction of community is variable and contextual. With specific regards to South Africa, the cultural concept of Ubuntu is highly relevant to conceptualisations of community.

The practice of community engagement is also variable. Literature about practices of community engagement tend to be presented from researchers’ or practitioners’ perspectives (such as what program design or implementation procedures were employed to engage communities), with less evidence garnered from community members about their lived experiences of engagement. Conceptual models exist which theorise the practice of community engagement. However, current models tend to focus on processes and outcomes of community engagement, but not influences on community engagement.
The concluding part of the chapter explored South African and international literature related to theory about influences on community engagement in SRHR promotion. This body of literature highlighted multiple programmatic and community-level factors as influences on engagement. However, once again, a good deal of this evidence is garnered from researchers’ and practitioners’ views, with less understanding of community members’ perspectives on their own engagement. Also, some of the evidence is drawn from studies that did not explicitly aim to explore the concept of ‘community engagement’ in SRHR promotion. Rather, the focus of research was often on other concepts, for example stigma (Lorway et al. 2014) or sexual identities (Germanos 2015), through which insights into community engagement were able to be gained. Similarly, very scant literature provided insight into community members’ perspectives on the meaning of ‘engagement’, and none specifically sought to explore this as the key research question. Thus, the discussion has highlighted an overall need for further research to develop an understanding of the meaning of community engagement in SRHR promotion which is situated within, and sensitive to, the South African cultural context, and from community members’ perspectives.

Furthermore, while the literature reveals existing and well-accepted conceptual models outlining processes of community engagement, present models do not include consideration of the influences on community engagement, nor specifically in relation to the unique context of SRHR issues in South Africa. This highlights a present opportunity to explore influences on community engagement in SRHR issues in South Africa, and to develop a model to inform theory and practice in this area.

Given the increasing emphasis on community-based interventions to address the great burden of SRHR problems in South Africa, and the importance of community engagement to the success and sustainability of these interventions (International HIV/AIDS Alliance 2010; Orza 2011; WHO 2011a), it is important to understand influences on community engagement in SRHR interventions, and what else could be done to promote community engagement, in order to inform the development of future interventions. This provides the impetus for the research project discussed herein, which seeks to develop a contextual understanding of community members’ perspectives and experiences of community engagement in SRHR promotion to inform future program design and delivery. The next
chapter describes in detail the methodological approach, and methods undertaken, to carry out the research.
3.1 Introduction

The literature review in the previous chapter revealed several gaps in current knowledge regarding community engagement in SRHR promotion in South Africa, which gave rise to this research. This chapter sets out the aim and objectives of the research, and describes the methods employed to conduct the research. This includes first framing the research within the epistemological, theoretical and methodological approaches. The chapter describes the conduct in the field, including participant sampling and recruitment, and data collection methods. Strategies for data management are also outlined. Following this, the processes for data analysis are discussed, highlighting how they were congruent with, and appropriate for, the theoretical frameworks which guided the research. The chapter concludes with a discussion of the trustworthiness and rigour of the research, the ethical issues encountered in the design and conduct of the research, and how these were addressed.

3.2 Research aims

The aim of this research was to theorise about community engagement in community-based sexual and reproductive health and rights promotion in South Africa. To achieve this, the research explored the following questions:

1. What does the concept ‘community engagement’ mean in the context of communities in South Africa?
2. What factors influence community engagement in community-based SRHR promotion either positively or negatively in communities in South Africa?

To answer the first question, the research explored community members’ perspectives of what ‘engagement’ meant to them, and the different forms that community engagement in SRHR promotion could take in their communities. To explore the second question, the research asked community members about their experiences of community engagement in SRHR promotion in order to identify the range of factors which support or hinder engagement. These included exploration of individual, socio-cultural, contextual and programmatic factors.
3.3 Theoretical and methodological approaches

3.3.1 Epistemological and theoretical positioning of the research

The research adopted a hermeneutic form of inquiry. A hermeneutic inquiry uses an interpretive approach which focuses on understanding how people experience and make sense of the world (Brown and Heggs 2011). This involves undertaking multiple iterations of investigation which are critically reflected upon in order to inductively inform further inquiry and the construction of knowledge (Grbich 2007). These multiple iterations were undertaken by the researcher and field assistants during data collection phases, as well as through other ongoing processes of reviewing the literature and data analysis. This is detailed further in section 3.4.1 below. Ongoing critical reflection was important in this study given the researcher’s position as etic to the communities and cultures of the research settings (as mentioned previously in section 1.2.1 and discussed further in section 3.7 below), to ensure culturally and contextually appropriate interpretation of the data.

Specifically, a social constructivist epistemology was chosen, which is congruent with a hermeneutic approach. Social constructivism was appropriate as it seeks to explore how individuals’ experiences and interpretations of reality are socially constructed based on culture, class, gender, historical and political contexts, and social norms (Berger and Luckmann 1966; Grbich 2007; Liamputtong 2017). All these factors were considered important to consider in this research. In particular, social constructivism emphasises the embeddedness of social factors in shaping individual experiences and meanings (Lock and Strong 2010). Therefore, this epistemology was appropriate for this research given the contextual nature of ‘community’ and ‘community engagement’, and the unique demographic, socio-epidemiological, socio-historical and cultural contexts surrounding SRHR matters in South Africa, as highlighted in the previous chapters.

Identifying specific theoretical frameworks is critical in the design and conduct of research (Crotty 1998; Jirojwong and Liamputtong 2009; Creswell 2018). For this study, two frameworks were used - symbolic interactionism and intersectionality. Symbolic interactionism is an inductive approach that also explores individuals’ subjective experiences, so fits with the constructivist epistemological position outlined above.
Symbolic interactionism examines how individuals make meaning from symbols and social interactions in society to actively shape their actions toward those things, and shape their subjective realities (Blumer 1969, Denzin 1992; Stryker 2002). This framework was appropriate for this research which explored the multiple and interacting factors influencing community engagement in SRHR promotion, including social and cultural symbols such as behaviours, physical signs and appearances, and language metaphors which held particular meanings and so contributed to attitudes, values and interpretations regarding community engagement in SRHR promotion. These symbols are elaborated on in the findings chapters, particularly with regards to the factor of ‘stigma’ (chapter 5) and the theme of ‘representations’ (chapter 8). It is worth noting here, however, that one of the criticisms of symbolic interactionism is that it may be viewed as an individual model of social action rather than a sociological one; that is, it may be considered a micro-level theory which only takes account of the individual context rather than being a broader social theory relevant for understanding the macro-level social context (Meltzer et al. 1975). However, Stryker (2002) argued that symbolic interactionism is a framework for understanding society and the interactions of individuals are central to this; notions of ‘self’ and ‘society’ exist in relation to one another and both are essential for understanding social interactions. Thus, symbolic interactionism was considered appropriate for this research which elicited individual perspectives and experiences regarding engagement in order to theorise about meanings of, and influences on, community-level engagement, thus linking the individual and community levels.

Intersectionality (Crenshaw 1989) examines and conceptualises how race, class and gender interact to produce multiple states of oppression (Gopaldas 2013). This framework complements the social constructivist epistemology as it enables exploration of how these factors interact in contextual ways. Additionally, while the intersectionality framework facilitated exploration of individuals’ subjective experiences, it also enabled the influence of the broader societal context of intersecting oppressions to be explored, thus linking narratives of individual-level engagement with community-level engagement. These considerations were important for this research in the context of contemporary South Africa which has a history of race-based and class-based power struggles, and the researcher’s position as etic to the research community and culture, and emic to a colonising culture.
(introduced previously in section 1.2.1, and discussed further in section 3.7). Thus, this framework was important to enable the researcher to be cognisant of these factors and explore their influences on community engagement in SRHR promotion in this context.

Throughout the research, the researcher sought to apply these lenses of symbolic interactionism and intersectionality in the collection and interrogation of the data. This was facilitated by the engagement of locally-based field assistants to co-facilitate the research (as discussed previously in section 1.4, and further discussed in section 9.3.1). Other ways this was done are detailed below where data collection and data analysis are discussed (see sections 3.4.3 and 3.4.5, respectively).

### 3.3.2 Methodological frameworks

Within the theoretical frameworks identified, ethnographic and participatory methodologies were applied to guide the design and conduct of the research. Ethnography requires the researcher to acquire a nuanced knowledge of the culture and cultural context in which the research is being conducted (Liamputtong 2008). This was critical for this research given the researcher’s etic position to the culture and communities in which the research was conducted. The researcher’s positionality is discussed further throughout section 3.4 below.

Ethnographic methods, including immersion and observation (discussed more in section 3.4.3f – data collection methods), helped the researcher to acquire a deeper level of cultural knowledge to understand participants’ experiences of community engagement in their cultural context. This involved the researcher giving specific attention to critically exploring the social, structural, cultural, familial, religious, historical and political factors which influenced engagement and which were specific and relevant to the context (Liamputtong 2009). Furthermore, ethnography enables multiple theoretical frameworks to be drawn upon to inform research (Harper and La Fontaine 2009), so was appropriate for the multiple theoretical frameworks that informed this study. In particular, ethnography emphasises the voices of groups that have traditionally been marginalised (Liamputtong 2009) and so was congruent with the intersectionality framework adopted which sought to explore the multiple experiences of oppression which may have influenced experiences of engagement.
To further assist with an ethnographic exploration, participatory methods were used to involve local community members who had expert ‘insider’ knowledge of the communities and cultures involved in the research. Community-based participatory research (CBPR) is an emergent methodology which is now popular in health and social research, particularly with marginalised populations (Salimi et al. 2012, Banks et al. 2013), and was applied in this research. The foundation of CBPR is collaboration and shared decision making between the researcher(s) and partners (including partner organisations and community members) (Ayala and Elder 2011). In CBPR, partner organisations and community members are not considered passive participants in, or subject to, the research; rather, they are treated as active agents in determining the conduct of the research and their participation in it. While the initial concept for this research was derived by the researcher based on her previous experiences living and working in South Africa (see previous discussion in section 1.2.1), community members and partner organisations were engaged to help shape the specific approaches and methods used for the research, to identify research sites (communities), to identify field assistants for the research (as discussed previously in section 1.4 – research team and governance), and were engaged in data collection and preliminary data analysis. These strategies demonstrate the community-based participatory approach to the research.

A participatory approach was considered particularly important for this study for several reasons. First and foremost was the researcher’s position as etic to the cultural context and communities in which the research was set. Working collaboratively with people within each setting enabled relationships of mutual trust and respect to develop, and to reduce any perceived power differentials between the researcher and community or participants. Trusting relationships were also important to facilitate the conduct of the research, such as in activities such as participant recruitment and language interpretation (these are discussed further in 3.4.2 below, and section 9.3.1 in chapter nine). Furthermore, community members’ contributions to shaping the research conduct, particularly data collection and preliminary data analysis, helped the researcher to develop a deeper cultural knowledge for interpreting participants’ constructions of reality. It also enabled the participants and communities to have an empowered voice in how their experiences were constructed and interpreted in a meaningful way. Thus, the collaborative and participatory approach fit well with the constructivist framework guiding the research.
3.4 Methods

3.4.1 Timeline of the research

This research was conducted over a period of time from 2011 – 2018 (Table 3.1). The research project was formally commenced in 2011, following a prior period of immersion in the field (as discussed in section 1.2.1). Engagement with partner organisations for this research began in 2011 during the conceptualisation stage, in which the research protocol was designed and application for ethics approval completed. Engagement with these partners continued through periods of fieldwork for data collection during 2012, and for data familiarisation and preliminary data analysis throughout 2013. Overall, the predominant period of engagement with the partner organisations, field assistants and communities was over three years, from the beginning of 2011 until around the end of 2013. While data collection and preliminary analysis in the field were completed within those three years, a longer period of deeper level data analysis by the researcher, and the write-up of findings, continued over a further five years from the beginning of 2014 until the end of 2018. This period also involved the researcher revisiting the literature around the topic for currency of evidence to contextualise the findings. The review of the more contemporary literature, particularly over the period of 2016 – 2018, revealed some but overall few additional substantial contributions to the theory of community engagement practice, or this specific topic area of community engagement in community-based SRHR promotion in South Africa. Rather, the new literature tended to focus on conceptualisations of community (see section 2.4.1), and on the expanding area of community engagement in clinical trials related to SRHR promotion (see section 2.5.2). Thus, the researcher was still able to engage in inductive data analysis and finalisation of findings to address a persisting gap in evidence.
Table 3.1: Timeline of the research

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Philosophy candidature commenced.</td>
<td>April 2011 – December 2011</td>
</tr>
<tr>
<td>Initial contact with partner organisations made; research protocol and ethics application developed and approved.</td>
<td></td>
</tr>
<tr>
<td>First field visit to South Africa by the researcher. Involved meetings with partner organisations to confirm research communities and field assistants; initial meetings with field assistants; training of field assistants; introductions to communities; commencement of participant recruitment and data collection by researcher and field assistants.</td>
<td>January 2012</td>
</tr>
<tr>
<td>Ongoing participant recruitment and data collection by field assistants.</td>
<td>February 2012 – June 2012</td>
</tr>
<tr>
<td>Regular contact via telephone between researcher and field assistants/partner organisations to discuss research processes and iterative recruitment and data collection. Data familiarisation and preliminary data analysis commenced – review of field notes, discussion with field assistants about their observations in order to inform the next round of participant recruitment and data collection.</td>
<td></td>
</tr>
<tr>
<td>Second field visit to South Africa by the researcher. Involved meetings with partner organisations and field assistants to discuss participant recruitment and data collection, and undertake further participant recruitment and data collection.</td>
<td>June 2012</td>
</tr>
<tr>
<td>Ongoing participant recruitment and data collection by field assistants.</td>
<td>June 2012 – November 2012</td>
</tr>
<tr>
<td>Regular contact via telephone between researcher and field assistants/partner organisations to discuss research processes and iterative recruitment and data collection. Data familiarisation and preliminary data analysis continued – review of field notes, commenced transcription of some data sources (English language sources), discussion with field assistants of their observations and any emerging themes or gaps in order to inform the next round of participant recruitment and data collection.</td>
<td></td>
</tr>
<tr>
<td>Third field visit to South Africa by the researcher. Involved meetings with partner organisations and field assistants to discuss participant recruitment and data collection, and undertake further participant recruitment and data collection.</td>
<td>November 2012 – December 2012</td>
</tr>
<tr>
<td>Data analysis undertaken by researcher, with involvement of field assistants. Involved transcription and translation (when required) of all remaining sources, inductive thematic coding manually and in NVivo™ data management program, regular phone contact with partner organisations and field assistants to assist (e.g. debrief, seek clarification on points or</td>
<td>Jan 2013 - Dec 2013</td>
</tr>
</tbody>
</table>
Data analysis by researcher continued, with involvement of supervisors for discussion.  

<table>
<thead>
<tr>
<th>Task</th>
<th>Time Period</th>
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<tbody>
<tr>
<td>Commenced write-up of thesis (introduction chapter, methods chapter, findings chapters)</td>
<td>January 2014 – ongoing until completion</td>
</tr>
<tr>
<td>Revision and re-drafting of literature review.</td>
<td>2016 – ongoing until completion</td>
</tr>
<tr>
<td>Continued write-up and finalisation of full thesis.</td>
<td>2018</td>
</tr>
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3.4.2 Participant sampling and recruitment

Eligibility criteria for participation

Participants were sought from multiple groups across each research setting (the research settings were previously described in section 1.3). These groups included former and current community-based SRHR program workers, community members currently or previously engaged with community-based SRHR promotion programs, and community members who had not been engaged with SRHR promotion programs.

People were eligible to participate if they were aged 13 years or older. They could be of any gender or ethnic group. Program workers needed to be currently working, or have previously worked within the past five years for an organisation in the design and/or delivery of a community-based SRHR promotion initiative in either a paid or voluntary capacity. Other community members needed to have been living in the community at a time when a community-based SRHR promotion initiative was occurring in the community, and could have either engaged with it or not. Community members could also include community leaders such as the community chief, headmen, local councillors, church leaders and others in notable positions as identified by the field assistant in each community. There were no additional exclusion criteria.

Sampling and recruitment methods

Participant recruitment was undertaken in partnership with the field assistant and key contacts in partner organisations in each research site, in accordance with the community-
based participatory approach to the research. The recruitment and training of field assistants was discussed previously in section 1.4 (research team and governance). There were both advantages and potential limitations to the use of bilingual research assistants; these are discussed in the final chapter (chapter nine – conclusions) where strengths and limitations of the research are discussed (sections 9.3.1 and 9.3.2 respectively).

A purposive approach to sampling was used initially as this method enables a deep, rich and contextualised exploration of issues that are relevant to the research question (Liamputtong 2017). Participants were purposively sought for their ability be able to comment on their experiences of engagement (or non-engagement) with SRHR promotion, and to ensure a cross-section of participant groups were involved (for example, a mix of current program workers, former program workers, engaged community members, non-engaged community members). These people were approached by the field assistant(s) and/or researcher, and the study was introduced to them using the participant recruitment script (Appendix B). The recruitment script was read and explained to participants by the researcher and/or field assistant verbally in either English or isiXhosa, depending on the individual participant’s preference.

Upon expressing interest in the research, potential participants were then provided with further information through the Plain Language Statement (PLS) and Consent Form (CF) (Appendix C). This information was made available to participants as a written document (in English language in its original form, and translated in to isiXhosa by field assistants), or could be read verbally to participants in either isiXhosa or English according to a participant’s preference. isiXhosa and English are two of the eleven official languages of South Africa, and spoken in the communities in which the research was conducted. The researcher observed that English was also often spoken, but more so by young people born in the era of democracy (from 1994 onwards) and who have been engaged in formal education, as English language is now taught in schools in traditional communities. The researcher noted that English was also more commonly spoken by those in urban settings compared to peri-urban or rural areas. Participants were required to provide their consent to participate prior commencement in the research by either signing the CF or providing verbal consent which was digitally recorded, depending on their literacy skills and preference.
Snowball sampling was used to facilitate further participant recruitment (Handcock and Gile 2011). Throughout data collection, participants were asked about, or may have suggested, other people who could be suitable to participate. These people were then approached by members of the research team. In some instances, a form of respondent-driven sampling (Heckathorn 1997) was also used to recruit new participants, in which existing participants informed friends and associates about the research taking place. Individuals who were interested could then approach the researcher, rather than the researcher approaching them. This approach was appropriate for the research context given the sensitive nature of the research topic, and the position of the researcher as an ‘outsider’ to the community. Further, respondent-driven sampling offered an empowering way for community members to participate, in line with the values of the research.

On occasion, convenience sampling and opportunistic sampling were also used as additional recruitment strategies. These methods enabled the researcher to collaborate with the field assistants within the everyday norms of the community context to recruit participants, and so was in line with the CBPR approach. Additionally, the lead researcher thought that her position as an educated white woman, undertaking research aligned with higher education institutional practices, could have contributed to perceived power and status differences among some community members, which could have adversely affected recruitment and participation in the study. This was based on the researcher’s observations that community members’ nature and level of engagement with the researcher altered when the research was introduced in a formal way. For instance, the researcher observed that some community members, when meeting with the researcher, became shy, spoke more formally themselves, gave shorter and less elaborate answers, exhibited stiffer body language, and even wore professional attire. Thus, convenience and opportunistic sampling were used to facilitate participant engagement and recruitment in less formal situations, such as when field assistants and/or the researcher were attending community activities unrelated to the research, or during ordinary daily tasks such as walking together to the shop, while collecting water, cooking, or minding children. In these situations, general conversation between the research and/or field assistant(s) and community member(s) would often led to discussion about the purpose for the researcher’s visit to the community and nature of her work. This led to some community members expressing interest in the research, and research
processes such as informed consent, privacy and confidentiality were then able to be introduced in a less formal manner.

Participant recruitment occurred across the five conveniently-selected research sites (refer back to section 1.3 for details of site selection) throughout 2012, until the point of theoretical data saturation; that is, until the researcher determined that no new themes were emerging and no new informants were required. This was determined by undertaking recruitment concurrently with data collection, data familiarisation and preliminary data analysis. This involved examining the data as it were collected to identify the issues being raised, and being attuned to gaps in the data or questions to follow up on (Grbich 2013). This enabled the researcher to identify emerging issues in the data, and purposively seek to recruit participants to address any identified gaps or questions. For example, ongoing examination of data revealed that sexuality was somewhat of an emerging topic, but not covered with depth by the existing participant cohort in the early phases of data collection. Thus, subsequent recruitment and data collection purposively sought participants who would be able to provide further informed or specific comment about this topic, such as members of the LGBTIQ community, and program workers in the area of LGBTIQ health. Another gap identified was in male participation in the research. Thus, participant recruitment sought to enhance male participation in the research to elicit males’ perspectives. This approach of concurrent participant recruitment and data analysis to achieve theoretical sampling and data saturation was suitable for the interpretive and constructivist approaches to the research, and for the inductive thematic approach adopted for data collection and analysis, in which meanings are constructed from the data (Sandelowski 2000) (see section 3.4.5 - data analysis for further discussion of this technique).

**Participant characteristics**

A total of 78 people (including the five field assistants) contributed data for this research. Participants were predominantly female (56 female, 22 male; no participant identified as transgender or gender non-specific). The vast majority of participants (71 people) were of Xhosa or other Black South African ethnicity. Five participants identified as White South African or European (three males and two females), including one Afrikaans male; one male was of Indian ethnicity; and one female of Coloured ethnicity. The age of participants
ranged from approximately 16-60 years. The majority of participants (n=67) were either currently or previously involved with SRHR promotion organisations or activities in their communities; only 11 participants were not currently or previously engaged with community-based SRHR promotion.

3.4.3 Data collection methods

Multiple qualitative methods with participatory elements were used to collect data for this research. These were immersion and observation (with field notes), interviews, focus group discussions, the researcher’s reflective diary, and other forms of creative methods preferred by participants (such as poetry) which are described further below. Participants were offered the choice of methods to provide data; this was designed to be supportive of the participatory and empowering values of this research design as it enabled participants to select the method(s) which they considered would meaningfully enable them to share their views and experiences. This also enabled participants to exercise greater control over their engagement in the research. Each of the data collection methods is discussed in detail below.

Immersion and observation

Immersion and observation are important and central processes in the conduct of ethnographic research (Frankham and MacRae 2011). Immersion involved the researcher spending periods of time living in the setting (Frankham and MacRae 2011). This included a period of one year living in Xhosa community in the Eastern Cape prior to the commencement of the research, as discussed previously in section 1.2.1. Additionally, the researcher spent a further three periods of time in the communities throughout the research (as outlined in Table 3.1). During her time in communities, the researcher became engaged in the field setting to the best of her ability. This included the researcher attending community events such as imbizos (community meetings convened by community chiefs and/or headmen), festivals, weddings and funerals; engaging with community organisations such as schools, churches and health organisations; and contributing to general community and family life such as collecting water, agricultural activities, child-minding, and cooking and cleaning in the home. These immersion activities helped the researcher to develop a
deeper understanding of the culture in which she was situated, and some deeper ability to interpret cultural meanings within the cultural setting (Jones and Somekh 2011).

Participant observation (Harper and La Fontaine 2009) involved the researcher recording and reflecting upon her impression of events and occurrences. The researcher adopted an unstructured, or ‘ad libitum’ form of observation (Lee 2000) for this research. This method does not follow a pre-determined procedure or set of criteria for recording observations; rather observations which the researcher thought were relevant to the research questions or to her general understanding of the community were recorded as they arose. Examples of the kinds of observations recorded which were related to the research questions were the types of SRHR promotion initiatives in communities; demographic characteristics (such as age, gender, ethnicity) of those participating in community activities or absent from community activities; individual and group interactions in community events; and attitudes and responses to SRHR topics and the research project. Examples of the kinds of observations recorded which related to the general community context were patterns of daily living and activities (for instance, gender roles related to work and household duties). Observations were recorded by the researcher using handwritten field notes in the researcher’s reflective diary (discussed further below), and voice recorded memos which were later transcribed for analysis (transcription is discussed further below in section 3.4.4 – data management).

A limitation of observation as a method of data collection is that it is dependent on the ontological position of the researcher; that is, “…it depends to a very great extent on how the observer conceptualises the world and his or her place within it” (Jones and Somekh 2011: 131-132). This will subsequently influence the data which is observed and recorded, and how it is analysed and interpreted by the researcher (Jones and Somekh 2011). In particular, ad libitum sampling is open to observer bias about what the researcher considers interesting or relevant, and so the observation data becomes a product of the choices the researcher makes about what to observe and record (Lee 2000, Jones and Somekh 2011). Also, events and factors which are clearly visible and capture the researcher’s attention are more likely to be recorded, compared to more hidden, subtle, missing or nuanced occurrences (Lee 2000). Thus, the researcher’s reflective diary (discussed further below) was a crucial tool used concurrently with observation to enable the researcher to critically examine her observations.
and interpretation, and identify any bias. For instance, the researcher paid particular attention to gaps or absences in the community and data, such as infrastructure, programs and services that were lacking; or sub-groups that were absent from particular facets of community life or not engaged in SRHR promotion or other community-based activities. Observation of events was undertaken concurrently with preliminary data analysis to help the researcher identify further areas for observation and note.

**Researcher reflective diaries**

Fieldwork diaries are commonly used in qualitative social research in complement with other methods to record data, reflections and interpretations, and other miscellaneous field notes such as memos, descriptive events and interpretations (Holly and Altrichter 2011). The researcher’s reflective diary was used to complement other data collection techniques such as observation (described above) to record observed events, practices and interpretations based on reflections. Examples of the kinds of information recorded by the researcher in her diary include key quotes, and notes about participants’ engagement and interactions. The diary was also used as a management tool to inform the ongoing design and conduct of the inductive research by recording logistic notes and memos (such as key informants to contact), and factual information relevant to the research (such as important historical dates and events).

The researcher’s reflective diary was an important tool in this research given the constructivist epistemology of the research in which participants’ contributions were subjective and open to interpretation (Holly and Altrichter 2011). The diary enabled the researcher to undertake ongoing critical reflexivity to continually question her position as visitor to the community and the pre-existing cultural lenses, or implicit bias, assumptions or interpretations which she may have applied, and any influence these may have had on the data (Frankham and MacRae 2011). Her reflexive process involved repeated readings of her diary, particularly as new entries were made, in order to see any similarities or contradictions with previous entries (Holly and Altrichter 2011). She was also able to note any emergent questions as they arose which she could return to and seek to answer through further observation or data collection, or seek to clarify with field assistants.
Field assistants were also asked to keep fieldwork diaries to record objective events and data as well as interpretive information. Only one field assistant did this when the recording equipment which was to be used to digitally record interviews failed. In this situation, the field assistant recorded comprehensive notes about interview responses and other observations related to the interviews, such as participants’ body language. Nevertheless, the lead researcher discussed field assistants’ interpretations, observations and other important matters with each field assistant frequently throughout field work whilst in South Africa, as well as during frequent phone conversations after the lead researcher had returned to Australia. The information conveyed by the field assistants to the lead researcher was recorded in the lead researcher’s field dairy.

Semi-structured interviews

Semi-structured interviews were offered as one of the options for data collection methods. Participants who opted for an interview could also choose either an individual interview or a paired interview with another participant, depending on their comfort and preference. Interviews enable meaningful participation by providing the opportunity for individuals to express their personal views, experiences, beliefs and constructed realities in their own terms. They also provide the opportunity for participants to raise issues of importance to them (Liamputtong 2009).

A semi-structured approach incorporating open-ended questions was adopted to enable flexibility in the interviewing process, and enable researchers and participants to explore unanticipated matters as they arose (Barbour and Schostak 2011). A draft topic guide for the interviews was developed in English by the researcher, with input from her research supervisors who have experience in cross-cultural research and interviewing. The project field assistants were also consulted about the draft topic guide to provide a local perspective on relevant cultural concepts and the appropriateness of the topic guide. The draft topic guide was discussed with the field assistant in each research site, and adapted to be suitable for each setting. This was to ensure that necessary important attention was given not only linguistic differences, but also to ensure the underpinning concepts were culturally appropriate in each setting (Gregg and Saha 2007). The topic guide was then tested on each
of the field assistants separately, and further refined as needed. The kinds of topics addressed included the nature of participants’ own engagement in community-based SRHR promotion, participants’ perceptions of broader community engagement in SRHR promotion, and perceived facilitators or barriers to community engagement in SRHR promotion.

In total, 19 semi-structured interviews were undertaken, involving 22 participants. These included 9 participants who took part in once-off individual interviews. A further three interviews took place in pairs (interviews numbered 1, 2, 4, 5 and 17), and one interview involved three participants (interview 19). Four individuals participated in more than one interview (for instance, to clarify or elaborate on information, or add new information); Thotyelwa took part in two individual interviews, Vuya took part in one individual and one paired interview, Thandiwe took part in two paired interviews, and Fundiswa took part in one individual interview and one interview as a group of three people. See Table 3.2 below for details.

Interviews ranged in time from 30 minutes to 90 minutes, and occurred at a place mutually agreeable by the participant and researcher (and/or field assistant). Examples of places interviews took place were in community centres and participant homes, or in the general community such as when undertaking a walk. Interviews were conducted by either the researcher, a field assistant, or jointly by the researcher and a field assistant. Participants were informed that if they chose to have an interview with the researcher only, the interview would take place in English. If they preferred to speak isiXhosa, they could choose to have an interview with the field assistant, or jointly conducted by the field assistant and researcher. In the case of co-facilitated interviews, most participants chose to still speak predominantly in English, although in a small number of instances participants switched between using English and isiXhosa. While the researcher does have some moderate ability to understand and speak isiXhosa, the field assistant provided live interpretation for the researcher during interviews when isiXhosa was used to enable the interview to progress and develop more fluently. The strengths and limitations related to field assistants acting as interpreters in cross-language research are discussed in sections 9.3.1 and 9.3.2 in the final chapter.
Table 3.2: Interview participants

<table>
<thead>
<tr>
<th>Interview number</th>
<th>Interview type</th>
<th>Participant name (interviewee number)</th>
<th>Participant characteristics*</th>
<th>Location (research setting number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Paired; once-off</td>
<td>Esihle (1)</td>
<td>Male youth</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>Paired; first of two interviews</td>
<td>Thandiwe (2)</td>
<td>Adult female</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Paired; once-off</td>
<td>Zandile (3)</td>
<td>Female youth</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Paired; once-off</td>
<td>Thulisa (4)</td>
<td>Female youth</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Individual; first of two interviews</td>
<td>Vuya (5)</td>
<td>Adult female</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Paired; second of two interviews</td>
<td>Vuya (5)</td>
<td>Adult female</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Paired; once-off</td>
<td>Ndiliswa (6)</td>
<td>Adult female</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Paired; once-off</td>
<td>Babalwa (7)</td>
<td>Adult female</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Paired; once-off</td>
<td>Funeka (8)</td>
<td>Adult female</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Individual; once-off</td>
<td>Uaka (9)</td>
<td>Adult male</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Individual; once-off</td>
<td>Qaqamba (10)</td>
<td>Female youth</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Individual; first of two interviews</td>
<td>Thotyelwa (11)</td>
<td>Adult female</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Individual; second of two interviews</td>
<td>Thotyelwa (11)</td>
<td>Adult female</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>Individual; once-off</td>
<td>Luyolo (12)</td>
<td>Male youth</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Individual; once-off</td>
<td>Lwazi (13)</td>
<td>Male youth</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>Individual; once-off</td>
<td>Anathi (14)</td>
<td>Female youth</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Individual; once-off</td>
<td>Andile (15)</td>
<td>Male youth</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>Individual; once-off</td>
<td>Khanyiswa (16)</td>
<td>Female youth</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Individual; once-off</td>
<td>Lulama (17)</td>
<td>Female youth</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>Individual; once-off</td>
<td>Paki (18)</td>
<td>Male youth</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>Paired; once-off</td>
<td>Bukelwa (19)</td>
<td>Adult female</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>Paired; second of two interviews</td>
<td>Thandiwe (2)</td>
<td>Adult female</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>Individual; first of two interviews</td>
<td>Fundiswa (20)</td>
<td>Adult female</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>Group of three; second of two interviews</td>
<td>Fundiswa (20)</td>
<td>Adult female</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>Group of three; once-off</td>
<td>Mncedisi (21)</td>
<td>Adult female</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>Group of three; once-off</td>
<td>Daluxolo (22)</td>
<td>Adult male</td>
<td>1</td>
</tr>
</tbody>
</table>

* According to the United Nations definitions, the term ‘youth’ refers to those aged 15-24 years, and the term ‘adult’ refers to those aged 25 years and over (United Nations
Department of Economic and Social Affairs [UNDESA], n.d.). These age conventions are adopted in this research to describe participants and community members.

In all situations except research setting three (described previously in section 1.3), interviews were digitally recorded after participants gave their consent. Additional hand written notes were also taken in all situations. In research setting three, the field assistant (Paki) conducted individual interviews with six participants but due to a problem with the recording equipment the interviews were not recorded. In these instances, the field assistant offered participants the option of either undertaking the interview orally while the field assistant took comprehensive hand-written notes, or having a written copy of the topic guide provided to them in English or isiXhosa for participants to write their answers (thus providing participants with an open-ended written questionnaire). If participants elected to have a written questionnaire, the field assistant was available to then discuss and/or clarify any questions that participants had. Written answers were provided by participants in both English and isiXhosa. Following completion of the questionnaire, the field assistant then engaged in further in depth discussion with each participant about their responses, and recorded additional hand-written field notes.

Each individual questionnaire and interview, and the field assistant’s observations and reflections, were then discussed in-depth with the lead researcher. The in-depth discussion between the field assistant and researcher was digitally recorded, and the written questionnaires were provided to the researcher.

Focus group discussions

Participation through focus group discussions was another participatory and empowering option provided to participants which, like semi-structured interviews, enabled participants to exercise some control over the nature of the discussions. Six focus group discussions were conducted (four were jointly by the researcher and field assistants, and two were conducted individually by the lead researcher), involving 46 participants. Table 3.3 outlines the characteristics of each focus group.
A risk with focus groups is that they may not necessarily elicit or represent individuals’ own personal views or attitudes; rather, Barbour and Schostak (2011) caution that they are a social process in which participants co-produce responses to convey information or an account which is a result of, and contextual to, that particular group and their interactions. Thus, the researcher’s observations and reflections were an important tool in conducting the focus groups. For instance, the researcher was attuned to observing individuals’ participation as well as group dynamics during the focus groups. This enabled the researcher to ensure inclusiveness and engagement of participants, such as by re-directing the conversation to other participants if one participant was dominant, or purposively directing questions to participants whose voices were quiet. The researcher was also attuned to group interactions and the recurrent phrases used by one or multiple participants, and the nature of group agreement or divergent views (this is further discussed in section 3.4.5 – data analysis). Additionally, the observations were helpful to reflect upon later during data analysis to help the researcher contextualise her interpretation. At the conclusion of each focus group, the researcher and field assistant debriefed on the conduct and content of the discussion, as well as the nature and conduct of the group, to help enhance rigour in the data collection and analysis processes (rigour is discussed further in section 3.6).
Table 3.3: Characteristics of focus groups

<table>
<thead>
<tr>
<th>Focus group number</th>
<th>Research setting number</th>
<th>Participant characteristics</th>
</tr>
</thead>
</table>
| 1                 | 5                       | Co-facilitated by the researcher and field assistant  
  15 adult participants: 13 females, 2 males; all identified as Black.  
  All volunteer members of a community-based organisation which undertakes basic community-based health promotion, support and activism for SRHR and other health and wellbeing issues. Despite the efforts of the researcher and field assistant, six participants did not actively engage in discussion beyond providing their name and some details about their role in the organisation by way of introduction.  
  Language: English and isiXhosa  
  Duration: 49 minutes                                                                                                                                       |
| 2                 | 4                       | Facilitated by the researcher  
  5 adult participants: 3 females, 2 males; all identified as Black.  
  All employees of partner organisation number one. All currently engaged in SRHR promotion interventions at the community implementation/practice level.  
  Language: English  
  Duration: 30 minutes                                                                                                                                  |
| 3                 | 4                       | Co-facilitated by the researcher and field assistant.  
  5 participants, including a mix of youth and adults; all female.  
  Participants predominantly identified as Black (four participants) and one was a member of the Coloured community. The group comprised a mix of those currently engaged with SRHR initiatives implemented by partner organisation number one, those engaged with SRHR initiatives through other organisations, and those not currently or previously engaged in SRHR interventions.  
  Language: English and isiXhosa  
  Duration: 1 hour and 56 minutes                                                                                                                             |
| 4                 | 4                       | Co-facilitated by the researcher and field assistant.  
  5 participants, including a mix of youth and adults; all female.  
  All identified as Black. Most of the participants (four participants) were not currently engaged in SRHR promotion and had not previously heard of the organisation they were recruited for the study through (partner organisation number one). Two of these participants had previously been engaged with some form of SRHR promotion in the past through other organisations. One participant was currently still engaged as a peer-educator in the community.  
  Language: English and isiXhosa  
  Duration: 58 minutes                                                                                                                                  |
| 5                 | 4                       | Co-facilitated by the researcher and field assistant.  
  4 participants, including a mix of youth and adults; all female. All identified as Black. Two of the participants were previously or currently engaged with SRHR promotion, nor had heard of the organisation they were recruited for the study through (partner organisation number one).                                                                 |
The remaining two participants also had not previously heard of partner organisation number one, but were currently engaged as peer-educators in community-based programs with other organisations.
Language: English and isiXhosa
Duration: 35 minutes

<table>
<thead>
<tr>
<th>6</th>
<th>1</th>
</tr>
</thead>
</table>
| Facilitated by the researcher. The group comprised of one employee of partner organisation number one (adult male) who co-facilitated the discussions. An additional eleven people participated; ten youth who were members of a youth club run by partner organisation number one (5 females, 5 males, all Black), and one community member (adult male who identified as Indian). | Language: English and isiXhosa
Duration: 42 minutes |

Other emergent methods initiated by participants

In addition to the choice of participation methods provided by the researcher, participants also opted to contribute information in other ways that were meaningful and comfortable for them. These methods included written poetry; demonstrations of work carried out by individuals or organisations (such as inviting the researcher to accompany participants on community work, or showcasing artefacts such as craft items and other publicising materials they had developed to promote SRHR); community walk-throughs; and opportunistic open discussions. These additional and alternative methods were uncommon, however. With the exception of opportunistic open discussions, each of these additional methods was used in only a single instance.

The poems written by a participant were treated as written transcripts in the data analysis (see section 3.4.5 for data analysis procedures). When the other forms of information were provided, the researcher made notes about it in her reflective diary. Some opportunistic discussions were digitally recorded (with participants’ permission) when possible, and comprehensive written field notes were made in the researcher’s reflective diary when discussions were not recorded. The discussions explored a range of topics specifically relevant to the research questions, as well as the broader social context in which the research was situated. The topics reflected issues which participants considered meaningful based on their own subjective experiences. Examples of topics discussed include socio-normative gender roles and expectations, marriage and sexual relationships, schooling and further education, and aspirations for the future, among others. The open discussions enhanced the
participatory nature of the research as they were often initiated by participants (including field assistants), and posed a lower risk of symbolic violence (see section 3.5 for a discussion of symbolic violence) compared to other data collection methods used, as they enabled participants to fully initiate and direct the agenda and raise any topic they thought was important. They also supported the ethnographic nature of the research as they allowed the researcher to develop a more nuanced understanding of the social and cultural context in which the research was being conducted.

3.4.4 Data management

All data collected in the field by the researcher were stored securely while in the field. Digital data were transferred immediately while in the field to the personal computer of the researcher which was password protected. Hard copy materials and the computer were stored in a locked space in the researcher’s secure accommodation. Field assistants collected data using digital recorders and hard copy documents. Field assistants were provided with USB sticks to transfer the digital recordings to. The USB sticks were password protected to prevent unauthorised access. Field assistants were required to securely store the research equipment and data in a locked facility in their home or a partner organisation until the researcher was able to take receipt of the data. Upon the researcher’s return to Australia, all digital forms of data were transferred to the password-protected workstation of the researcher at her university. Hard copies of data were stored in a locked filing cabinet in the researcher’s lockable office at the university.

All data were transcribed and translated (when required). Focus group discussions, interviews and open discussions that took place entirely in English were transcribed by the researcher. Discussions involving the use of isiXhosa were transcribed and translated by a professional transcription and translation service. This enhanced the rigour of the research as it enabled the interpretation provided by the field assistant during the discussions to be checked for accuracy. However, there are limitations associated with the practice of cross-language interpretation and translation in research; these are further discussed in section 9.3.2.
All data were de-identified to protect anonymity and confidentiality. Each participant was assigned a participant number and a pseudonym which was used in transcripts and any other documents containing data. All other information which could potentially identify a participant or another person (for example, a person mentioned by a participant) was also de-identified and assigned a pseudonym. This included community names, organisation names and places. Details of the pseudonyms assigned were entered into a Microsoft Excel database. This database was password protected and only accessible by the researcher.

All data (digital recordings, transcribed documents and field notes) were uploaded in de-identified form into the computer software program for data management, NVIVO™ (version 10), for storage and management. Data analysis is discussed in the following section (3.4.5).

3.4.5 Data analysis

Theoretical approach to data analysis

The data analysis process sought to be systematic and methodical to ensure thoroughness, but also to be flexible given the constructivist epistemology and the ethnographic and participatory methodologies underpinning the research. Thus, an inductive thematic approach was adopted with grounded theory methods. Additionally, a semiotic schema analysis was also employed to further interrogate the data.

Thematic analysis was chosen as it is a flexible approach that can provide a rich and complex representation of data (Braun and Clark 2006), and is widely used in ethnographic research (Grbich 2007). Grounded theory was the method of thematic analysis used as it is congruent with the constructivist approach and aim of the research which sought to theorise from the data rather than to test a pre-derived hypothesis (Grbich 2007).

Multiple versions of grounded theory have developed over time and each reflects slightly different philosophies about the data collection and analysis process. For this research, Charmaz’s (2006) version was predominantly used as a guide. Charmaz’s constructivist approach to grounded theory strongly acknowledges the active role of the researcher in constructing and influencing data collection, and in constructing meaningful categories from
the data during analysis. Charmaz (2006) posits that the researcher’s own realities and lived experiences fundamentally influence the way researchers undertake iterative data collection and analysis, and these processes cannot be separated from the researcher’s subjective realities. Thus, this version was most appropriate for this research given the cross-cultural and ethnographic nature of the research. The researcher was highly cognisant of her position as etic to the culture and communities of the research, and so sought to consciously consider how this may have influenced the research, including data analysis and interpretation.

Data analysis methods

Data were analysed using a four-phase coding process beginning with familiarisation (Ritchie and Spencer 1994), followed by Strauss’ (1987) three steps of open coding, axial coding and selective coding through the constant comparison of data. These steps are described in further detail below. The four steps were unique and distinct yet iterative. This began during data collection in the field, through data familiarisation, and continued for a lengthy duration upon the researcher’s return from the field (as referred to previously in Table 3.1 in section 3.4.1).

i. Familiarisation with the data (preliminary data analysis)

Data familiarisation commenced concurrently with data collection to help inform continued data collection, and continued until after the completion of data analysis, as described previously in section 3.4.1. Data familiarisation allowed the researcher to develop an overview of the breadth and topics of information gathered (Ritchie and Spencer 1994), through the constant comparison of data. This was done by multiple readings of field notes, and re-listening to recorded interviews and focus group discussions. Additionally, copies of three transcripts representing a diversity of participants, settings and data collection methods were selected to be read and reviewed. These were annotated by the researcher, with notes made about the kinds of topics and ideas raised, and the researcher began to note recurrent themes and key issues.

The data familiarisation process resulted in five broad topic areas being identified which were relevant to the research questions. The five topics provided a framework for the
researcher to then identify specific pieces of data relevant to the five topic areas, and thus to answering the research question. The five topic areas are outlined in table 3.4.

**Table 3.4: Topic areas identified through data familiarisation**

<table>
<thead>
<tr>
<th>Topic area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concepts of community engagement</td>
<td>Information related to the nature of engagement, forms of engagement, what engagement looks like or how it is practiced, how engagement it is represented in community life.</td>
</tr>
<tr>
<td>Positive aspects related to engagement</td>
<td>Good outcomes/benefits of engagement. Includes data about participants’ perspectives and experiences of gains for themselves, for others, or for the community generally as a result of engagement in SRHR promotion issues and initiatives.</td>
</tr>
<tr>
<td>Negative aspects related to engagement</td>
<td>Bad outcomes/negative consequences of engagement. Includes data about participants’ perspectives and experiences of negative consequences for themselves, for others, or for the community generally as a result of engagement in SRHR promotion issues and initiatives.</td>
</tr>
<tr>
<td>Reasons for engagement and influences on engagement</td>
<td>Information about factors that acted as determinants – either positive or negative - in community engagement in SRHR promotion.</td>
</tr>
<tr>
<td>Other general concepts</td>
<td>Other topics and information of interest or relevance to the research questions not otherwise classified above.</td>
</tr>
</tbody>
</table>

The researcher established these five topic areas as nodes in the data management program, NVivo™ version 10.

**ii. Open coding**

All transcripts from interviews, focus group discussions, the written responses to interview questions (from research community number three), and the written poems were inductively coded using open coding (Strauss and Corbin 1990). The primary units of data were individual words or phrases present in the data set. First, transcripts were manually coded using Microsoft Word™. Each transcript was read and any meaningful segment of data related to any of the key topic areas were highlighted to assist in the processes of data reduction and management. Electronic copies of all transcripts were then uploaded into the
Nvivo™ program for storage, sorting and management. The data segments highlighted through manual coding were copied into the relevant node(s) in NVivo™, building a bank of data relevant to each of the key topic areas. This provided the researcher with a more meaningful and manageable data set to work with by removing any irrelevant information.

Next, each segment of data was then ascribed a code which described the idea it related to (Strauss and Corbin 1990). Where possible, words and phrases from the data were used as code names in order to stay true to the data and the contextually relevant terms used by participants. The researcher used a Microsoft Excel™ spreadsheet to keep a record of the descriptive codes in each topic area to ensure consistency in coding where data were similar. However, the set of codes was not prescriptive or limited. Rather, more codes were developed and ascribed as they arose in the data. That is, the constant comparison of the data and the codes enabled the breadth of data to be captured through new codes being developed and ascribed where data did not fit with those already in use. No restriction on the number of codes was applied, so codes continued to develop within each topic area as more data were reviewed. Concurrently throughout the open coding process, the researcher made annotations on the documents about any other point of interest such as conflicts or contradictions that appeared in the data, or other notable points relevant to a critical ethnography, such as representations of power relationships (Grbich 2007). Throughout this process the researcher also inductively developed a series of memos to record observations about any points of interest, summaries of emerging key themes, or any relationships between ideas as they began to emerge (Grbich 2013). Different types of memos were developed, including code memos (related to the creation of codes), theoretical memos (related to observations about relationships between codes and subsequent emerging themes) and operational memos (related to aspects of the research design and conduct, which helped give further nuanced detail and context to the codes) (Jaccard and Jacoby 2010).

iii. Axial coding

Following the completion of open coding, axial coding was undertaken (Strauss 1987). This involved the researcher examining the list of codes and the data within each code to identify any similarities between codes and the ideas they represented. Codes that related to similar ideas or concepts were grouped together to form concepts. Throughout this stage, the
researcher referred to the notes made in her reflective diary and the memos created to help contextualise the codes and emergent themes. Also, various functions of the NVivo™ data management program were used including text search queries, word frequency queries and word trees to help the researcher to understand the data in the contexts in which they were used.

iv. Selective coding

After emergent concepts were established through axial coding, selective coding (Strauss 1987) was undertaken. This involved the researcher further interrogating the concepts to explore whether there were any relationships between them in order to develop key themes as the basis of theory (Jaccard and Jacoby 2010). The process of selective coding was an iterative one, in which the researcher examined the concepts while closely reviewing the observational data recorded in her reflective diary and the memos created during analysis. The observations and questions posed in these sources helped the researcher to further interpret and contextualise the data, and to critically question and refine the developing themes. Throughout this process, the researcher made various iterations of visual representations of the data such as concept maps and theoretical models to try to interrogate and explore the complex, non-linear relationships between emerging themes, in order to refine the emerging theory.

Semiotic analysis

Throughout all stages of the data analysis, a semiotic analysis was concurrently applied to further interrogate the data. A semiotic analysis is a method of language analysis which can take many forms. It seeks to reveal deep and hidden meanings of cultural signs and symbols present in a culture and shared among a population by examining the language used to represent them (Grbich 2007). The researcher applied the semiotic analysis through close attention in data collection (interviews, focus group discussion and informal conversations) and close examination of the transcripts to identify commonalities in participants’ discourses. This included identifying common speech patterns or repetition of words or phrases, the use of metaphors, and the use of cultural constructs which could be interpreted as shared thinking and understanding (Ryan and Bernard 1994, Quinn 1997, Bernard and
Ryan 2010). During data collection, the researcher would ask participants and field assistants to explain any unfamiliar word, phrase or concept. When analysing the data, the researcher highlighted commonalities or contradictions in expressions and meanings within individual transcripts and across transcripts, and considered the context in which statements were made to try to understand their meanings.

The semiotic analysis was important in this research given the researcher’s position as an outsider to the cultural context of the research setting and population. A conscious language analysis facilitated her to develop a deeper and more culturally sensitive understanding of the data by paying close attention to language use and interrogating the nuanced or unfamiliar cultural concepts in the data which may have otherwise been missed. Additionally, while the purpose of this research was to develop understanding about community engagement in SRHR promotion, it did this through collecting individuals’ narratives and data. Thus, it was necessary to understand how meanings represented in individuals’ accounts may have related to community-level engagement. A semiotic analysis helped to draw the links between individuals’ experiences and broader cultural understandings which were shared among the population.

### 3.5 Reflexivity and positionality of the researcher

As indicated previously (see section 1.2), the researcher’s subjectivity was on of being etic to the communities and cultures of this research. Furthermore, she was highly conscious of her identity as a White Anglo-Saxon woman, of middle-class status and tertiary educated, living and engaging with Black majority communities in the post-colonial, post-apartheid South Africa. In particular, she was highly conscious of her desire not to enact symbolic violence. Bourdieu (1989) coined the term ‘symbolic violence’ to mean a process whereby extant social class inequalities are maintained through internalised acceptance of the status-quo by a subordinate group, based on their lived experiences of their social worlds (including the objective structures, and social, structural and institutional factors influencing their social experiences). Bourdieu linked this to individuals’ experience of habitus; that is, the way people think and behave based on their experiences of their social worlds. Habitus is discussed in greater depth in chapter eight. Further, Connolly and Healy (2004) explained symbolic violence “is an act of violence precisely because it leads to the constraint and
subordination of individuals, but it is also *symbolic* in the sense that this is achieved indirectly and without overt and explicit acts of force or coercion” (p. 15; original emphasis). Thus, symbolic violence may be imposed through the usual, everyday and taken-for-granted structures and practices in society. In the case of this research, an example would be through researcher-participant interactions which would reinforce race-based and/or class-based power differences.

So, the researcher employed multiple strategies throughout all stages of the research design, implementation and data analysis to minimise this risk. These strategies are discussed in other sections, but include collaboration with local field assistants in study design, data collection and data analysis (section 1.4), the adoption of epistemological and methodological frameworks to facilitate reflexivity throughout the research (sections 3.3.1 and 3.3.2), the use of data collection methods which enabled participant choice and empowerment, and researcher reflexive diaries (section 3.4.3). Further details of strategies to enable reflexivity are also discussed in sections 3.6 and 3.7 below. The researcher recognises that following the completion of the field work and report, efforts must be made to continue to engage the communities involved in the research in the dissemination of the findings, in order to continue to minimise any risk of imposing symbolic violence. This is an important ethical and practical matter, to ensure meaningful and appropriate methods and messages of dissemination. It will also help the community to see the outcomes of their involvement in the research, and the research overall, and potentially avoid ‘research fatigue’ which could otherwise lead to dispondence or mistrust with future research initiatives (Clark 2008).

One particular point of focus of reflexivity by the researcher, particularly while analysing the data and writing up the findings, was to be closely attuned to recognising and representing the diverse and nuanced voices of participants rather than homogenising or generalising their views. For instance, in this research participants presented viewpoints which in some instances were their own views, but in other instances were their views or assumptions about others’ perspectives. Thus, the researcher took great care to clarify participants’ statements, and elicit whether they were indeed their own views or their perceptions of broader community views. The researcher also gave specific attention to this in the presentation of
findings and discussion (chapters five to eight) and conclusions, to enhance the trustworthiness of the research, and ensure that participant perspectives were accurately and meaningfully represented. This particular skill, developed through this research, is one that the researcher has now taken into several areas of her work such as when analysing data in other research activities, in undertaking more critical reading of other literature, and in her supervision and mentoring of students.

3.6 Trustworthiness and rigour

While qualitative research engenders flexibility, it nonetheless requires that any study be carried out be trustworthy and rigorous (Hansen 2006). Trustworthiness refers to the authenticity of the research, and whether the research represents the existential experiences and ‘truths’ of the matter. Rigour, sometimes called reliability, refers to the strength of the research design including the suitability of methods, the transferability of the research findings and implications to other similar contexts, and the legitimacy of the research process for the context and situation (Hansen 2006, Liamputtong 2009, Grbich 2013). Attention to rigour in research design and methods helps ensure the essence of the spirit of qualitative research is captured (Sandelowski 1993).

Thus, in this study, the researcher gave particular attention to processes to enhance the trustworthiness and reliability to ensure the values of flexibility, cultural appropriateness, participation and empowerment were upheld. This was particularly important given the cross-cultural nature of the research and the potential for latent meanings to be missed or misunderstood in this context; the researcher sought to ensure that the research methods were suitable, and authentically captured and represented participants’ experiences.

Liamputtong (2009) devised a framework of strategies to enhance trustworthiness and rigour in qualitative research, which was used to inform this research. The framework set out two types of strategies: strategies for the research design and process, and strategies related to people (researchers, participants and communities). Strategies used in this research which related to the research design and process included immersion and engagement in the field, selection of appropriate methodological frameworks, reflexivity, and triangulation. Strategies used which related to people included member checking. These strategies are each
discussed below, but sometimes in overlapping ways as the strategies were often applied concurrently; for instance, member checking was applied in tandem with the methodological approach adopted (community-based participatory research methodological approach), and reflexivity was applied throughout all stages of the research process, concurrent with the adoption of methodological frameworks, immersion and triangulation.

First, the researcher undertook extensive periods of immersion and engagement in the field prior to the commencement of the research, and then throughout the research. This was previously described in sections 1.2.1 (origins of the research) and 3.4.3 (data collection methods). The initial period of immersion helped shape the selection of theoretical and methodological frameworks, and subsequent periods of immersion were shaped by the frameworks adopted. The researcher gave great consideration to theoretical and methodological frameworks relevant to research in a cross-cultural context given her dual positions as a novice researcher and someone who was etic to the culture in which the research was conducted.

Similarly, the participatory research methodology (discussed previously in section 3.3.2 – methodological frameworks) was adopted to enhance the trustworthiness and reliability of the research in a cross-cultural setting. For instance, the researcher sought to liaise with partner organisations and field assistants throughout the research. This included in conceptualising the research approach and methods, and in developing appropriate and acceptable research questions, to enable opportunities for meaningful contributions (Mosavel et al. 2005). Data collection instruments were also developed in collaboration with field assistants to ensure the language used and concepts addressed would be appropriately understood, and would elicit responses which reflected participants’ personal views and experiences to enhance authenticity.

Theoretical and methodological frameworks were selected which facilitated the practice of reflexivity and the development of consciousness about the researcher’s subjectivities. Doing so helped illuminate any tacit assumptions held by the researcher, and helped raise the researcher’s awareness of the ways in which any socio-cultural assumptions could influence the construction of data collection and interpretations. Adopting such a critical
consciousness subscribes to Silverman’s (2010) principle of refutability in which the researcher seeks to be critical and refute assumptions in the data in order to enhance the trustworthiness of the research.

Triangulation was also applied to various aspects of the research process. Various types of triangulation were applied, including theoretical triangulation, methods triangulation, data source triangulation, analysis triangulation and researcher triangulation (see Kimchi et al. 1991). Theoretical triangulation was applied through the adoption of multiple theoretical and methodological frameworks to view the research questions. Methods triangulation was applied through the utilisation of multiple data collection methods. Similarly, data source triangulation was used to collect data from multiple participants across multiple sites. This enabled a breadth and diversity of multiple truths to be captured to enhance validity. The multiple methods of data collection ensured participants could provide data in ways they considered most meaningful for them (previously discussed in section 3.4.3 – data collection methods). Further, it enabled the researcher to check her interpretations by looking across data sources in combination with a practice of reflexivity (for instance, by looking across interview and focus group data with field notes and the researcher’s reflective diary) to ensure a close and contextual reading of the data and a trustworthy interpretation.

Triangulation was then applied to the analysis of the data through combining an inductive thematic analysis with a semiotic analysis to capture the culturally contextual meanings of words, phrases and ideas to ensure these were authentically understood and represented in the themes.

Researcher triangulation was used through the engagement of local field assistants to help the researcher ensure rigour in the implementation of the research in the cross-cultural context, and also ensure a trustworthy interpretation of information in the local cultural context. The researcher and field assistants engaged in regular reflection, including after each interview or focus group discussion and during preliminary data analysis, to discuss and clarify key points or concepts to ensure the researcher’s understandings were culturally and contextually appropriate and relevant. This helped to ensure that participants’ voices and meanings were privileged over any tacit assumptions or interpretations by the researcher, to
enhance the trustworthiness of the data. This process of reflection was also used to identify gaps in sampling or data collection which needed to be filled, and enhance validity.

Finally, member checking was used to ensure participants’ voices and any nuanced meanings in their accounts were captured and privileged over the researcher’s own interpretation, to enhance trustworthiness. The researcher was highly conscious of noting the language used by participants and verifying the meaning or understanding of any unfamiliar terms or phrases (or those that were used in a manner that seemed unusual to the researcher) through member checking and respondent validation (Silverman 2010), by frequently checking with participants and field assistants (member checking). Furthermore, the researcher then sought to adopt the same language as participants in her engagement with participants, when appropriate.

3.7 Ethical considerations

The research was granted ethical approval by the Deakin University Human Research Ethics Committee (approval number DU-HREC 2011-200) (Appendix A). Several potential ethical issues needed to be considered and addressed in relation to this research, the most prominent ones being the potential for symbolic violence, ensuring informed consent, and determining the appropriate age for participation. Each of these are discussed further below.

Many of the potential ethical issues stemmed from the cross-cultural nature of this research, and the researcher’s position as an outsider. For instance, the researcher’s identity and position as a white, educated person from a ‘Western’ higher education institution raised the potential risk of symbolic violence being imposed (the concept of symbolic violence is discussed above in section 3.5). Thus, the researcher sought to enable empowering and emancipatory research processes for participants, as described throughout the methods. Specifically, the researcher was highly conscious of her positionality given the historical context and contemporary legacy of apartheid; her consciousness about perceptions of power and privilege was particularly heightened when initially engaging with potential participants and seeking informed consent. The researcher had to be alert to cultural differences and sensitivities, and take steps to not inadvertently transgress cultural norms by imposing her own cultural assumptions or lens upon the research (Lee-Treweek and Linkogle 2000, Piper.
and Simons 2011). Strategies to try to reduce this risk were embedded in the research design, such as the CBPR approach to the research involving close collaboration with local field assistants, methodological triangulation to enable participants to have choices in determining their own participation, and the utilisation of a researcher reflective diary (all discussed previously in sections 3.3.2 and 3.4.2). Additionally, the researcher exercised a willingness to develop knowledge and understanding of the cultural context, to learn and be transparent and flexible, and to ensure appropriate communication with community members in order to demonstrate cultural sensitivity (Liamputtong 2008). Specific ways in which these things were done in this research have been described previously in the methods (section 3.4).

One particular ethical challenge was ensuring truly ‘informed’ consent. The ethical dilemmas with this were related to perceptions of power and symbolic violence in the cross-cultural context, and language barriers, in seeking to ensure informed consent. Language and literacy comprehension (in English and isiXhosa) and comprehension of research processes among participants was highly variable, with some participants having little or no writing or reading literacy. The researcher did not wish to potentially exclude participants based on limited language and literacy skills. Additionally, the researcher was highly cognisant of her position as an educated and professional white ‘visitor’ in seeking informed consent, and did not wish to impose any symbolic power imbalances which may have influenced community members’ decision to participate. To mitigate these risks, the research design allowed for multiple ways of the researcher and community members engaging in the consenting process, including the provision of the PLS and CF in written and oral forms, and in the language of participants’ choice (as described previously in section 3.4.2 – participant sampling and recruitment). Additionally, the researcher drew upon the field assistants who acted as key conduits to facilitate communication between the researcher and potential participants, and potential participants could also choose to participate by engaging with the researcher or field assistant.

Another substantial ethical consideration was the decision to include young people under the age of 18 years in the research, and enable them to consent for themselves rather than seeking parental or guardian’s consent. The legal age of consent according to Australian research ethics standards is 18 years; people aged under 18 years who wish to participate in
research will ordinarily require a parent or legal guardian to consent on their behalf (National Health and Medical Research Council [NHMRC] 2007). However, in the context of this research, seeking parental or guardian consent on behalf of a young person was considered inappropriate. Many young people under the age of 18 years often already fulfil social roles of responsibility and decision making such as being a head-of-household or caregiver for dependents (ECSECC 2012). Data from the last census to be undertaken prior to this research commencing (the 2011 census), around the time ethics approval was being sought to recruit young people as participants, demonstrated there were more than 15,000 households in the Eastern Cape headed by young people aged under 19 years, with more than 2,000 of those being headed by a child aged 10-14 years (Lehohla 2014). Thus, young people aged under 18 years were considered to be able to demonstrate a level of maturity commensurate with being able to consent for themselves. Excluding young people from consenting for themselves would have potentially impinged upon the young peoples’ right to participate, and would risk potentially imposing paternalism by enforcing and reinforcing dominant ‘Western’ values governing the research (Ramcharan 2013). Additionally, seeking parental or guardian consent could have posed barriers or even harm to young people participating based on the sensitive nature of the topic. Socio-cultural norms and values regarding intergenerational relationships often prevent open discussions about SRHR issues between parents and children (Abrahams and Jewkes 2012, Nkani and Bhana 2016, Mjwara and Maharaj 2018). This could have made it inappropriate or uncomfortable for young people to raise the sensitive nature of the research topic with their parents in order to seek parental consent, and potentially prevented their participation. Thus, the researcher sought human research ethics committee approval to allow these young people to consent for themselves given relevant socio-cultural factors, and this was granted.

3.8 Chapter summary

This chapter has described in detail all aspects of research design and conduct applied in this research to explore the research questions. The epistemological positions, theoretical frameworks, methodological approaches, and specific methods of data collection, management and analysis were all chosen to privilege participants’ accounts of their lived experiences of community engagement in SRHR promotion. These design elements were
purposely chosen to give voice to participants, and to ensure that the research was empowering for participants through their participation experiences.

Furthermore, all aspects gave close consideration to the exploring this topic within the unique cultural context and settings of the research, and with cognisance of the researcher’s role, implicit assumptions and potential influences within a cross-cultural context. Despite the attention given to these aspects of research design and conduct, several ethical challenges and limitations to the research arose. The chapter contained a discussion of some of the key ethical issues encountered, and how they were managed to support the ethnographic and empowering values underpinning the research, and enhance the validity and rigour of the research. A discussion of the limitations of the research is contained in chapter nine (conclusions). The following chapter is the first in a series of chapters presenting key findings from the research.
CHAPTER FOUR
COMMUNITY ENGAGEMENT CONCEPTS AND UNDERSTANDING
4.1 Introduction

This is the first of five chapters presenting the findings of the research. This chapter discusses participants’ perspectives on the meanings of community engagement, and the forms of knowledge which inform those meanings and the practices of community engagement. Thus, this chapter specifically addresses the first research question which seeks to understand what the concept of ‘community engagement’ means among communities in South Africa.

The chapter begins with a discussion of participants’ locally-held meanings of community engagement, highlighting that meanings are intertwined with the practices of engagement; for instance, inclusivity and non-discrimination are both core to the meaning of engagement as well as ways of practicing engagement. The chapter then unpacks the various forms of community-held knowledges and beliefs about SRHR issues as expressed by participants. These knowledges, beliefs and meanings were a prominent influence on community engagement in SRHR promotion for themselves and the community. This chapter provides an important context and foundation for the following four findings chapters, as the factors presented in the ensuing chapters numbered five to seven, and the final themes presented in chapter eight, interact with the types of community knowledges and beliefs knowledge presented in this chapter.

Participants’ accounts revealed a range of knowledges and beliefs about SRHR issues. Their accounts included discussion of their own beliefs, as well as their commentaries on knowledges and beliefs held among the community more broadly. Although the latter perspectives are interpretive perceptions about others’ views and beliefs, they do provide insights into social discourses which may influence community engagement in SRHR promotion. Participants’ discussions revealed that forms of scientifically factual knowledge and lay knowledge are simultaneously present in communities. In the context of this research, factual knowledge refers to that which is understood and accurate within a ‘Western’ scientific ontology; this is the discourse that tends to be presented by SRHR organisations and programs. Lay knowledges are those which are understood by participants or community members to be true based on personal and traditional community-held beliefs.
Discussion about the forms of knowledge begins with a focus on the influences of the ‘Western’ scientific ontology on community engagement. This includes highlighting some contentions about the state of knowledge in communities. Perceived gaps in knowledge (among individuals and the broader community) were also revealed by participants. Views about the influence (positive or negative) of the current state of knowledge and knowledge gaps on community engagement in SRHR promotion varied among participants, and these different perspectives are highlighted.

Following this, the local ontologies regarding SRHR issues and the perceived influences (predominantly negative) of this form of knowledge on community engagement are discussed. This part of the discussion is much briefer than that on ‘Western’ scientific ontologies, and participants tended to discuss views about the beliefs they thought were held among the community generally, rather than their own personal beliefs. Throughout the discussion, links to other influences are raised, such as links to stigma, which are further discussed in subsequent chapters.

4.2 Participants’ understandings of community engagement in SRHR promotion

Participants rarely articulated a specific definition of ‘community engagement’. Rather, meanings about community engagement were derived by the researcher from interpretations of participants’ narratives about lived experiences of community engagement. Several key concepts were revealed by participants to be both values and goals of community engagement in SRHR promotion. These included community connectedness, inclusivity, and the wellbeing of others and the community overall. This highlights the complexity of factors involved in community engagement.

Several participants discussed social connectedness and the idea of a shared humanity as core underpinning values of community engagement in SRHR promotion. Lindani highlighted this when she discussed her engagement in SRHR promotion activities:

*I’m a member of the support group. It is because I’m affected. Because my sister and mother are HIV [positive]. So I can’t just stay sitting, inactive.*
Lindani’s statement highlighted that her experiences with SRHR promotion were intricately linked to those of her family, and with her sense of connectedness with others. Some participants believed that the value of connectedness in community engagement was shared widely among the community. Fundiswa expressed this when she spoke of the collective ‘we’ while discussing community engagement in SRHR promotion programs focused on HIV prevention:

As we are saying, if you are not infected you are affected.

(Fundiswa, adult female: interview 19)

This sense of inter-personal connectedness represents the cultural concept of *Ubuntu* (previously introduced in section 2.4.1). This concept was explicitly named by one participant:

... when they come here [to the SRHR support group] they do not see themselves different from us, like, Nobuntu. [Meaning ‘we are one; we are working together’]

(Ciko, adult male: focus group 1)

In this instance, Ciko highlights how oneness and social connectedness, or *Ubuntu*, is both a process of community engagement, as well as an outcome of community engagement in SRHR promotion.

Several participants described how inclusivity was a central process and outcome of community engagement in SRHR promotion. Some discussed examples from their experiences of inclusivity in community-based initiatives such as HIV support groups. Inclusivity as a process in community engagement was understood as, and practiced by, actively welcoming and accepting people in the community. In particular, participants across multiple focus groups and interviews discussed inclusion as valuing and practicing non-discrimination, and enabling opportunities for participation by all:
I think it is an important thing now [to get a mix of people involved in SRHR promotion, such as HIV positive people, HIV negative people, older generations, youth], because they are together. There’s no one said, ‘I am HIV negative, you are HIV positive’. There’s not that discrimination now – ... – [not] judging. They are just together.

(Vuya, adult female: interview 3)

...it [the program] does not discriminate, all are welcome. [HIV] Positive and negative people.

(Fozaka, adult male: focus group 1)

Similarly, participants viewed the mixing of different socially-constructed groups in society (for instance, groups constructed as different on the basis of HIV status, being those who are HIV positive and those who are HIV negative) as important for social inclusion and thus community engagement:

It’s a mix. ... [the] support group, it’s open. Because someone who is HIV positive is ... helped with [by] someone who is not HIV positive. So the support group must be open for everyone.

(Vuya, adult female: interview 3)

Vuya repeated this sentiment in a later interview:

Now we mix the groups together. Because there are, even the ones who is not affected can help the affected ones.

(Vuya, adult female: interview 4)

Her reiteration of this point across two interviews emphasised her view that community engagement is about inclusivity. The successful mixing of different groups and bringing people together demonstrates how inclusivity is not only a process of community engagement, but also represents an outcome of community engagement.
Contributing to the wellbeing of others and the community was also prominent in participants’ understandings of community engagement. Several participants used the phrase that “staying at home doesn’t help” to express their view that inactivity or a lack of involvement by individuals in community SRHR activities does not contribute to the wellbeing of others or the community. Conversely, individuals’ active involvement in community activities was viewed as contributing to promoting the wellbeing of others and the community:

*Here at [organisation], [we are] doing Home Based Care work. Caring for the sick and those who cannot do anything for themselves. I look after them because I realised staying at home … people don’t have anyone to care for them. I decided I must join and take care of the people.*

(Nozibele, adult female: focus group 1)

*I am* here in [organisation] doing Home Based Care since 2010. I am on the side of the old people looking after them. I realised staying at home does not help, so I decided to join others. …I take the feeling of a sick person to me.

(Nokukhanya, adult female: focus group 1)

Nokukhanya’s comment supports the idea that helping others is part of community engagement. She also reinforced the centrality of connectedness and solidarity with others through her expression that “I am on the side of the old people”, and “I take the feeling of a sick person to me”, suggesting she feels empathy with others as part of her experience of community connectedness and community engagement.

The expression that “staying at home doesn’t help” and the idea it entails was repeated by several members of the same organisation and focus group discussion (focus group one). The idea that contributing to the wellbeing of others and the community was also discussed by participants in other research sites. This highlights the widespread view of this concept as central to the meaning of community engagement.
Overall, community engagement in SRHR promotion was constructed as a process aimed at promoting social connectedness, inclusivity and community wellbeing. The achievement of social connectedness, inclusivity and community wellbeing were also seen as an outcome of community engagement.

Participants also viewed engagement in SRHR promotion as part of everyday community practices and interactions. That is, it was seen as being embedded within or integrated with other civic activities rather than as a separate undertaking. Discussions about community engagement in SRHR promotion often occurred concurrently with discussions about participation in society more widely. Fundiswa demonstrated this when discussing her engagement in SRHR promotion activities and in society more broadly:

_We are all together, in terms of being activists. On pushing our existence, you know, in this society._

(Fundiswa, adult female: interview 19)

Several participants considered that engagement in SRHR promotion provided opportunities to develop other civic and life skills, social connections and opportunities for social inclusion; in particular, civic rights and empowerment were raised by several participants:

_Now I am a member of the support group … I know my rights._

(Thandiwe, adult female: field notes)

This demonstrates the integration of engagement in SRHR promotion with other social goals and outcomes; in this case, engagement in SRHR promotion initiatives was a determinant of broader social participation, inclusion and engagement in the community.

In other cases participants first engaged in other civic activities, and this facilitated opportunities to engage with SRHR promotion. For example, Ciko, a community member who has a disability, explained that he initially became engaged with an SRHR-based support group because of his perception that the group provided support and opportunities for civic participation for people with disabilities:
I saw disabled people coming here. When I asked, they said there is help here. I have just arrived so they will show me where to help. I can do some hand work [e.g. sewing].

(Ciko, adult male: focus group 1)

Ciko’s comments that “they will show me where to help” and “I can do some hand work” demonstrate that his paramount reason for initially engaging with the organisation was to engage with other civic participation, not specifically SRHR promotion. However, Ciko subsequently became engaged in learning more about SRHR issues through participating in workshops. He also engaged with other community members around SRHR promotion by delivering SRHR education and awareness-raising initiatives in the community. Similar accounts were shared by other participants, such as Thandiwe and Esihle (interview one), who described how they became engaged in community programs in order to gain computer skills with a view to enhance their employability. Through their initial program engagement, they became engaged in SRHR promotion.

Similarly, Nonzukiso discussed her role as a member of a community-based support organisation for people living with HIV or AIDS which included community members who were HIV positive and HIV negative. The predominant activity of the group was to provide home-based care to community members living with HIV or AIDS, as well as others in the community who were sick or experiencing isolation and difficulty. The organisation also undertook other activities such as providing a crèche for children, community garden projects to help improve food security, and small income-generating activities such as sewing. When discussing her own initial engagement in the organisation, Nonzukiso explained:

What attracts people is we work with our hands. ... We sew and grow vegetables, and we educate each other about working with hands and social lifestyle.

(Nonzukiso, adult female: focus group 1)
Although Nonzukiso was speaking of her own experience and views, in saying “what attracts people”, she framed the discussion in a way that revealed a perception that her views are shared by others in the community. Her example shows that she, and possibly others in the community, value opportunities to engage and connect with other people, to participate in other activities and civic life (“social lifestyle”), and to obtain opportunities for education through community-based SRHR promotion initiatives.

The bi-directional relationship between engagement in SRHR promotion and civic engagement demonstrates the contextual nature of community engagement, and highlights how the individual and community contexts interact to influence the practice of community engagement in SRHR promotion.

The discussion so far has provided insight into community meanings of ‘community engagement’ in this research context, revealing that community members’ perspectives and experiences of community engagement are multifaceted. A key insight which emerge was that understandings and experiences of community engagement in SRHR promotion are linked to community connectedness, inclusion and wellbeing. Also, community engagement in SRHR promotion does not occur in isolation, and cannot be considered separate from broader community life or civic engagement. Rather, it is embedded within everyday community life and context. This point is returned to in chapter eight, when the superordinate theme of the relational environment as an influence on community engagement in SRHR promotion is discussed. Now that the meaning of ‘community engagement’ in the context of this research has been established, the remainder of the chapter will focus on understandings of different forms of knowledges and beliefs influencing community engagement in SRHR promotion.

4.3 The influence of a Western scientific ontology on community engagement

4.3.1 Perceptions about the state of factual SRHR knowledge among the community

Participants expressed contradicting views about the degree of factual SRHR knowledge that existed among individuals and at the community level, particularly knowledge related to HIV and AIDS. Some participants perceived differences in the state of community-wide
knowledge across different community locations, such as suburban communities, peri-urban communities, township communities and rural communities. For instance, some shared a view that factual knowledge was generally widespread in suburban and township communities:

**Veliswa:** I think even if you live in the suburb, even if you live in the township. Everybody knows about HIV and AIDS.

**Viwe:** Yeah they –

**Veliswa:** Everybody knows about it. They – you’ve got no excuse. You see it on the TV, you see it on posters-

**Bukeka:** School –

**Veliswa:** You have it in the school. Even if you don’t go to school, you know about HIV and AIDS.

**Viwe:** I think more, more, more information about HIV is given every day. And it’s ignorance. If you’re ignorant about it, obviously you, you won’t do anything about it.

(Members of a youth group associated with an SRHR organisation: focus group 6)

In contrast, there was a recurring view among participants from both urban and rural settings that factual knowledge was scarce in rural areas. In focus group three, Brenda held this view particularly strongly, and stated the point multiple times:

_I would say – that [in rural] areas, it’s like people are so very uneducated when it comes to HIV. I would say that they still don’t know what it is._

(Brenda, adult female: focus group 3)
[We need to] take what we know to the [rural] areas where there’s nothing [no information]. Because hardly people [have information], you’d be surprised to see the old ladies that are infected. You don’t know how.

(Brenda, adult female: focus group 3)

Her view was reinforced later by others in the same focus group:

Nokwanda: I will say, in rural areas, most people are blank.

Researcher: What do you mean ‘blank’? What are you meaning?

Lindani: They don’t have information.

Nokwanda: They don’t have information.

(Nokwanda, female youth; and Lindani, female youth: focus group 3)

Others were uncertain about their own level of factual knowledge about SRHR generally, and thus considered they were limited in what they could meaningfully comment on. For instance, Lwazi made the following comment:

I can’t say I know. I can’t say I don’t know. Because the only time I heard about this SRH it’s when we are speaking with friends. No one ever told me, professional, formally or unformally [sic], in fact. We share experience when we are talking with friends. So, I can’t rate myself as I know or I don’t know.

(Lwazi, male youth: interview 11)

Lwazi was commenting based on his own experiences in a peri-urban township. The extracts above highlights the diversity of participants’ perspectives about SRHR knowledge among communities, especially that concerning HIV and AIDS. In particular, the participants’ accounts highlighted perceived differences in knowledge across different community locations, thus drawing attention to the interplay of ‘knowledges’ with the social context.
4.3.2 Perceptions about the influence of factual knowledge on community engagement in SRHR promotion

While there was a common view among participants that factual knowledge about SRHR issues was an important influence on community engagement in SRHR promotion, views varied about whether this influence had positive or negative effects on engagement. Some participants shared their own experience of how having some knowledge facilitated their further engagement in SRHR promotion. For instance, when asked about her engagement with partner organisation one, Ntombi began by explaining that she was not presently (at the time of the research) engaged with the organisation in any way but would like to be:

> It is interesting for me. I want to know what is going on and what they are doing in my community. ... I would like to be part of them, in that group, whereby we could teach them [community members] and let them learn and let them understand that this [HIV] is alive and this is there. ... And I would love to be part of it, if I may say.

(Ntombi, adult female: focus group 4)

When probed further on the reasons for this, she explained that it was linked to previous experiences of SRHR promotion, and the knowledge she had gained from those experiences:

> I used to work, I stayed in [city] ... That was '96 [1996]. Then I stayed there for about ten years. Then I worked at ... another place that was called [organisation name]. We were looking after children, small children, babies up to seven years. Only TB [tuberculosis] babies and HIV positive babies.... We would give them medicine and medication and they would teach us how they live. How do people who are positive [live] ... all that stuff. So that's why I know a lot. So that's how I know all these ways of living with the AIDS.

(Ntombi, adult female: focus group 4)

For Ntombi, the factual knowledge gained through previous experiences stimulated her interest in further engagement in SRHR promotion. Further, her desire to engage in SRHR
promotion to contribute to enhancing community knowledge and wellbeing reinforces the meanings of engagement which were previously presented in section 4.2 of this chapter.

In contrast, some participants discussed how having some factual knowledge could contribute to disengagement from SRHR promotion activities:

There are people who are serious about life that I know, who are, who knows – who have knowledge about it, but there are few of them. The rest of us, we don’t engage ourselves in this, in programs like this...Because, we are comfortable with what we already know.

(Lwazi, male youth: interview 11)

Lwazi’s statement indicates that he has made a conscious decision to not engage with SRHR promotion based on his perceptions of the knowledge he already possessed. In sharing his own experience, Lwazi situated himself in the collective (‘us’, ‘we’), indicating his perception that his view is shared by others in the community. This was supported by several other participants who discussed their observations or opinions regarding community members consciously deciding not to engage in SRHR promotion. They described this occurrence as a form of ‘ignorance’. The discussion about ignorance is expanded on in section 4.6 below.

4.3.3 Gaps in factual knowledge influence community engagement in SRHR promotion

Participants discussed self-identified gaps in their own factual knowledge, and perceived gaps in factual knowledge among the broader community, as key influences on community engagement in SRHR promotion. Views about whether these gaps facilitated or inhibited community engagement in SRHR promotion varied. Participants discussed their own experiences of how a perceived gap in their factual knowledge stimulated their initial or sustained engagement in SRHR promotion. In these instances, the desire to gain more knowledge was a key motivating factor in their engagement. Several participants in focus group three who had not previously engaged in community-based SRHR promotion organisations or activities expressed this:
She said … she knew about HIV but she’s got a little information so that’s why she wants to [come to partner organisation one] [and get more information], so that she can help her friends.

(Nokwanda, female youth; interpreting for Nikelwa, female youth: focus group 3)

Nokwanda: [Interpreting for Lindani] She [Lindani] said when she joined here, she wants to – she had the information about HIV before –

Researcher: A little bit or a lot?

Nokwanda: A little bit. And that’s why she said she joined the support group … if she have [sic] the information she will try to help the community. if probably someone else in her family would be infected by [HIV], she’ll know what to do, she’ll know how to help that person also, so.

(Nokwanda, female youth; interpreting for Lindani, female youth: focus group 3)

Some also discussed how they perceived gaps in factual knowledge among their broader community, and how this positively influenced their own personal engagement. That is, some described how their perception of community-level knowledge gaps motivated them to acquire information and skills in order to share these with their communities. These participants thought they would then be able to contribute to addressing the knowledge gaps in their communities, and contribute to positive community-level outcomes. For instance Lindani, in addition to identifying her own knowledge gap (above), perceived a gap in the broader community’s knowledge which prompted her to act:

…she wants to tell you, to know she wanted information, because she sees, she saw in her area most people are ignorant. Some [others] would say they know the information, they know about HIV, but they don’t want to do anything about it. So that’s why she joined.

(Nokwanda, female youth; interpreting for Lindani, female youth: focus group 3)
This highlights a link between the individual and community-level experiences of engagement, in that Lindani’s individual experience of engagement was influenced by her perceptions of community-level engagement. It also draws links to the meanings of community engagement discussed in the previous chapter, which emphasised community wellbeing and contributing to the community as central underpinnings of community engagement.

The above accounts reveal how participants own engagement had been influenced by perceived knowledge gaps. Additionally, some participants discussed their views on how knowledge gaps influenced engagement among the broader community. Some participants thought that gaps in community-wide knowledge tended to pose a barrier to the broader community engaging with SRHR promotion initiatives. They thought this was due to gaps in factual knowledge and the concurrent persistence of lay knowledge and lay discourses in the community, including myths and misinformation. This is discussed further, with examples, in section 4.5.

On the other hand, some participants expressed the view that gaps in factual knowledge did facilitate broader community engagement as community members sought to gain greater factual knowledge:

   They come [to participate in organisation’s programs] because they want to; they want the information about the SRHR

   (Zandile, female youth: interview 2)

   Many people want to get involved to these programs like these, because some they are HIV [positive], they don’t know how to help themselves; they have [an] STI, they don’t know how to help themselves and others they reject them, you know? That’s why they want to be part of this.

   (Nceba, female youth; focus group 5)

This view was mostly held by participants who were involved with SRHR programs either as program workers or participants, based on their experiences in programs. Thus, these
participants may have a different perspective from other community members regarding community-wide engagement.

Several participants also suggested links between gaps in factual knowledge among the community and the existence of predominant socio-normative attitudes in their communities regarding SRHR issues. For example, Nokwanda highlighted the particular socio-cultural norms of silence and inter-generational conservatism surrounding discussion of SRHR issues. She believed norms contributed to knowledge gaps among young people, as full and frank knowledge was not shared with them by parents. Nokwanda expressed that the gaps in factual knowledge contributed to rousing curiosity and encouraging risky SRHR behaviours, contrary to SRHR promotion. Nokwanda used an analogy to demonstrate this:

...[if] a parent say[s] “abstain” to try to educate [children] on ABC [Abstain, Be Faithful, Condomise to prevent the spread of STIs], [children] say, “I will say to my mother, “yes, I will do that” but why my mother is not telling me why must I not do that? So I want to experience [sex], while I’m telling this person I’m doing ABC, while I’m having three boyfriends or while not abstaining; I’m having sex. I want to experience [sex]. ……I’d say teenagers, if you are telling them “Please don’t sit on that chair”, [they] will ask “why must I not sit there?”. And [the parent] keep on saying “Please don’t sit there”... [They] will go and sit there.

(Nokwanda, female youth: focus group 5)

Several other participants shared the view that socio-cultural norms such as shame, silencing and stigma, particularly in an inter-generational context, contributed to gaps in factual knowledge and poor community engagement in SRHR promotion. Some of these factors, such as stigma and intergenerational relationships as influences on engagement, are discussed further in chapters five and six respectively.

4.4 The influence of a lay ontology on community engagement

Alongside the scientifically factual ontology discussed above, participants also discussed lay knowledges and beliefs present in communities which they thought influenced community engagement in SRHR promotion. These discussions were predominantly participants’ views
about what they thought the wider community believed to be true, rather than reflecting their own personal views; however, the participants’ perspectives about the community were informed by their own lived experiences as community members and their local ontologies.

Participants were commonly of the view that lay knowledges were often comprised of, and contributed to, discourses of SRHR based on misinformation, myth, fear and stigma. Furthermore, they perceived that these discourses arose from simultaneous gaps in factual knowledge. Participants viewed this as a barrier to community engagement in SRHR promotion. The following passage is one example which demonstrates the interaction of lay knowledge, misinformation present in lay discourses, and incomplete factual knowledge. Other examples are provided further on, specifically in relation to the topic of stigma (see section 5.3):

Bukeka: Most of the people didn’t even know where HIV came from …. Like those workers, they didn’t even know what a condom is used for. Because they’re saying that it’s, it will make you -

Veliswa: it will make your penis –

Bukeka: - it will make your penis not breathe, it will make you not to feel the intercourse. So there was a very much lack of awareness about condoms and HIV and AIDS.

Ahmed: And in case she didn’t give [discuss] any disadvantages and advantages of using condoms. That’s why they were so ignorant about the stuff, telling them the penis won’t breathe, etcetera, etcetera.

(Members a youth group associated with an SRHR organisation: focus group 6)

In the passage, Bukeka stated her view that there is a lack of awareness regarding HIV and condom use, and Ahmed suggested that an incomplete provision of factual knowledge (information about the advantages and disadvantages of condom use) was not given. However, rather than demonstrating an absolute lack of knowledge about HIV and the health-promoting benefits of condoms, this passage reveals the privileging of local
knowledges and beliefs, which the community understand to be true, about this issue. That is, participants deemed community engagement in SRHR promotion messages and behaviours (in this case, the use of condoms) was negatively influenced by the presence of lay beliefs. This narrative also suggests that peoples’ engagement (or lack of engagement) with SRHR promotion may be influenced by the priority placed on different aspects of sexual and reproductive health. For instance, in this example there appears to be a higher priority placed on perceived satisfaction of a sexual experience, coupled with a belief that engagement with the SRHR promotion messages and behaviours about condom use will decrease that satisfaction. Participants in the focus group perceived this contributed to low engagement with health-promoting messages and behaviours. This further demonstrates how knowledges and community engagement interact with the context of everyday life (such as other priorities).

In general, most participants were themselves able to distinguish between ‘factual’ (scientifically-accepted) health-promotion knowledge and lay community knowledges. However, there were instances which revealed that some participants did possess gaps in accepted SRHR health-promotion knowledge, and concurrently held lay beliefs. Further discussion of this, and examples to demonstrate, are provided in the following chapter in the section where stigma, discrimination and assumptions are discussed (section 5.2).

4.5 Ignorance as an influence on, and enactment of, poor community engagement

Another knowledge-related aspect raised often by participants was ignorance. The term ‘ignorance’ (or ‘ignorant’) was repeatedly used by participants in different contexts, and sometimes with varying meanings. Ignorance was sometimes described by participants as the perceived lack of factual knowledge among individuals or the community generally. This was demonstrated by Ahmed’s example above (when he discussed a lack of factual information about the advantages and disadvantages of condom use). Ahmed’s example revealed that he understood ignorance to be the lack of factual knowledge which gave rise to the privileging and persistence of lay forms of knowledge and beliefs in the community (for instance, that the penis will not breathe with a condom on). This form of ignorance among the community - a lack of factual knowledge - was generally viewed by participants as
perpetuating myth, fear and stigma regarding SRHR issues, and thus was considered to pose a barrier to community engagement.

However, in contrast, some participants perceived ignorance as a conscious decision by community members to disengage from SRHR promotion despite, or because of, the SRHR knowledge they considered they already had:

*But still, others are still ignorant, they don’t want to change.*

(Nokwanda, female youth: focus group 3)

_Fundiswa:_ Especially in the urban areas, you know these suburbs that you are staying in, the people will whisper.

_Researcher:_ Even when there’s so much work being done and so much – you know, so many organisations promoting knowledge and awareness, big awareness days, mass media [campaigns] like ‘loveLife’ and ‘Soul City’ [SRHR programs]? Even though there’s so much public information?

_Fundiswa:_ Ignorance. It’s ignorance.

_Researcher:_ Ignorance? What do you mean by ignorance?

_Fundiswa:_ People, they have said ‘no’. They just choose not to listen. They think that they heard enough of HIV .... As much as they said they get enough, but they are not on the right track.

(Fundiswa, adult female: interview 19)

The above examples highlight the perception that some community members actively choose not to listen to or act upon SRHR promotion messages. Thus, ignorance was seen as a barrier to community engagement as well as an outcome of engagement (the demonstration of disengagement).
Others linked the conscious decision making and inaction to other barriers such as fear, intertwined with lay knowledge and gaps in factual knowledge:

*Nokwanda*: [interpreting for Lindani] She wants to tell you she sees in her area most people are ignorant. Some would say they knew, they know, the information, they know about HIV, but they don’t want to do anything about it.

*Researcher*: And why is that?

*Nokwanda*: [interprets and responds] She said they’re scared to know about their status...

*Researcher*: I’m just trying to really understand. Are they scared to know their status just because they think they know what happens when you’re HIV positive, that it’s incurable and they’ve heard bad things?

*Nokwanda*: [interprets and responds] They’ve got that information that when you’re infected you’re going to die.

(Lindani, female youth; with interpretation from Nokwanda, female youth: focus group 3)

This example suggests a link between ignorance and fatalistic beliefs, linked to forms for knowledge and knowledge gaps. Fatalism is further discussed in chapter five (section 5.4).

**4.6 Discussion**

This chapter began by revealing participants’ understandings of the meanings of community engagement, including how community engagement is meaningfully practiced and experienced. The discussions revealed the centrality of social connectedness, inclusiveness and community wellbeing to meanings and practices of community engagement in SRHR promotion.
These concepts reflect the underpinning cultural values of *Ubuntu*. The concept of *Ubuntu* was previously described in chapter two (section 2.4.1). *Ubuntu* has been used in previous research as a framework for understanding South Africans’ experiences with SRHR issues like HIV (Angotti et al. 2018). The study by Angotti et al. (2018) revealed how community members living with HIV or AIDS employed strategies for taking care of themselves which ultimately involved a focus on ensuring the wellbeing of the community at large. The authors explained, “Care for one another and a sense of community monitoring and responsibility reframe the individualistic imperative and reflect a collective obligation attendant to the shared humanity within a community” (p. 272). This present research adds to the body of literature linking *Ubuntu* with SRHR issues, specifically community-based SRHR promotion.

Literature has also previously linked *Ubuntu* to concepts like social connectedness and social inclusion in South Africa (see Samuel and Bagwiza Uwizeyimana 2017). Social connectedness refers to the relationships people have with others which are constructed through the interactions of a range of social and cultural factors (Taket et al. 2009). Participants in the current study spoke of this widely in describing understandings and experiences of community engagement. However, literature about *Ubuntu* (discussed in section 2.4.1) suggests that the concept is broader than just social connectedness. Rather, *Ubuntu* incorporates a fundamental emphasis on the wellbeing of the collective (Murove 2014, Mangena 2016). This emphasis was also strongly and repeatedly articulated in the current research in relation to meanings of community engagement.

In the present research, participants’ discussions of social connectedness and inclusiveness alluded to the related concept of social capital. Social capital moves beyond simply social connections between people or groups to include access to norms, values, opportunities, resources and social mobility (Putnam 1995, Szreter and Woolcock 2004). Samuel and Bagwiza Uwizeyimana (2017) have argued that social connectedness helps to provide access to social capital by developing resourcefulness, and facilitating access to resources and opportunities, and developing participatory capacity among community members. Findings from the present research reveal forms of bonding and bridging social capital are entwined with constructions of community engagement in the settings of this research. For instance,
participants shared the view that community engagement was about connecting with others of similar social situations (bonding social capital), but also developing links between different groups in society (bridging social capital); this was particularly discussed in relation to community-based organisations and groups being inclusive and welcoming of all. Other aspects of social capital such as social status, opportunities and resources were evident in participants’ conceptualisations. For example, some spoke of skills and attributes they considered were transferable and would facilitate other opportunities for social inclusion and capital, such as access to employment. These instances help to draw the links between participants’ perspectives of community engagement and aspects of social capital.

The chapter also revealed two predominant forms of knowledge regarding SRHR issues that were present in the communities where this research took place; a scientifically accepted or ‘factual’ ontology, and locally-held lay ontology. The findings illuminate the complexity, contextuality and multi-dimensionality of multiple forms of knowledge and belief systems in relation to community engagement in SRHR promotion. There were contentions regarding the current state of factual knowledge among the community. There were differences of opinion among individuals both within groups (such as in focus group six) and across the data cohort (between participants across different interviews and focus groups) about whether factual knowledge about SRHR issues was widespread or not, with some believing it was while others considered there was a widespread lack of factual knowledge among communities. Low levels of knowledge about various aspects of SRHR issues, particularly regarding service access, among populations of youth in South Africa is reported in literature (Ministry of Social Development 2014). There is much less literature about the state of knowledge among adults or the communities more generally. Participants in this study included a cross-section of youth and adults who shared their own experiences, and shared their views about their communities broadly.

A second point of difference in opinions was whether the various forms of knowledge influenced community engagement in SRHR promotion positively or negatively. The discussion in this chapter focused on the positive influence that factual knowledge can have on community engagement, such as by furthering individuals’ desire to acquire more knowledge and thereby contribute to enhancing community-level knowledge and wellbeing.
outcomes. This reveals a link between individual-level knowledge and engagement, and community-level outcomes. There was some brief discussion of the potential negative influence of scientific knowledge on community engagement on SRHR promotion, such as a perceived sense of satisfaction with one’s current state of information; this was linked to a local understanding of ‘ignorance’.

Gaps in scientifically factual knowledge held by community members were also discussed as either a positive or negative influence on community engagement in SRHR promotion. Some participants discussed how gaps in factual knowledge were a key facilitator of their own engagement in SRHR promotion in order to acquire greater knowledge and fill this gap. Some were of the view that this was the case for members of the broader community also. This suggests there may potentially be a role for personal agency in self-identifying knowledge gaps. However, the ability of an individual to exercise such agency may be influenced by social and cultural norms which intersect with, and thus impact on, forms of knowledge and knowledge gaps; some of these are picked up on in the ensuing chapters. Thus, the influence of knowledge, or knowledge gaps, on community engagement on SRHR promotion interacts with the broader context of the community. The specific role of personal agency in identifying knowledge gaps and any subsequent influence on community engagement was not interrogated as part of this research, so there is potential for future research into this.

Participants also discussed how gaps in factual knowledge could pose a barrier to community engagement in SRHR promotion, as gaps in factual knowledge occurred simultaneously with the privileging of lay knowledges and beliefs. Participants believed this often gave rise to myth, misunderstanding, and negative understandings of SRHR issues. However, this was a perception held by participants about the wider-community rather than their own experiences. This aspect of the findings was only briefly introduced here, as the factors of myth, misunderstanding and stigma – and the role of various forms of knowledge in these factors – are explored in depth in the following chapter (chapter five). Understanding the different forms of knowledge that exist, and their influences on community engagement in SRHR promotion, provides an important foundation for
understanding a range of other key influences on community engagement which will be explored in the ensuing chapters.

The topic of inter-generational relationships was briefly raised in the discussion of knowledge gaps; that is, some participants thought that intergenerational factors contributed to knowledge gaps by inhibiting the transfer of information from older generations to younger generations. Nokwanda used an analogy to highlight this. Other research has similarly highlighted the age-sensitive or generational-sensitive nature of discussions about SRHR issues, and has identified use of euphemism, synonyms and even gestures in discussions about issues of sex and sexuality to avoid direct discussion (Ndinda et al. 2011). The sensitive nature of SRHR issues, particularly in an inter-generational context, are further discussed in in chapter 5 (stigma) and chapter six (connectedness).

4.7 Chapter summary

This chapter presented the first of the key findings related to understanding meanings of community engagement in South African communities, and influences on community engagement in this context. Community members’ meanings of community engagement were linked to processes and outcomes of community inclusiveness, connectedness and wellbeing. This demonstrated a culturally contextual understanding of community engagement which reflected deeper cultural underpinnings of Ubuntu. Thus, this present research adds to the body of literature about community engagement by developing culturally contextual understanding of engagement which articulates the centrality of Ubuntu in this context. Concurrently, the findings add to the body of literature about Ubuntu by specifically linking Ubuntu with meanings of community engagement, and then drawing this together with understanding SRHR-related matters.

The first of the key factors influencing community engagement – knowledge - was also discussed in detail in this chapter. Knowledge was multi-faceted, including individual and community-level knowledge, and western scientific and lay forms of knowledge. These different aspects of knowledge were interactive, and were found to influence community engagement in both positive and negative ways in any given situation.
The findings presented in this chapter provide the basis for the remaining chapters of findings, as they illuminated the contextual meanings of community engagement to which all subsequent discussions relate. The discussion of the various knowledges also provides an important platform because, as will be revealed in the ensuing chapters, many of the other factors influencing community engagement are in-turn influenced by, or interact with, different forms of knowledge.
CHAPTER FIVE

“STIGMA IS STILL THE PROBLEM RATHER THAN HIV ITSELF”
5.1 Introduction

This chapter focusses on the second key factor found to influence community engagement in SRHR promotion: stigma. Overall, participants’ discussions of SRHR-related stigma was dominated by a focus on HIV and AIDS-related stigma with less discussion of stigma regarding other SRHR issues. The chapter begins with a broad discussion of the nature of stigma and related factors, such as assumptions and judgement, and the barriers these factors pose to community engagement in SRHR promotion. The discussion highlights one particular type of assumption and stigma; that based on physical appearances. The chapter then moves to discussing counter discourses presented by participants to challenge community assumptions and stigma to enhance community engagement. The prominent factor of fatalism and its negative influence on community engagement in SRHR promotion is also briefly discussed. Throughout the chapter, links between stigma and the influences of knowledge and knowledge gaps (discussed previously in chapter four) are made. Overall, the chapter demonstrates how stigma operates variably and interactively at the individual and community levels to influence community engagement in SRHR promotion in predominantly negative ways. This chapter also introduces how stigma contributes to overarching community discourses and superordinate representations of SRHR issues which are discussed further in chapter eight, while simultaneously being shaped and reinforced by those discourses in an interdependent and perpetuating relationship.

5.2 Stigma as a barrier to community engagement

Participants discussed how stigma practiced at both the individual and community levels posed a challenge to community engagement in SRHR promotion. Stigma practiced at the individual level took forms such as assumption, judgement, labelling, stigmatising language, and overt acts of discrimination. Stigma practiced at the community level took the forms of negative community-held beliefs and stereotyping, which were linked to community-held lay knowledges. Stigma was considered by participants to be such a powerful barrier to community engagement in SRHR promotion that one participant considered it to be the dominant challenge that communities face regarding SRHR promotion:

*Stigma is a process.....Stigma is still the problem rather than HIV itself.*
Fundiswa’s description of stigma as a ‘process’ captures the complex and perpetuating nature of stigma. This was also present in other participants’ discussions, as some described how stigma and the enactment of stigma (for instance, acts of discrimination) were both an influence on, and the outcome of, poor community engagement in SRHR promotion. Although participants considered stigma to be a major barrier to community engagement in SRHR promotion, they simultaneously thought that this barrier could not be overcome without the engagement of the community:

So we’ll never fight the stigma alone.

This highlights the complexity of community engagement as both an ongoing process and an outcome.

Participants repeatedly linked SRHR-related stigma to prevailing community social norms and values. For instance, Thandiwe and Esihle were members of a community-based youth development organisation which ran peer-education workshops for SRHR promotion, among other activities. They shared their perceptions of how stigma by individuals and the general community stems from broader socio-normative community values and beliefs regarding sexuality and morality:

*Thandiwe:* It is still difficult [to talk about SRHR issues] in our communities because people ... they are interpreting you like you are, like you are looking like you – eh, [turning to Esihle] Esihle, do you know what I am meaning? What’s the word for [lewd, immoral]?

*Esihle:* If you talk about it they look at you like if you talk about adultery or something like that.... Like, someone who really enjoys talking about sex.

(Thandiwe, adult female; and Esihle, male youth: interview 1)
In this case, the participants expressed feelings of being judged and stigmatised by others because of their involvement with SRHR promotion initiatives, and for discussing SRHR issues publicly. They thought that such community-held stigma contributed to perpetuating socio-normative values, and a culture of shame and silence among the community regarding SRHR issues. This was perceived by other participants too, such as Fundiswa and Paki, discussed later in this section.

Several participants were of the view that stigma related to HIV and AIDS was more widespread and more commonly enacted in the community compared to stigma about other health issues:

*People, they are okay to test if there is diabetes, pressure [high blood pressure] it’s fine. But if I say, ‘Why don’t you test to know your [HIV] status?’ … Eish! [indicating shock and emphatic dismissal of the suggestion]*

(Thandiwe, adult female: field notes)

This example highlights the interactions between individual-level factors such as personal attitudes, behaviours and beliefs, and community level factors such as normative beliefs that SRHR issues – and in particular HIV and AIDS issues – are taboo, sensitive and should not be talked about. Participants perceived this inhibited individual and community-wide discussions about HIV and AIDS and posed a barrier to community engagement in health promotion initiatives. For instance, the example above suggests personal attitudes and behaviours regarding voluntary testing for HIV were influenced by the community climate of stigma regarding HIV. While the individual attitudes and behaviours were influenced by community-level factors, the resulting avoidance behaviour and silence were considered by some participants to reinforce community-held views of SRHR issues as private and taboo. Thus, multiple individual and community-level factors including beliefs, attitudes and normative cultural values interacted to contribute to and perpetuate stigma.

So insidious was the stigma associated with HIV and AIDS in particular that in some communities the topic is not talked about directly, but rather in code. Fundiswa explained:
Fundiswa: [People in the community say] so this person’s got Z3 [a type of car].
Or you’ve got Omo [washing detergent], or you’ve got ‘House In Vincent’ [Vincent is a suburb of a city in the Eastern Cape].

Researcher: What does that mean? House in Vincent?

Fundiswa: H-I-V - ... Or you know when you are obtaining standards [school grades] you write STD 3 [standard 3] – so that means it will be HIV [three letters] and then the fourth as a number is AIDS [four letters]. So you’ve got standard 4.

Researcher: Ah, okay. And so they’ll just whisper ‘that person’s standard 4, that person’s got a House in Vincent’?

Fundiswa: Yes.

Researcher: Whereas Z3 and Omo - ?

Fundiswa: Z3 it was a kind of a car, a long time ago. So when they say it is a Z3, it’s H-I-V [counts out three fingers]

Researcher: HIV – three [letters] [count on fingers]

Fundiswa: Exactly.

Researcher: And what was Omo?

Fundiswa: Omo is the soap, you know?

Researcher: Yeah and again, it’s three [letters, representing H-I-V]?

Fundiswa: Yes

(Fundiswa, adult female: interview 19)
Fundiswa believed that this kind of community-wide stigma about HIV and AIDS perpetuated the hidden and taboo nature of the issues, and subsequently compounded the influence of stigma as a barrier to community engagement in SRHR promotion related to HIV and AIDS.

Another participant, Paki, observed that stigma posed a barrier to community members engaging conspicuously in public. However, he reported that community members would seek to engage with SRHR promotion information and opportunities more privately. He provided this perspective based on his experience as a peer-educator in a community-based SRHR-promotion and youth empowerment program:

[Community members think] ‘Now people, when I’m talk about this [SRHR issues], they will judge me’ ..... But, but you will find that... they will call you when they see you talking in public. They will act as if they’re not listening, like they don’t care. But when they see you walking alone they will come to you and [say], ‘I hear you talking on that day, and I didn’t listen well because there were people ... and my friends. .... But I would like to know more’. ... So now you have to give a little, that person time.

(Paki, male youth: interview 16)

Both Paki’s and Fundiswa’s examples demonstrate the way that stigma operates interactively at the individual level to influence individual attitudes and behaviours, and the community level to shape and reinforce community values, beliefs and practices. These individual and community-level influences simultaneously contribute to, and are influenced by, overall societal level representations of SRHR issues as taboo. These representations are further discussed in chapter eight.

Participants discussed assumptions, judgement, stigma and discrimination overwhelmingly in relation to HIV and AIDS. However, there were instances in which participants discussed these factors in relation to other SRHR issues, such as teenage pregnancy and sexuality. This demonstrates that these factors span the topic of SRHR generally. In relation to the topic of sexuality, participants explained:
Gugulethu: Yeah [the] problem with the community is that the community is discriminating – it’s too much discrimination.

Chorus: Discrimination

Gugulethu: To those guys [gay men] and –

Lindani: Lesbians

Gugulethu: - lesbians

(Members of focus group 3)

Because at the end of the day, if you look at some of the rural areas, you’ll find that people from a certain area will notice that ‘this one doesn’t want to get married’, and they start asking questions.

(Gugulethu, adult female: focus group 3)

Gugulethu perceived an implicit community-held assumption held among the community that a person who does not conform to socio-normative values and practices regarding marriage must be gay. Gugulethu suggested that homosexuality was generally poorly regarded among the community, and was associated with stigma and acts of discrimination toward people who are homosexual. This was her perception of the broader community’s view of the situation, but did not necessarily represent her own view on the matter. However, she qualified her statement somewhat with her view that this negative attitude was mostly held by those in the community who had little engagement in SRHR issues. In contrast, participants in the focus group who were engaged with SRHR promotion (including Gugulethu) revealed personal views regarding homosexuality and other SRHR issues which were more positive, accepting and inclusive.
5.3 “We see the treatment on his face or his body”: physicality as a particular cause of stigma.

Physicality – that is, physical appearances - was a recurring topic discussed by participants as a considerable and predominantly negative influence on community engagement in SRHR promotion. Physicality was discussed as a particular form of stigma in which physical appearances and the meanings ascribed to those appearances interacted with community knowledges (predominantly lay forms of knowledge) and assumptions.

Participants explained that a commonly held belief among their communities was that HIV and AIDS can be physically seen in the changing shape of peoples’ bodies. Several participants reported a community-held belief that a thin, gaunt looking person was HIV positive or had AIDS. Madoda illustrated the perception as:

...somebody lying in bed with, you know, their bones and their remains, and really thin and their head is bigger than the rest of their body.

(Madoda, adult male: focus group 6)

Bukelwa shared her own personal experience of encountering this community-held belief:

They laugh because [of] my HIV. So I said to them, ‘I’m HIV [positive]’. [They ask] ‘Why you are not so thin?’ And I told them, not everybody [who] has HIV is so thin.

(Bukelwa, adult female: interview 17)

These accounts reveals the common community assumption that thinness and/or weight loss are visible signs of HIV or AIDS. However, others participants discussed an alternative understanding among communities that weight gain was also a physical indicator of HIV or AIDS. For instance, some discussed that a well-known side-effect of some anti-retroviral (ARV) drugs, used for the management of HIV, is weight gain. Thus, if a person was observed to gain weight, this gave rise to community assumptions that the person was taking ARVs for HIV management, and this was a source of judgement and stigmatisation. Thandiwe described her own experience of a time she went to the clinic to obtain her usual dosage of one particular...
ARV, named tenofovir, but the clinic was out of supply. Instead, she was provided with an alternative ARV (named D4T) which has side-effects including weight gain. Thandiwe explained that this side-effect was widely known among the community. Thandiwe went on to say that she was upset and distressed by the situation as she believed the clinic was not acting in the best interests of herself and others who received the alternative treatment, but rather was contributing to their experiences of stigma:

So we were there [at the clinic] to complain – “Why you give us D4T instead of tenofovir?” Why [do] they make people to laugh at us?

(Thandiwe, adult female: field notes)

This rhetorical question, “Why [do] they make people to laugh at us?”, conveyed her concerns that the action of the clinic was ill-considered and would result in herself and other recipients of the treatment being stigmatised. In this situation, the interaction of observed changes in body shape with factual knowledge (that the side-effect of ARVs may include weight gain) and lay beliefs and assumptions in the community (that weight gain is due to ARV use and thus an indication of HIV positive status), contributed to the stigma.

Several participants discussed either their own experience or their view that the fear of inadvertent disclosure of a HIV positive status, and anticipated stigma, prevented individuals from engaging with SRHR promotion behaviours such as treatment adherence. Participants also perceived that such stigmatising beliefs prevalent in the community presented a barrier to community engagement in SRHR promotion. That is, they thought the labelling and demarcation of people based on physical appearances, and associated assumptions about HIV status, contributed to discrimination, social isolation and exclusion of people who were believed to have HIV. Such discrimination and isolation was considered to be contrary to the values and practice of community connectedness, which was the essences of community engagement (discussed previously in chapter four). Thus, stigma and the associated consequences of discrimination, isolation and exclusion inhibited community connectedness, and thus community engagement.
Several other participants also discussed assumptions and stigma associated with weight gain and HIV status from their perspective as community members, rather than as subjects of the assumptions and stigma themselves. However, it is interesting to note that in discussing their perspectives of the community situation, their own beliefs and attitudes were revealed. This is demonstrated through the following dialogue:

_We see the treatment on his face or his body [when taking D4T]. They get bigger here and here and here [indicates face, ankle, hips]_

(Thandiwe, adult female: field notes)

_Cebisa:_ We judge people.

_Ntombi:_ We judge. We judge them. We know that she or he is positive, like, you know?

_Cebisa:_ We judge. As soon as we know that she or he is positive like, like the rumours that have been going around that ARVs change your shape, if you look at how my body is shaped, if I suddenly shape like you, they will tell me that "they are on me big time" [meaning ARVs are in her body to manage HIV].

(Cebisa, female youth; and Ntombi, adult female: focus group 4)

_Part of the problem – it’s more like a challenge - you see like when we’ve got a family member that got HIV and AIDS and they don’t want to disclose, they don’t disclose to the family, to anyone else; they just keep it to themselves. But, you know that they do have it. You know that they’re always sick. You see their photos that, ‘Oh, this person is HIV positive’. But still they don’t disclose._

(Nolusindiso, female youth: focus group 6)

These passages reveal that individuals and the community cast judgements and stigmatise based on interacting lay and factual knowledges and gaps in factual knowledge among
individuals and the community, and their own lived experiences of SRHR illnesses and stigma. Interestingly, the above passages also reveal that while participants commonly discussed their views about the wider community’s beliefs and subsequent actions in judging and stigmatising, they sometimes subscribed to these same beliefs and stigmatising attitudes and practices. For instance, Thandiwe was herself the recipient of stigma based on the community’s assumptions about her physical appearance, but her statement that “We see the treatment on his face or his body” subscribes to the same assumption about others. Similarly, Nolusindiso revealed her own assumptions that one can ‘see’ someone has HIV through peoples’ physical appearances in photos, thereby subscribing to the same common social discourse and stigma regarding physical appearances and HIV.

Some participants did recognise their own role in subscribing to stigmatising beliefs and practices as part of the collective community (for instance Cebisa and Ntombi who state, “We judge”). Similarly, some participants identified assumptions made by fellow participants, and challenged their peers on such socio-normative subscriptions when they did arise in discussions. The following exchange between Aphiwe and Cebisa demonstrates this:

Aphiwe: But what if sometimes someone stays with you and is HIV positive and doesn’t want to test? [Be]cause like one of my cousin at home - you can see she is HIV positive.

Cebisa: Sorry, sorry, sorry, sorry, sorry, sorry, sorry! [interjecting to challenge Aphiwe] How do you see someone [is HIV positive] first?

(Aphiwe, female youth; and Cebisa, female youth: focus group 4)

The exchange continued, drawing in other participants from the focus group, to reveal how commonly held assumptions and stigma regarding SRHR issues are shared:

Aphiwe: She was pregnant. Then she only went once to the clinic to get [a] normal check-up. When you go for [a] pregnancy check-up they also do HIV tests. We told her to go to the clinic again, for the sake of the baby. She never went and the baby was still-born and she has never been
[back] to her healthy state. Her weight goes up and down, up and down. Now she in a bad state.

Ntombi: Do they know [the] symptoms [of HIV]?

Aphiwe: Her mum is HIV positive and she also suspects that she is also HIV positive.

Ntombi: But it's difficult to say he is, she is, HIV positive.

Cebisa: Yes.

Aphiwe: It's difficult to know but when we say 'let's go to the clinic and test', she refuses.

Cebisa: The most important thing is, even with all symptoms –

Ntombi: - I know there are symptoms, while she doesn’t.

Cebisa: For example, in 2004 I was pregnant with twins and I got very sick, with pink lips -

Aphiwe: - she is also like that -

Cebisa: - if you look here [in front of your face], you will be able to place a teaspoon [in front of your mouth; Cebisa demonstrated by placing a teaspoon in front of face to use as a mirror as she pursed her lips and examined them, to ‘test’ for HIV positive status by the colour and appearance of her lips]. I tested and I was clean.

Ntombi: Hmmm. But I, now that I know you do have that mouth positive [for HIV].

Aphiwe: We know it [a HIV positive status] that way.

Cebisa: And yet unfortunately the twins never survived. There was no HIV but...
Aphiwe: You can’t hide it.

Cebisa: With all the Doctors I went to I was clean, now [but] stories came - people saying the twins gave me complication and I couldn’t carry them. I don’t understand why when a baby dies, we Black people are –

Ntombi: - We say because she was positive. Ya.

Aphiwe: She is not well and you can see in her body

Ntombi: I also, I don’t like the fact that someone is sick now we have to believe that she is positive, because there were no tests done to prove that.

Aphiwe: She doesn’t want to test.

Ntombi: She can be sick with TB [tuberculosis], or maybe something else.

Aphiwe: I wish we can get to know what’s wrong with her and see how we can help.

Ntombi: Maybe she is scared because of [she] knows, “I'm this sick”. Maybe [she thinks] ‘I'm positive so no I can't go [to the clinic].”

Cebisa: Maybe she doesn’t feel that there is someone close enough in the family that she can trust.

(Participants in focus group 4)

In the above exchange, Aphiwe continues to subscribe to her assumptions which stigmatises a sick person as being HIV positive despite no clinical diagnosis, based on the person’s behaviour (for example, not wanting to go to the clinic), and what she believes and understands to be true (for instance, that pink lips are a physical sign of HIV positive status) through comments such as “we know it that way”, that “you can’t hide it”, and “you can see it in their body”. This is despite challenges from Ntombi and Cebisa, including Ntombi clearly stating her recognition of, and objection to, stigmatising assumptions (“I don’t like the fact…we have
to believe that she is positive”) and offering an alternative (“she can be sick with…something else”). Thus, participants’ subscriptions (either conscious or unconscious) to the assumptions and stigma are linked to the forms of knowledge they have, in particular the presence of lay knowledges and beliefs in the community. So strongly embedded are the lay knowledges in community understandings about SRHR issues that even some participants who were engaged with SRHR promotion sometimes privileged lay beliefs over factual knowledge.

The above examples all demonstrate how individual-level knowledges, beliefs and attitudes interact with community-level SRHR knowledges, and negative community-level representations of SRHR issues as a taboo subject (discussed further in chapter eight) to influence community engagement in SRHR promotion.

5.4 Fatalism as a key influence on, and representation of, poor community engagement

A related concept found to influence community engagement was fatalism. Participants discussed fatalism as a barrier to community engagement in HIV prevention and health promotion initiatives specifically; it was not raised in relation to any other SRHR issue. As with stigma, while participants commonly discussed this issue in relation to individuals, their discussions linked fatalism with community-held knowledges and beliefs, and community engagement in SRHR promotion. For instance, several participants discussed the prominent lay belief in their communities that HIV is not manageable, and leads to death. They were of the view that community members commonly subscribed to this fatalistic belief. This perspective was shared broadly among participants across the research sample, highlighting the widespread nature of this view:

Some of them they, maybe they don’t accept it [a HIV positive status], or some of them as that may be, ‘I am gonna die’, but - you know what? There’s a lot of stories going around saying that if you are HIV positive you’re gonna die this bad [death], or it’s gonna be this painful, or in two months you’re gonna be dead. So, with all these myths going on, I mean… they, to me it seems like [community members think] ‘I’m human, so it’s just gonna happen to me’.
But I think the lack of knowledge in this [HIV]....The lack of knowledge, as well as, I say, knowing about their status. They’re afraid of they’re sick and they’re going to die. So they’re [they have a] lack of knowledge because there are many people who are HIV positive, they live healthy cos they’re [sic] follow and trust their [treatment and management] instructions..... Lack of knowledge, they [it] contribute to the people going to see they are sick and they are going to die because they [are] stressed.

(Thulisa, female youth: interview 2)

Researcher: Why do people become scared?

Zandile: Surely, they have a lack of information. Because all they know is if someone is HIV positive sure they are going to die. That’s on their mind.

(Zandile, female youth; interview 2)

...others make no attempt to know about HIV. They think if somebody’s HIV positive they are just going to die....

(Gugulethu, adult female: focus group 3)

These participants’ comments highlight the multiple influences of forms of knowledge contributing to fatalistic attitudes and low or non-engagement among the community. For instance, Brenda discussed the presences of “stories” and “myths”; Zandile mentioned a lack of information; and Thulisa made an explicit statement about community members’ lack of knowledge regarding the aetiology and management of HIV. All of these matters of knowledge were linked to fatalism. Gugulethu also linked lay knowledge and beliefs with ignorance (that “others make no attempt to know”) which was discussed in the previous chapter (section 4.5), and fatalism, demonstrating intricate links between these multiple factors contributing to poor engagement.
It is noteworthy that in these examples, participants were themselves able to identify particular beliefs as myth or incorrect knowledge, but recognised that they were commonly held beliefs among the wider community. The conversations clearly highlighted links between individual-level knowledges, beliefs, attitudes and behaviours, with community-level lay knowledges and beliefs. These interactions contribute to, and are informed by, conceptualisations of SRHR issues as dangerous and fatal. This is discussed further in chapter eight.

5.5 Challenging stigma to enhance community engagement in SRHR promotion

Participants’ views varied about whether SRHR-related stigma in communities was constant or had changed over time, and what could be done to address stigma. This topic was discussed predominantly in relation to HIV-related stigma, but there was some discussion of stigma related to sexuality. Some participants thought that stigma has decreased somewhat over time, alongside a perceived increase in factual knowledge about SRHR in the community:

[In the past]...if we knew [about HIV], people do not understand it and do not know it, and [if] you [are] disclosing your status then [it] would have been disaster, you know, because people will stigmatise you, people will judge you. It’s unlike now when we understand people’s HIV and we relate to people with HIV. Back then it was difficult for people to disclose, and if you did disclose people would, you know, look at you and treat you in a different way.

(Madoda, adult male: focus group 6)

Madoda also perceived that interpersonal relationships were an influence on reducing stigma (“…we relate to people with HIV”). This concept of interpersonal connections is discussed in considerably more depth in the following chapter (chapter six).

Despite Madoda’s opinions, participants more commonly believed that SRHR-related stigma, particularly regarding HIV, remained a strong and persistent barrier to community engagement in SRHR promotion. After sharing his own views, Madoda asked others in the focus group for their views about any changes in HIV-related stigma over time:
Madoda: Okay, so [with] all this information [about HIV], have peoples’ opinions changed about HIV?

Nomphelo: I say no.

Madoda: With all this information?

Nomphelo: I say no.

Veliswa: No.

Madoda: So people are still behaving the same?

Nomphelo: Some people are so [self] centred, they can always tell themselves, ‘there is this kind of disease and it’s going nowhere.’

(Members of a youth group associated with an SRHR organisation: focus group 6)

The perception that stigma was still extensively prevalent in communities and had not greatly decreased over time was widely shared by participants across the study sample, irrespective of age, gender, location, or experiences of engagement in SRHR promotion.

Some participants discussed their views about ways to address and reduce stigma, especially HIV-related stigma. Several things were suggested which were all interconnected. Central to their ideas was the need to increase scientifically factual knowledge among the community to dispel myths and misunderstandings embedded in lay knowledges. Participants also spoke of the need for discourses and actions which normalise HIV and its management within everyday community life, and the need to create social connectedness and integration across different groups in the community as part of the education and normalisation processes.

If you are talk[ing] about the HIV, like you are having asthma, you go and report you are having asthma, so, we understand your disease, so you are changing your behaviour, eat your treatment.

(Bukelwa, adult female: interview 17)
Here, Bukelwa likened the stigmatised issue of HIV to other common illnesses which are not stigmatised, but which are more neutral in terms of their social perceptions and acceptance. Others spoke about decreasing stigma by increasing community knowledge and understanding about the manageability of HIV, and living well with a HIV positive status (colloquially known as ‘living positively’):

_It’s a personal option [to disclose one’s HIV status publicly or not]. But we do encourage people living with HIV to disclose to us so that you know how to handle them, you know how to treat them, and you just know that this person [is] living with HIV so maybe if they go through an illness while he’s sitting with you, you understand that, you know, ‘this person is sick’. Alright, if something happens to someone [but] you don’t know what’s going on with them, it’s very difficult. But... it also helps you to know that this person’s HIV positive so that you have boundaries in terms of how are you going to handle them, what are you going to do with them – sexually, you know, as in sexually._

(Madoda, adult male: focus group 6)

These comments highlight the links between addressing interconnections of discourses which promote ‘living positively’ and normalise rather than stigmatise HIV, with knowledges and stigma at both the individual and community levels in order to shape new, positive conceptualisations of HIV as a part of community life, and as manageable rather than taboo. Participants believed that these new discourses of normalisation and ‘living positively’, and representations of HIV as manageable, could positively influence community engagement in SRHR promotion by contributing to a climate of acceptance and inclusion.

Participants thought that the community could challenge stigma by creating links between groups in the community, and mixing diverse groups together in shared activities and education. Gugulethu discussed this in relation to stigma attached to sexuality, while Vuya and Ndiliswa expressed the same thought about HIV-related stigma:

_I think the mixing can [mean that] people go, let go, past the discrimination that they’ve got because taking people who are only gays and forgetting about people who_
are straight won’t take away the stigma from the people. But if you take both those that are straight and those that are gay, and you do some education on them, they will know that these people haven’t asked for this, you know, they are born with it, you see? Even those that are born with this, living with this gay life, will make them know that, “I’m right. It’s my right. I have to stay the way I am. Cannot force myself to be something else”.

(Gugulethu, adult female: focus group 3)

Researcher: And who comes to it [the support group]? Is it just people who are affected by HIV?

Ndiliswa: Infected and affected.

Vuya: No. Now we mix the groups together. Because there are even the ones who is not affected can help the affected ones. They have knowledge, they -

Ndiliswa: The HIV has stigma- “that group is for HIV positive people”. We are trying to say that it is for everybody.

(Ndiliswa and Vuya, adult females: interview 4)

Here Vuya distinguishes between people who are affected and not affected. However, she shares a common underpinning with Fundiswa’s view (stated earlier in section 5.2) that all people can share in SRHR promotion together to advance SRHR promotion and community engagement in SRHR promotion. Ndiliswa highlighted the common community assumption that all people associated with the HIV support group are HIV positive. However, Vuya and Ndiliswa shared their own view that inclusive, non-discriminatory places which welcome all people could help to break down that assumption and associated stigma. This was seen as a pathway to developing a sense of connectedness between HIV positive and negative people in the community, and thus to enhancing community engagement in SRHR promotion. This reinforces the understandings of community engagement presented previously in chapter four. It also suggests participants consider that actually practicing community engagement can help
to mitigate other factors which act as barriers to community engagement, thus reinforcing the complex and interactive nature of stigma and community engagement. It also highlights the role of community-level factors such as of the work of community groups in shaping the social context in which SRHR promotion occurs, and influencing community engagement in SRHR promotion.

5.6 Discussion

This chapter has focused on the topic of stigma, which emerged as a key factor influencing community engagement in SRHR promotion in South African communities. A particular form of stigma - physicality-based stigma – was highlighted, and related concepts like fatalism were also discussed. Stigma was revealed in this research to itself be influenced by a range of interacting factors. While the influence of stigma was contextual, participants’ experiences overall tend to demonstrate it poses a considerable barrier to community engagement in SRHR promotion. Discursive factors such as labelling and cyphered language, and symbolic factors such as physical signs or perceived symptoms, contributed to the manifestation of stigma in this research context.

Stigma is a social construction based on local knowledge and belief systems, and the exercise of power by dominant groups to maintain status relative to those constructed as deviant (Goffman 1963, Barter-Godfrey and Taket 2009). Stigma was widely discussed by participants in this research in relation to various SRHR issues including sexuality and teenage pregnancy, but predominantly in relation to HIV and AIDS. Stigma as a barrier to SRHR promotion in South Africa has been widely discussed in previous literature, also predominantly in relation to HIV and AIDS. Abrahams and Jewkes (2012) posit that stigma is a complex, multidimensional social process, and that measuring stigma is difficult given the variability in definitions and conceptualisation of stigma, and differences in study types and measurements. Accordingly, the literature reveals mixed findings about the presence and role of stigma in communities, particularly HIV and AIDS-related stigma. For instance, despite the acknowledgement of the limitations of measuring stigma, Abrahams and Jewkes (2012) noted multiple studies have found decreases in perceived SRHR-related stigma in South Africa overall, yet internalised stigma remained fairly constant. Makoae et al. (2009), Cloete et al. (2010) and Peltzer and Ramlagan (2011) all found that stigma and discrimination toward people living with HIV and
AIDS was decreasing (self-reported by participants), although Peltzer and Ramlagan (2011) clarified that it still remained high.

Stigma related to SRHR issues, in particular HIV and AIDS, stems from many different sources and takes different forms, but one key manifestation revealed by this research was stigma based on perceptions of SRHR issues as linked to immorality. This was conveyed through normative community attitudes and values regarding sensitive SRHR topics, specifically, that matters of sex and sexuality are considered taboo. Some participants discussed that some SRHR issues, particularly HIV, were so stigmatised and taboo that they could not be openly talked about in the community. They also shared some of the less direct ways stigma is present, such as through the use of cyphered language and synonyms in everyday language to describe HIV, such the word ‘Omo’ (a common household washing detergent) to mean HIV (discussed previously in section 5.2) and discursively construct HIV as secretive and hidden. This is supported by other research which has also identified the use of metaphors to describe HIV in other settings throughout South Africa (Stadler 2003, Ndinda et al. 2011), demonstrating this common practice. Cloete et al. (2010) also spoke of how people in communities label stigmatised illnesses like HIV using other names or do not name it at all.

Another key form of stigma in the community was based on symbolic representations of physicality, and the local meanings attached to those symbolic representations. Stigma related to physical appearances has also been noted in other studies as a negative influence on health promotion efforts (Dlamini et al. 2009, Katz et al. 2015, Mjwara and Maharaj 2018). For instance, Dlamini et al. (2009) found a significant and consistent correlation between perceived HIV-related stigma and adherence to ARV medication treatment regimes. They found that people who reported higher perceived stigma also reported lower medication adherence, and vice-versa; those who reported lower perceived stigma reported more consistent medication adherence. They cite several possible reasons for this, including fears about medication side-effects such as changes to one’s physical appearance, which may result in inadvertent disclosure of one’s HIV status.

While participants in the present study predominantly discussed physicality-based stigma with regards to HIV, a broader body of literature identifies physicality-related stigma associated
with other SRHR conditions such as teenage pregnancy. For instance, in one study exploring the perspectives and experiences of early motherhood among females aged 18-24 in KwaZulu-Natal, some participants reported physical changes associated with particular hormonal contraceptive use, which influenced their choices and decision-making regarding contraception (Mjwara and Maharaj 2018). In a multi-site study conducted in Durban and Cape Town, Bhana et al. (2010) discussed how the occurrence and visibility of a teenage pregnancy was linked with negative community perceptions.

The findings of Bhana et al. (2010) also revealed that some SRHR-related stigma is gendered. Bhana and colleagues argued that the social burden of a teenage pregnancy is predominantly borne by females, presumably because of the intersections of the physical signs of pregnancy which reveal the woman as mother while theoretically the male father could remain anonymous and ‘invisible’, with the socio-cultural values underpinning perceptions of gender roles (such as fatherhood being seen an enactment of masculinity, and thus not stigmatised). There is a broader body of literature which also reveals that stigma contributes to, and is reinforced by, undesirable representations of SRHR issues as gendered (feminised) (Petros et al. 2006, Cloete et al. 2010, Abrahams and Jewkes 2012). While this present research did not highlight the gendered nature of stigma specifically, it does reveal the gendered representations of SRHR issues (discussed in chapter eight), to which stigma contributes.

The potential role of social capital in seeking to challenge and redress stigma was revealed in this research. As highlighted in section 5.5, participants perceived a way to challenge stigma was by creating opportunities for different socially-constructed groups (such as those who are HIV positive and those who are not) to mix together. This is akin to fostering bridging social capital to connect different groups. Similarly, the role of community groups or organisations (such as support groups) in combatting stigma by being inclusive and promoting a culture of acceptance and inclusivity in the community may contribute to linking social capital, by connecting individuals and community groups with community advocacy structures. However, research findings are contested about the role of community support groups in reducing stigma. For instance, while participants in this present study saw community-based support groups as a potential channel for breaking down stigma, Dlamini et al. (2009) found that participants who were involved in support groups reported high levels of self-perceived and experienced stigma.
More recently, Masquillier et al. (2015) used regression analysis to compare the effects on felt stigma of using either a treatment buddy (an informal support arrangement with a close friend or relative who was aware of a person’s positive HIV status) or a peer adherence supporter (PAS; a more formalised support arrangement with another person who was also living with HIV and so had a shared understanding). They found that among participants in their study, having a treatment buddy decreased feelings of stigma while having a PAS increased feelings of stigma. This highlights the importance of bridging social capital between those who directly experience HIV and others in the community, for ameliorating experiences of HIV-related stigma in the community. The role of interpersonal connections in community engagement in SRHR promotion is discussed in more detail in the following chapter.

The act of disclosing an HIV positive status was also considered by participants to be a way of breaking down stigma, and this could also lend to opportunities for developing social capital by strengthening ties between people or groups, and cultural capital by helping promote an environment which was accepting of people with HIV. Other research has also demonstrated how public disclosure can help to enhance social capital or be a form of activism to respond to and counteract stigma (Goudge et al. 2009, Wouters et al. 2009, Abrahams and Jewkes 2012, Maman et al. 2014). However, Goudge et al. (2009) noted that doing so was complicated by intersectionalities of identity and experiences including gender, poverty, and relationship status. Disclosure is discussed in further detail in chapter seven.

5.7 Chapter summary

This chapter discussed multiple aspects of stigma as an influence on community engagement in SRHR promotion in South Africa. Physicality was highlighted as a particularly prominent form of stigma which posed a barrier to community engagement in SRHR promotion. Fatalism was a related factor also prominently discussed as a barrier to engagement. Fatalism was revealed to be both a determinant of stigma and poor community engagement, as well as the outcome of stigma and poor community engagement, highlighting the variable and contextual nature of stigma in relation to community engagement.

The findings demonstrated that stigma was related in multiple, complex ways to the factors raised in the previous chapter such as different forms of knowledge and knowledge gaps, and
other related factors including symbolic factors (for instance, physical signs and their contextual interpretations), discursive factors (for instance, language), and normative community values and beliefs (for instance, that SRHR matters are lewd, immoral and taboo). Knowledge factors interacted with stigma at both the individual and community levels, and in bi-directional ways. For instance, individual beliefs were influenced by socio-normative lay knowledge and discourses about SRHR issues, stigma and fatalism in the community. In turn, these individual-level beliefs (and associated behaviours) contributed to perpetuating negative community discourses and stigma.

HIV and AIDS-related stigma in particular was underpinned by the broader socio-cultural context in which SRHR matters are deemed private, and discussions related to death are taboo. This context poses a further barrier to community engagement in SRHR promotion. Representations of SRHR issues as taboo, and the influence of the socio-cultural context in community engagement in SRHR promotion, are discussed further in chapter eight.

Overwhelmingly, participants revealed the implications of stigma (particularly related to HIV) were predominantly negative, posing a barrier to community engagement. However, in a small number of cases, participants described how stigma in the community had more positive implications for engagement in SRHR promotion, such as motivating some peoples’ engagement and activism in SRHR promotion. However, reports of positive outcomes should be considered with some caution, as these outcomes tended to be perceived or experienced by participants who were engaged with SRHR promotion. Thus, such outcomes (or perceptions of such outcomes) may be influenced by their unique context and experiences (for example as HIV and AIDS activists or home-based care workers), and may differ from people not engaged in SRHR promotion. Participants reinforced the view that stigma is not a static state as they discussed perceived opportunities to challenge and address stigma. These discussions highlighted the role of social capital in challenging stigma and enhancing engagement by enhancing community inclusiveness, connectedness and wellbeing.

It is important to note that stigma, and associated contributory factors, were discussed by participants in this research predominantly in relation to HIV and AIDS. The researcher made multiple attempts to expand the discussion and explore stigma in relation to a greater breadth
of SRHR issues, but the focus of participants’ discussions consistently remained on or returned to HIV and AIDS. The role of factors such as perceptions of fatalism, knowledges and assumptions informing judgement, and overall stigma in relation to a range of other SRHR issues warrants further specific exploration.

The following chapter discusses a range of other factors that operate interactively at individual and community levels to influence community engagement in SRHR promotion, but whose influences are considerably more variable in that they are sometimes negative and sometimes positive, contingent on the context.
CHAPTER SIX

THE ROLE OF CONNECTEDNESS IN ENGAGEMENT
6.1 Introduction

This chapter discusses the third emergent factor of this research, the role of connectedness as an influence on community engagement in SRHR promotion. Two main aspects of connectedness are discussed in this chapter. The first, discussed in section 6.2, is social connectedness; that is, nature of interpersonal connectedness and relationships, and the influences these have on individual and community engagement in SRHR promotion. The discussion includes how connections to other people associated with, or affected by, SRHR issues can influence engagement either positively or negatively (section 6.2.1). This is followed by discussion of one particular type of relationship – intergenerational relationships – and the influences of this on community engagement in SRHR promotion in section 6.2.2. The second aspect, discussed in section 6.3, is issue-connectedness; a felt-connection to, or experience of, SRHR issues either directly oneself or indirectly through family or friends. The influence of issue-connectedness on community engagement in SRHR promotion could be either positive or negative, and examples of both are provided in section 6.3.1.

Juxtaposed to the influences of having social connectedness and issue-connectedness, having limited issue-connectedness could also influence community engagement either positively or negatively. Examples are discussed in section 6.3.2. The fluid influences of issue-connectedness on community engagement are drawn together in section 6.3.3.

Finally, data revealed a perceived propensity for individuals and groups in communities to attribute concern for SRHR issues to ‘others’, rather than perceive the possibility of their own risk or vulnerability regarding SRHR issues. This tendency highlights the coexisting and interactive influences of social connectedness (in individuals construction of their identities and sense of belonging to social networks and groups) and issue-connectedness (in the propensity to either perceive possible susceptibility and a connection to SRHR issues or not). This is discussed in section 6.4.
6.2 Social connectedness and community engagement in SRHR promotion

6.2.1 The influence of interpersonal connectedness and relationships on community engagement in SRHR promotion

Social connectedness, in the form of interpersonal relationships, was revealed by participants to be a key influence on their own engagement in SRHR promotion, and community engagement more broadly. Several participants thought that interpersonal relationships could inhibit community engagement in SRHR promotion. Gugulethu shared her view that having a personal acquaintance with a community member involved with SRHR promotion posed a barrier to community engagement. She discussed this with reference to an example of a local community health worker who was working in their own community, and so was known to community members:

*If she’s [program worker] from [community], she cannot educate people from that rural area. She can’t. They won’t listen to her. They won’t.*

(Gugulethu, adult female: focus group 3)

Gugulethu and others in the focus group discussion explained their reasoning behind their perspective:

*Nokwanda:* Yeah. Just like when I went with Phozisa [female peer] to [community] they listened, listened a lot. They wanted to know everything, asking questions, all of them ask questions, all of them. Then when I just came in they say, “Where is Phozisa?” [I said] “She is not with us anymore”. And they were like, “Okay”. I never saw them again.

*Researcher:* Because she’s not from that community?

*Nokwanda:* Yeah….. I think it’s easier for them to talk with this stranger rather than to the person that they know.

(Participants in focus group 3)
These participants gave their views from their perspectives as volunteer program workers and community members. Similarly, Paki shared his experiences from his co-existing positions as community member, SRHR program peer-educator, and field assistant in this research. His perspectives confirmed that in some contexts, existing relationships could inhibit community engagement in SRHR promotion:

**Paki:** When the people in our community see a white guy or a white lady, if you call them they respond because they want to come close to this person. And they want to speak, they want to become a friend with this person. So now when you [e.g. researcher, or white person external to the community] call them [to participate in or engage with SRHR promotion activities], it’s not difficult. But when we are all Black – as I said, I don’t mean to offend anyone by saying this, there’s that reluctance. “Who are you? What do you know?” You see? So, “We grow up together”, and “Who are you, do you think you know better than me?” You see, there’s that mindset. But when this, they hear that there’s this guy, Jack [an international visitor and volunteer SRHR program work] coming from [a city in the United Kingdom], here with us, they want to come.

**Researcher:** Whereas you’re someone from the community so, as you say, “How can you know more than me? I know you, I’ve seen you grow up”?

**Paki:** Yeah. And then, “I know after your grade twelve, you didn’t do much”. Mm, all those things. But when there’s someone [from] outside, they come. They want to see this person. Even now - believe me - I will hear people [say] – “We saw you walking with that white lady” [the researcher] [laughter]. “What is she doing here?” You see, you see. So now, it’s when I get a chance of talking – You see? [I will say] “She is doing this, and busy with this”, and then, [they will say] “Okay, okay. Where did he [she] come from?” “[She] Come from-”. You see? And now, now they can trust it.

(Paki, male youth: interview 16)
In the examples above, interpersonal connections were considered to inhibit community feelings of trustworthiness and respect for SRHR program workers. The nature of the relationships gave rise to doubts about the legitimacy of community members who were known among the community to be undertaking SRHR promotion. A combination of individual-level factors and community-level factors interacted here to inform community perceptions; for instance, individual relationships interacted with community-held knowledges and beliefs about SRHR information, and socio-normative values about what constitutes legitimate and trustworthy information. This is demonstrated by statements by Paki such as “I know after grade twelve, you didn’t do much”, and rhetorical questions such as, “What do you know?” and “…do you think you know better than me?” Nokwanda also suggested that feelings of discomfort and low trustworthiness toward known community members exist, with her concluding statement that, “I think it’s easier for them to talk with this stranger rather than to the person that they know”.

Interpersonal relationships were also discussed as a barrier to community engagement because of the sensitive nature of SRHR topics, and the association with lewdness and immorality in discussing sensitive topics (as discussed previously in section 5.2). Participants discussed how some community members may feel embarrassment and shame in discussing sensitive, stigmatised topics such as SRHR issues, particularly with people known to them rather than strangers. Paki again discussed his experience of this as a peer-educator and research field assistant. He revealed that it was difficult trying to engage community members in this research. This barrier was compounded when a close family member (his brother) was involved:

**Paki:**  
It wasn’t easy, this one [interview with Andile], because maybe if it was somebody else he will be able to speak and to talk about it [SRHR topics] more.

**Researcher:**  
And do you think again that’s because you’re his older brother and he thinks that he can’t talk about it? Because one thing I’m learning is that, especially between mothers and fathers, and younger people, they can’t talk together -
Paki: Yes.

Researcher: - but is it the same even with older brothers and sisters, or is it [different]?

Paki: Yeah, sometimes. In some topics. Yeah there are topics that you feel, ‘I can’t discuss this with my younger brother’. You know why? Because we end up not being brothers – end up being, wanting to be this father figure to him. Or [the younger brother must be] this person who must listen to you because he’s younger than you. More especially when you lose your dad. Now you want to change to be [from being] a brother to be this... strict [person], you see? Maybe these are the challenges in the relationship. And secondly, maybe he doesn’t want me to see how much he knows.

Researcher: Right - so you’ll wonder what he’s being doing?! [laughs] –

Paki: Exactly! And [how he] knows those things, so he gave me little information [for the research].

(Paki, male youth: interview 16)

This passage also reveals that both intra-generational and inter-generational personal relationships could pose barriers to community engagement with specific issues. In this case, Paki is sharing his experience of an intra-generational relationship with his brother. However, Paki perceived the nature of the relationship shifted to more of an inter-generational type of interaction in the context of other factors such as the absence of their father. This highlights that the influence of interpersonal relationships is fluid and contextual. In this case, Paki considered that the closeness of his relationship with his brother was a barrier to community engagement.

In contrast, several participants thought that interpersonal connections could facilitate community engagement in some circumstances. Some described how interpersonal connections facilitated their engagement in very tangible ways, such as receiving outreach or an invitation from an acquaintance to engage with SRHR promotion:
Derek was doing his public education. I was invited – another friend said to me there was this guy doing public education on HIV and AIDS. That one who invited me was someone who knew that I’m living with HIV, and she know that I’ve been educating people about HIV in my area. So I decided to come and join Derek as he was doing his public education. And then he introduced me in this NGO and from then, yes I had my own information.

(Gugulethu, adult female: focus group 3)

The above explains Gugulethu’s experience of a direct interpersonal connection which commenced her engagement in SRHR promotion through one of the partner organisations involved in this research (organisation number one). She went on to explain that through her own engagement, she was able to work with the organisation to promote broader community engagement in SRHR promotion. Her role involved enhancing community understanding and knowledge about SRHR issues, and enhancing community connectedness. This supports the conceptualisation of community engagement discussed previously in chapter four.

While interpersonal relationships emerged as an important influence on community engagement, some participants suggested that how SRHR promotion was delivered interpersonally was a more important factor than who delivered it. Lwazi discussed this in his interview with Paki:

And the thing that makes it easy for me when I speak with my friends [is that] they’re using our language, the tsotsi [gangster] town language.

(Lwazi, male youth: interview 11)

Paki further explained this in his own way:

I see that it’s the manner of language. It’s a matter of language, and that background that he [Lwazi] drop [dropped] out early at school. Now, if you want to give him a book to read, it’s difficult. You see. And then now he’s afraid to go to people where they will ask questions. He won’t be able to answer them. …. Because when you ask this question of your suggestion for improvement [to facilitate community engagement in SRHR}
promotion interventions], he said, “They must try to use a language where everyone, more especially Xhosa, where we will be able to express ourselves”, you see? So really, it’s a matter of language, not the friends. It’s a matter of language.

(Paki, male youth; interview 10)

Lwazi and Paki’s comments highlight the view that the ability to relate to others involved with SRHR promotion is crucial for community engagement in SRHR promotion. Sharing some commonality in background and being able to feel comfortable in expressing oneself helped to build a sense of relatability and social connection, and enhance community engagement. Vuya added that trust was a critical factor overall. She thought that trustworthy relationships could develop between people of different ages:

Vuya: It’s better to share something with someone who is in your same age [group]. And also it’s good to get an experience to [from] someone who’s older than you. To get some information and knowledge.

Researcher: And from this community or from another community? Would [community members and program participants] be afraid if [program workers] were from this community, that they don’t want to talk in case others in the community find out? Or is it better to have someone from the community?

Vuya: Mmm, I think it’s good to have someone you trust, even if she is outside in this community.

(Vuya, adult female: interview 3)

While Vuya thought that positive relationships could be developed between people of different ages to influence community engagement positively, opinions about this varied among other participants, as the next section illuminates.
6.2.2 The influence of intergenerational relationships on community engagement in SRHR promotion

Intergenerational relationships were a specific type of relationship raised regularly across all communities and participant groups (including across rural, peri-urban and urban contexts, and diverse gender and age groups). Participants were generally of the view that intergenerational relationships (such as between an adult and a young person) were a substantial barrier to community engagement in SRHR promotion. This perspective was shared by youth and adult research participants alike. The participants who shared views on this matter were mostly those considered to be youth (aged 15-24 years). However Thotyelwa, an adult female and grandmother, shared the same view:

*Thotyelwa:* In our communities we don’t talk about sex. No. Even myself I’m not comfortable, as educated as I am, but I’m not comfortable talking about sex with these young ones.

*Researcher:* What about the young ones to other young ones?

*Thotyelwa:* They might be talking themselves, but for me I’m not comfortable to talk about sex to them. And obviously they will never be comfortable talking to me [about] sex as well. .... It’s too much. It’s really too much.

(Thotyelwa, adult female: interview 12)

Thotyelwa provided further insight as to why it may be difficult to discuss SRHR issues between generations. At this point in the conversation, Thotyelwa was speaking specifically about the SRHR topics of puberty and menstruation. Her explanation suggested conservative attitudes exists among older people about discussing sensitive, personal or private issues with young people, and what was considered age-appropriate information and discussion:

*And you see we [adults] are educated [about some SRHR matters], we can’t even tell her [grandchild] because we always see her as small, as young. Very young.*

(Thotyelwa, adult female: interview 12)
Thotyelwa’s comments are even more significant given her professional role as an SRHR program director. Through this role she regularly engages in public dialogue about SRHR issues with community members of diverse age groups. Despite her professional position, she still finds such conversations with young people difficult given the socio-normative cultural context of intergenerational relationships, and what is considered appropriate interaction and communication between generations. Sindiswa (a female youth) echoed similar sentiments that older generations attach embarrassment, secrecy and privacy to SRHR issues:

*Our parents, they don’t understand us, this generation, because they lived then. So when we ask them about sex, yoh, they think “I don’t know what you’re talking about. Dirty things, dirty life”. Sex, it’s life.*

(Sindiswa, female youth: focus group 3)

Zandile also illuminated the issue of inter-generational familial shame attached to SRHR issues in a poem she wrote about the issue:

*It’s such a shame and a pain to our parents [us] having a child at a very young age.*

(Zandile, female youth: written poetry)

So entrenched was the barrier of conservatism, shame and embarrassment attached to discussing SRHR issues that participants in focus group three described how sometimes they felt they could not be open about their work in SRHR promotion with older generations:

_Gugulethu: [interpreting for Nikelwa and communicating Nikelwa’s experience] You see. This explains it. When she goes home and the mother asks her “What were you doing? And where you were?”, and she tells her [mother] lies. She cannot tell the parent [that] it was about sex education, [or] it was about HIV.*

(Nikelwa, female youth; and Gugulethu, adult female: focus group 3)

Gugulethu’s own views supported those of Nikelwa:
Believe you in me, if our [my] mother was still alive, [she] wouldn’t appreciate what we are doing [SRHR promotion work].

(Gugulethu, adult female: focus group 3)

Several participants expressed the view that the shame and embarrassment felt by people of their parents’ and grandparents’ generations was because many of the older generations were lacking in education:

I would say, educate the parents. Really. Because our parents grew up in the 80s and 90s. And nobody spoke to them about anything. See for instance, um, teenage pregnancy.

(Brenda, adult female: focus group 3)

Researcher:  Do your parents talk to you about that [sex]?

All:  No

Gugulethu:  Not at all!

Nokwanda:  No. If you mentioned a boyfriend, or you mentioned sex and a teenager, “Hayi!” [No!]

[Laughter all around at expression]

“What are you talking about?!”

Researcher:  Really? Where do you get your information – your sister or your girlfriends?

Nokwanda:  Your friends.

Gugulethu:  There’s more education outside [the family]

Nokwanda:  Outside.
Brenda: No they [parents/adults] don’t speak. Um, I’ve heard at one of the workshops, in the Black culture, it’s like a scandal. If you talk about it, it’s like as Nokwanda said now, if you’re gonna ask your mother, “What is that?” And she will be so devastated, “This child is asking me this question”. It’s, I would say it’s because they don’t know how to say it. And about these things, [such as] to ‘come out of the closet’ [publicly disclose one’s homosexuality] I think it’s because our parents - they don’t know what gays and lesbians are about. Or even coming out with your [HIV] status. I think most of our parents would, like, have a heart attack if you tell them because they are uneducated. They don’t know the pros and cons, they don’t.

(Participants in focus group 3)

This contrasts with the view of Thotyelwa, above, who expressed that she was educated on SRHR topics. The difference in opinion between Thotyelwa and younger participants about the education levels of older generations could be partly to do with the nature of the SRHR issues discussed. Thotyelwa was discussing the timeless topic of puberty and sexual development about which older generations may be familiar. The other participants were discussing SRHR topics that are newer in scientific and social understanding, such as HIV and AIDS and homosexuality, and may not be as familiar or well understood among older members of the population. Another possible reason for the difference could be that Thotyelwa’s views and experiences regarding adult education of SRHR issues may be influenced by the fact that she is a highly educated professional in the field of SRHR promotion. Regardless, there was a generally distinct and strong view among the participants that education about contemporary SRHR issues among older generations is lacking.

Yola, a peer-educator, shared her understanding of why there is a perceived lack of education among the older generation. She linked the low educational status of community members to the historical socio-political context and a legacy of social exclusion. She described a
community-based adult literacy program operating in her community to illustrate this link. Nokwanda explained the program on Yola’s behalf:

'It’s a campaign of teaching old people who never went to school and dropped out because of the ancient history; those who are old who never [were educated], who grew up in a farm so they never went to school. So she is teaching them so that they can be able to read and write.'

(Nokwanda, female youth; interpreting for Yola, female youth: focus group 5)

Thus, there are multiple factors at the community level which interact to influence community engagement in SRHR promotion. These include community norms and values regarding intergenerational factors, community-held knowledges, and the broader context of socio-cultural-historical experiences and norms.

To address the barriers posed by intergenerational factors, participants in focus group three considered educating older generations a good strategy. They regarded knowledge as a channel for breaking down intergenerational barriers, and other related barriers such as shame and stigma. They thought this could help develop greater understanding and closer relationships between generations to achieve community engagement:

So I’ll say if we can [go door-to-door to speak with people one-on-one], we can educate them more on everything. And when these things happen to them and they know about it, I don’t think they will freak out that much. And I think that’s where discrimination comes in. Then there won’t be any of that, against anyone. If our parents really know how to deal with it, when to deal with it, I don’t think we would have a problem with it.

(Brenda, adult female: focus group 3)

Generally, participants considered that an intergenerational gap was a barrier to community engagement in SRHR promotion. Gugulethu discussed some agreement with this (as indicated in passages of dialogue above) but also presented a co-existing alternative perspective. Based on her experiences of engagement in SRHR promotion programs, she contended that being older was a facilitator of community engagement:
[If a younger peer-educator goes into the community to work, community members will think] “This spoilt brat that is here. She is here to spoil our kids [with] all those things [messages about SRHR].” But if I go there, they’ll be listening to me there, even asking me to come again with them. ... They listen to me because I’m older.

(Gugulethu, adult female: focus group 3)

It is possible that she perceived this because, while she may be older than many community members she engaged with through her work, she was not related to them. This could have contributed to a sense that appropriate social distance would facilitate interactions, rather than potentially being constrained by close familial relationships. Close familial ties were discussed by many participants as a barrier to community engagement. For instance, Paki spoke of sibling ties (cited earlier) and several participants above spoke of parental-offspring relationships. It could also be the case that young people observed Gugulethu was open to discussing SRHR promotion and so felt less of a barrier to engaging with her. However, her feeling of comfort and receptiveness in engaging reciprocally with young people was not shared by Thotyelwa who, like Gugulethu, was also a professional program worker of a similar generation. Their different experiences regarding the role of age in SRHR promotion suggests there may be other interacting factors playing a role in any given context. This again reinforces the variable and contextual nature of factors influencing community engagement in SRHR promotion.

6.3 Issue-connectedness and community engagement in SRHR promotion

Participants recurrently discussed how experiences with SRHR issues, or a perceived connection to the issues, could influence community engagement either positively or negatively. Discussions predominantly focused on experiences of living with HIV or AIDS, but occasionally touched on experiences of pregnancy, sexual assault, child sexual abuse and incest, sexual diversity, gender diversity, and sexual violence or gender-based violence and discrimination. The nature of the close experiences with SRHR issues could be either direct (such as experiencing an SRHR issue oneself) or indirect (such as being exposed to SRHR issues through a close personal contact). Thus, issue-connectedness was sometimes related to
aspects of social connectedness. Issue-connectedness also interacted with a range of other individual and community-level factors to influence community engagement.

6.3.1 Individuals’ experiences of an SRHR issue influences community engagement

Several participants spoke of how a close experience of SRHR issues influenced community engagement in a negative way. Participants tended to share their perspectives of the wider community’s experiences rather than their own negative experiences. They spoke mostly with regards to HIV, and strongly linked negative outcomes arising from close experiences with interacting factors of misinformation, ignorance, assumptions, stigma, fatalism and denialism. Close experiences of SRHR issues also contributed to community perceptions about the reality and relevance of SRHR issues and SRHR promotion. The relevance of SRHR issues and SRHR promotion is discussed further in chapter eight as one of the superordinate themes influencing community engagement in SRHR promotion. All of these factors, and their negative implications for community engagement, are discussed in detail in other chapters (for instance, stigma and related factors were discussed in chapter five, denialism is discussed in chapter seven, and relevance and reality of SRHR issues and SRHR promotion is discussed in chapter eight). Thus, the discussion here will focus on the positive ways close experiences with SRHR issues could influence engagement.

Participants described their personal experiences of how direct connections to SRHR issues positively influenced community engagement in SRHR promotion. They discussed how these experiences motivated their personal engagement by prompting their desire to contribute to community-level understandings and wellbeing regarding SRHR issues. For example Gugulethu was one who, like several others, explained that she became personally connected to SRHR issues when she was diagnosed HIV positive. This prompted her engagement in SRHR promotion organisations:

[I became involved when] I was looking [after] my sister’s kids, [they] were suffering from HIV, and I got infected. Now, I know [when] I got infected I wanted to know more about HIV. So I went [to organisation] .... [then] I only know [knew] about HIV and that it is the disease that is around and it’s here to stay. And I learnt about HIV. Just learnt about HIV, and I didn’t mind [think/care] about it [before]. I started minding
about it when I was involved, when I saw that among the family there are some people living with HIV. So, after knowing my status, way back in 2004, I said to myself, “Okay, now that I know I’m positive, I must know more about HIV”.

(Gugulethu, adult female: focus group 3)

While this example initially explains Gugulethu’s individual engagement, she elaborated to reveal links back to the conceptualisations of community engagement previously discussed in chapter four. That is, through her individual engagement, Gugulethu found that she was able to help others such as the children in her care. She thought she could help the wider community by contributing to enhancing their knowledge and understanding about HIV. Additionally, she perceived she was able to contribute to social connectedness and wellbeing among the broader community by helping to build connections between different groups in the community (such as HIV positive and negative people) through her work. Similar motivations and experiences were reported by several other participants, spanning different ages and locations.

Participants also discussed how a close connection to SRHR issues through indirect means could positively influence community engagement in SRHR promotion. Indirect experiences and connections included exposure to SRHR issues through interpersonal connections with other people who were directly affected. For instance, Lindani explained how she felt closely connected to, and affected by, SRHR issues because people close to her (her mother and her sister) were infected with HIV. Her articulate expression of this is recorded in chapter four (section 4.2) where meanings of community engagement were discussed. This reinforces the important role of social connectedness as both an influence on, and value of, community engagement.

In the same discussion group, Nikelwa revealed that four of her friends aged between 18-25 years had been diagnosed HIV positive. Consequently, Nikelwa felt closely connected to HIV in her own daily life. Both Lindani and Nikelwa similarly shared that their indirect experiences of HIV through their close relationships led to their engagement in SRHR promotion. They both engaged with a partner organisation (organisation number one) as they both wished to learn more about SRHR issues, in particular HIV, and wanted to be able to support their family and friends and their wellbeing. Several other participants shared similar examples of their own.
Although participants were sharing individual experiences, all of their accounts linked to the conceptualisations of community engagement discussed previously in chapter four which emphasised community connectedness and wellbeing.

6.3.2 Limited issue-connectedness can also influence community engagement

As well as discussing the influence of feeling a connection to SRHR issues, participants also discussed how a lack of connection to SRHR issues could influence community engagement either positively or negatively. A few participants discussed how limited connections with SRHR issues (either directly or indirectly) encouraged their own or broader community engagement. For instance, they discussed how limited issue-connectedness led to a self-perceived knowledge gap. This commonly prompted the participants’ desire and motivation to engage with SRHR promotion to address this gap and enable them to help themselves and their communities. Thus, this links to the previously discussed factors of knowledge, and knowledge gaps, as influences on community engagement (chapter four).

Conversely, others discussed how limited issue-connectedness could inhibit community engagement in SRHR promotion. These participants described how limited connection to SRHR issues contributed to perceptions of a low sense of perceived vulnerability or risk regarding SRHR issues among themselves and community members. They described perceived feelings of distance, dissociation or irrelevance regarding SRHR issues which posed a barrier to community engagement. For instance, Esona provided her perception about the community generally:

\[
\text{Maybe they think because they are not HIV positive it’s got nothing to do with them.}
\]

(Esona, female youth: focus group 4)

While Esona is commenting on her perception of others in the community, her comments may be suggestive of her own personal feelings and perceptions given that she is not currently, nor has previously been, engaged with SRHR promotion. Other participants shared similar views of their own:
Paki: [Interpreting for Luyolo] Here, here in [talking about] SRH, you said, “If they are talking about maybe teenage pregnancy”, you [Luyolo] [said] “It doesn’t affect me”.

Luyolo: I make babies, I don’t carry babies, so [laughter] … So, the difficulties of being pregnant and the nature and the hardships that you go through, it’s your choice…. but when they talk about sexual intercourse I listen carefully because I want to be master in”. [Laughter]

(Viwe, male youth; with interpretation from Paki, male youth: interview 10)

Viwe: Like, my family, I don’t know of anyone who has HIV and AIDS, so I don’t see myself as involving myself in HIV and AIDS.

Researcher: So it’s not real to you?

Viwe: I don’t, yeah, I don’t think that I should know much about it cos I don’t know anyone who does have it, and I can’t help anyone about it, and that’s … my sense that I have about it.

Researcher: So ‘It’s there but it doesn’t happen to me’?

Viwe: I’m in the mind – it’s like, “If I don’t know about it, I won’t get it. If I know more about it, maybe that’s when I’ll get it because I’ll be involving myself with people around HIV, so I don’t wanna do that”.

(Viwe, male youth: focus group 6)

Here, Viwe described that his own lack of connection to HIV and a related lack of knowledge about the issue was something that he was comfortable with. He described how this was a reason for his disengagement in SRHR promotion at a particular point in time. This highlights the negative implications that limited issue-connectedness can have for community engagement, and also links to the previously discussed influences of knowledge and ignorance (section 4.5). The comment by Viwe that, “If I know more…that’s when I’ll get it…so I don’t
wanna do that” also reveals the interactions between limited connection to SRHR issues and other community-level factors such as knowledges and beliefs, gaps in knowledge, and fatalism (discussed previously in chapters four and five, respectively), and perceptions of relevance (discussed further in chapter eight).

The influences of issue-connectedness on community engagement were more deeply probed by the researcher in focus group six. The researcher posed a hypothetical scenario and question to participants about the potential role of celebrities and public identities as role models to enhance community engagement in SRHR issues. The youth participants strongly agreed that this would be ineffective as they felt they had a substantial social distance from the celebrity rather than a close and relatable connection to them. This was found to contribute to a low sense of reality and relevance concerning SRHR issues and SRHR promotion (discussed further in chapter eight) and to pose a barrier to community engagement in SRHR promotion. Thus, this demonstrated a link between perceptions of social connectedness and issue-connectedness. They drew upon several analogies to illustrate their feelings:

Researcher: Yeah, would that [using celebrities and role models to promote SRHR issues] make a difference, or like that’s still not close enough?

Ahmed: It doesn’t make any difference –

Veliswa: Until you see them sick, or your family member will see you sick, like dying, that’s when it like really scares you.

Viwe: Like yeah, things happen on TV. I don’t take any notice

Researcher: It’s still not reality?

Veliswa: Seriously

Viwe: I would think [name of celebrity as an example] is paid to do that.

Viwe: Yeah, yeah, yeah.

Veliswa: I don’t care about that; it hasn’t happened here. Until it happens here, that’s when I’ll take notice. You see, I’ve got that belief -

Nolusindiso: - In New York they’ve got money, they’ve got money.

Veliswa: - you can handle it. Why can’t they handle it right now? And then, until it happens to me, this will not take place because I see it on TV right now. I’ve seen that New York has money, and, and, it’s basically a stable place.

Viwe: Besides I agree with what she’s [Veliswa] saying. We have problems here in South Africa, in the mines. People are striking. People are striking. We’re here in [city]. We don’t care about that. We don’t have mines here, do we?

Chorus: [laughter]

Viwe: We don’t have mines -

Researcher: So [you feel that] it doesn’t affect you?

Ahmed: You should though; a lot of farmers come from here; from the Eastern Cape

Nolusindiso: They come from rural areas.

Ahmed: They come from rural areas, but it still affects us [here in the city].

(Members of a youth group associated with an SRHR organisation; focus group 6)

The above highlights participants’ perspectives (with the exception of Ahmed, who challenged his peers’ views) that a connection to SRHR issues, either directly or indirectly through close interpersonal relationships, was important for community engagement in SRHR promotion.
Conversely, the absence of a close connection to issues could inhibit community engagement. This passage also highlights the role that connectedness to others, or conversely interpersonal distance from others, has in engagement in SRHR issues and SRHR promotion. Interestingly, Ahmed’s comment at the end of the passage (“They come from rural areas, but it still affects us”) challenges the dominant view of his peers and conveys his view that all people are connected. This is similar to Lindani’s earlier comment (in section 4.2) that she is affected because others close to her are affected. This supports the findings discussed earlier in chapter four that interconnection among people and a sense of a shared human existence is the essence of community engagement. In this particular focus group, however, Ahmed’s views were the exception rather than the norm. The conflicting views among participants about this point demonstrates the variability of views and experiences on this matter.

6.3.3 Experiences of connection and engagement in SRHR promotion are dynamic

The research revealed that the relationships between connectedness (social connectedness and issue-connectedness) and community engagement in SRHR promotion are dynamic, rather than static; changes in social connectedness or issue-connectedness could influence changes in engagement. For instance, Veliswa and Madoda discussed how their engagement changed over time through changes in their exposures, experiences and connections to SRHR issues through others:

**Veliswa:** ... [When] someone that you know has HIV, that’s when you start focusing on it. Until you know somebody. When you don’t know...you don’t care. You don’t have it, it doesn’t affect you. But on the real [in reality] it affects everybody. Everyone else.

**Madoda:** I think I agree with her [Veliswa]. Like before, I always used to hear of HIV and I never took it seriously until I went to a hospice which looks after HIV positive people, and you actually see somebody lying in bed with, you know, their bones and their remains..... That’s when you realise that HIV may [be] real, eh.

(Veliswa, female youth; and Madoda, adult male: focus group 6)
Here, they described how an initial lack of a close experience with SRHR issues was a barrier to engagement in HIV promotion as they did not feel it was relevant to them. However, over time their increased exposure through their social networks enhanced their sense of connection and their subsequent engagement. This demonstrates the dynamic nature of influences and outcomes of community engagement in SRHR promotion, which are contingent upon context and circumstance. Interestingly, Veliswa’s comments above initially suggested that an interpersonal connection was needed to facilitate engagement, and that changes in personal connections could induce changes in perceived relevance. However, the last part of her comment that “…on the real [in reality] if affects everybody. Everyone else” she acknowledges that everyone is affected by SRHR issues (in this case, HIV) perhaps because of, or despite, personal connections. This further supported Lindani’s previous comment (in section 4.2) which emphasised connectedness, and reinforced the conceptualisation of community engagement discussed in chapter four.

The dynamic nature of engagement in SRHR promotion was further evident through Viwe’s experiences. In a previously cited passage above (section 6.3.2), Viwe revealed a strongly-held initial view that he did not wish to engage in HIV-related issues. He discussed how a lack of connectedness to HIV, and a related perceived knowledge gap, contributed to his disengagement, and how a combination of fear and stigma acted as further barriers to his engagement (“If I know more about it, maybe that’s when I’ll get it because I’ll be involving myself with people around HIV, so I don’t wanna do that”). He experienced feelings of dissociation from the issues and a low perceived sense of relevance about engaging in HIV-related health promotion. However, in subsequent discussions he revealed how his attitude and engagement behaviours changed over time. He described how his initial limited exposure helped him identify his own knowledge gap and a need to learn more about the issues. This consequently positively influenced his engagement in SRHR issues:

*I wouldn’t be here, like I decided to come here to talk about it though I won’t use it [the knowledge gained through his participation]. But I don’t know, life is too long and I might have a kid with it. I might have a cousin with HIV and I’d like to have this information about how to help him later.*
Thus, here Viwe shares how a self-perceived gap in his factual knowledge stimulated his engagement in order to be able to help others. Viwe’s experience demonstrates the complex and changing nature of community engagement in SRHR promotion, influenced by multiple interacting factors. In Viwe’s case, the movement toward engagement was influenced by interactions of lay knowledges and beliefs he privileged, fear and stigma associated with those knowledges and beliefs, his social connections and sense of issue-connectedness, and low perceived sense of vulnerability for HIV. Viwe’s experience reflects aspects of other participants, such as Gugulethu (discussed above in section 6.3.1), in that self-identified limited experiences and knowledge gaps can act as a facilitator of community engagement in SRHR promotion.

6.4 Perceptions of vulnerability regarding SRHR issues: social connectedness and issue-connectedness interact

Beliefs about personal risk or vulnerability for experiencing SRHR issues also influenced community engagement in SRHR promotion, particularly concerning the issues of HIV and AIDS, and to a limited extent unplanned pregnancies, and gender-based and sexually-based discrimination and violence also. Participants discussed their beliefs about their own or others’ vulnerability to these SRHR issues, as well as the socio-normative community-held attitudes and beliefs about the susceptibility of particular individuals or groups to these issues. These perceptions were based on the social-construction of identities and group belonging. Some participants discussed their perception of a widespread tendency among the community to perceive particular SRHR issues (notably HIV and AIDS) and SRHR promotion as of little relevance to themselves, but rather, as the concern of other socio-demographic groups in society. They believed this inhibited some people’s sense of connection with the issues and thus posed a barrier to community engagement in SRHR promotion. They also thought the attribution of vulnerability to ‘others’ based on socially constructed groups inhibited community connectedness, and community engagement in SRHR promotion. In this sense, social connectedness (social networks and group belonging) and issue-connectedness (perceptions of connection to, or distance from, SRHR issues), interacted to influence perceptions of vulnerability, and subsequent engagement in SRHR promotion. Interestingly,
while participants discussed this factor as something they perceived among the wider community, their discussions revealed the same tendency performed by some participants themselves. Examples of this are presented below.

Perceived group differences were socially constructed on the basis of social and demographic characteristics including location of residence, social class, ethnicity, gender, age, relationship status, and socio-economic factors such as level of education. For instance, throughout data collection across all sites and community groups, participants often distinguished between people or groups based on location in a rural, peri-urban, suburban or urban area, and they discussed perceived group-based differences in vulnerability to SRHR issues (predominantly HIV) on these bases. This was particularly vigorously discussed in focus group six involving youth living in and around an urban area. Several participants discussed their perceptions of community-held beliefs about HIV vulnerability in urban areas compared to other locations:

_Nolusindiso:_ [Some people think]...it’s [HIV] only something that you can find, like, in the locations [informal settlements on the outskirts of urban centres] and stuff because it’s kind of like they think that they wouldn’t get that thing cos .. they’re more careful and –

_Viwe:_ - yeah

_Researcher:_ People in the suburbs think that?

_Chorus:_ Yeah, exactly.

_Veliswa:_ Like, they said that “She’s high class”, right? “You’re highly educated, you know about HIV, so why would you go and get yourself HIV positive?”

_Viwe:_ It’s like, it’s not a disease for poor people.

_Veliswa:_ But that’s what...people in the suburbs say. Like, I wanna tell you something, okay, Viwe. Okay. I’m gonna go back and tell [someone] “He’s got HIV [and] AIDS. He is highly educated, his mum is a teacher,
but still he goes and gets HIV and AIDS.” That’s what the people in the suburbs do.

(Members of a youth group associated with an SRHR organisation: focus group 6)

In this extract, Nolusindiso and Veliswa discussed their perceptions about people who live in the suburbs. In doing so, they spoke about suburban people and their perspective of SRHR issues in terms of ‘they’, what ‘they’ think, and what ‘they’ do. By doing this, Nolusindiso and Veliswa were distinguishing themselves from the people in the suburbs and the perceived negative attitudes and behaviours regarding engagement in SRHR issues of the suburbanites. However, in doing so, Nolusindiso and Veliswa implicitly or perhaps inadvertently subscribed to, and reinforced, socially constructed group differences regarding engagement in SRHR promotion.

Other participants in the same focus group shared their own personal perspectives rather than their perceptions of the wider community. In doing so, they tended to subscribe to the same beliefs that there are differences in SRHR candidacy and engagement in SRHR promotion based on location:

    Akhona: Then again, it depends on what kind of community again.

    Viwe: Yeah.

    Researcher: What do you mean?

    Akhona: It’s like, um, because, because you get different communities, even in [city], you get suburbs, you’ve got the city centre, even informal settlements. With informal settlements is just the same as [community]. For example, they accept you, but anything depends on what type of suburb you live in and other people you [are] around.

    (Akhona, male youth; and Viwe, male youth: focus group 6)
You know, people in the rural areas - they don’t care much about HIV and AIDS so they just do what they want to do.

(Nolusindiso, female youth: focus group 6)

These extracts from Akhona, Viwe and Nolusindiso are informed by their experiences and identities as young people living in an urban centre. Through their comments, they revealed their own tendencies to construct social groups and attribute SRHR concerns to particular groups based on socio-economic factors such as location of residence.

Several of the comments above also reveal attitudes about the role of individual agency and potential victim-blaming related to SRHR issues. For instance, in speaking from her position as an urban young person, Nolusindiso attributed some agency to people living in rural areas regarding vulnerability for HIV infection, with her comment, “they just do what they want”. Similarly, although Veliswa provided her perceptions of what others in the community believe and say, the multiple comments about being educated and going and “get[ting]” yourself HIV positive, and “still he goes and gets HIV…” revealed her view that victim-blaming and attribution of agency exist among the community. The group constructions based on location revealed intersections with perceptions about class, including socioeconomic status and education level. This was demonstrated by Veliswa’s comment associating being suburban with being high-class and educated.

Predominantly, the social construction of groups and associated attribution of vulnerability to some groups was considered to pose a barrier to community engagement in SRHR promotion by contributing to a low sense of issue-connectedness among some. However, in other instances, participants thought that identification of group differentiation had positive implications for community engagement in SRHR promotion. For instance, the implicit construction of different groups by some participants revealed their views about opportunities to enhance interpersonal interactions, understanding, social connectedness and social inclusion across different groups:

You get people that don’t even talk to gay people or to lesbians, but to us [members of organisation 7] it’s nothing, we actually love them.
Brenda went on to describe the interactions she has had with individuals and groups with sexual orientations and gender identities different to her own, including homosexual and transgender people. She discussed the work she does with gay and transgender individuals and groups through a community-based organisation, and her work to engage the broader community in health promotion activities related to gay and transgender health, wellbeing, rights and social inclusion. In doing so, she is simultaneously enacting community engagement, and striving to further enhance community engagement in SRHR promotion, by contributing to community inclusiveness and community wellbeing, as per the meanings of community engagement presented in chapter four.

Other participants challenged the notion of explicit group distinctions and the implications for SRHR promotion, contending that the nature of SRHR issues and engagement in SRHR promotion is universal and non-discriminatory. For example, Veliswa (previously cited above) shared her perceptions of what ‘other’ people “in the suburbs” would say about SRHR issues and promotion. However, when sharing her own view about SRHR issues and SRHR promotion, she commented:

> I think even if you live in the suburb, even if you live in the township, everybody knows about HIV and AIDS. Everybody knows about it. They – you’ve got no excuse. You see it on the TV, you see it on posters...You have it in the school. Even if you don’t go to school, you know about HIV and AIDS.

(Veliswa, female youth: focus group 6)

Her comment suggests that, despite the construction of social groups (in this case, those that live in the suburbs compared to those that live in informal settlement locations, or ‘townships’), she believes that there is no difference between the groups with regards to the relevance of SRHR promotion and engagement in SRHR promotion.
6.5 Discussion

This chapter has highlighted multiple aspects of connectedness, including social connectedness and issue-connectedness, which influence community engagement in SRHR promotion in variable ways. As with stigma (discussed in the previous chapter), participants’ discussions regarding connectedness and SRHR promotion predominantly focused on HIV and AIDS more than other SRHR issues. Also as with the topic of stigma, during data collection attempts were made by the researcher to expand the discussion to explore connectedness in relation to other SRHR issues, in particular issues of sexuality, gender diversity, and youth pregnancy. While there were some, but scant and brief, discussions about some of these other SRHR issues, discussions about HIV and AIDS remained predominant. Reasons for this would be purely speculative, but could include the high prevalence of HIV and AIDS in South Africa. This could possibly increase the likelihood that a person may have a direct or indirect experience with the issue or someone experiencing it. So despite attempts to address the gap in relation to broader SRHR issues, it does highlight the remaining need for more specific exploration of engagement, and factors influencing engagement, with regards to other SRHR issues beyond HIV and AIDS.

This research found that multiple facets of connectedness influenced community engagement in SRHR promotion acting as both facilitators and barriers in different situations. Connectedness, and its meaning, constructs, operationalisation and measurement, is hard to define, and has been defined in various ways in research (Markham et al. 2010). Some previous international research has sought to understand the influence of ‘connectedness’ on sexual and reproductive health. A review of studies focusing on connectedness in relation to adolescent SRHR outcomes identified and examined eight domains of connectedness: family connectedness, parent-adolescent general communication, parent-adolescent communication about general topics, parental monitoring or regulation, peer connectedness, partner connectedness, school connectedness, and community connectedness (Markham et al. 2010). While the review focused on the influence of connectedness on SRHR outcomes rather than engagement in SRHR promotion, it is still helpful in highlighting multiple domains of connectedness, and that connectedness does have an influence in relation to SRHR issues.
One area of connectedness that emerged in the present research which was not among the domains identified by Markham et al. (2010) was issue-connectedness. The present research found that issue-connectedness was a prominent and complex influence (both positively and negatively) on engagement in SRHR promotion. Issue-connectedness also interacted with various forms of social connectedness such as parental and peer connectedness. Also, Markham et al.’s (2010) review focused on studies from America, Australia, New Zealand and Europe, but did not include studies from South Africa. This highlights possible limitations in understanding the cultural appropriateness of the domains of connectedness identified, and the need for more culturally contextual studies to understand the meanings (including domains) of connectedness and the influence of connectedness in SRHR in any given situation.

However, several of the domains of connectedness identified by Markham et al. (2010) were evident in the present research as relevant to community engagement in SRHR promotion in South Africa; for instance, family connectedness, parent-adolescent communications, parental monitoring, and peer connectedness were all discussed in an inter-related way in this research as influences on community engagement in SRHR promotion. These were evident most particularly with regards to intergenerational relationships. All of these may be considered domains of social connectedness. Social connectedness was found to be a key factor influencing community engagement in SRHR promotion in this research, but other recent research has also linked social connectedness with community connectedness and well-being, and Ubuntu (Samuel and Bagwiza Uwizeyimana 2017), thus also linking social connectedness with the meanings of community engagement revealed through this research.

Intergenerational relationships emerged as a prominent form of social connectedness influencing community engagement in SRHR promotion both positively and negatively in different situations. However, overall these relationships were more commonly viewed by participants as a barrier to community engagement. It is notable that this perspective was shared mostly by participants who were female youth. There is opportunity for further exploration of this in future research among a wider diversity of ages and genders. Some adult female participants also discussed this factor, and their positions were mixed. For instance, one supported the view of the female youth that intergenerational relationships were a barrier to engagement, stating that she would find it difficult to engage in conversations about SRHR with
younger generations despite her professional role in the SRHR promotion sector. On the other hand, another adult female participant discussed how this would not be a barrier for her, given her professional experience. Adding a further layer of complexity to these discussions was the intersecting factor of close personal relationships (such as sibling or parental relationships, as opposed to those with greater social distance) and how those relationships further acted as either a barrier or enabler to intergenerational interactions. These variances highlight the contextuality of the influence of intergenerational relationships in community engagement in SRHR promotion. It is possible that other community members, such as male of varying ages, could have different perspectives about the role of intergenerational factors in community engagement in SRHR promotion, informed by their own temporal and gendered experiences.

Mixed perspectives about the role of intergenerational factors in community engagement in SRHR promotion are also presented in literature. There is a body of literature which consistently reports intergenerational factors are a barrier to discussion or disclosure of SRHR issues between young people and older generations (Ndinda et al. 2011, Abrahams and Jewkes 2012, Nkani and Bhana 2016, Mjwara and Maharaj 2018). However, interestingly, the research with teenage mothers in Kwa-Zulu Natal, Nkani and Bhana (2016) found that while social norms governing intergenerational relationships can pose a barrier by inhibiting discussions related to sex and sexuality between older generation mothers and teenage females, this situation altered if the teenage female had a pregnancy. In cases of pregnancy, there tended to be greater discussion between the older-generation mothers and the teenage females, as the teenage female was considered to have assumed adult responsibility in terms of an active sexual relationship. In these instances, the researchers found that communication between the older-generation mothers and teenage females primarily served to encourage abstinence and prevention of subsequent pregnancies. Similarly, Singh and Naicker (2017, 2019) also found that teenage mothers’ experiences of intergenerational support was fluid, and included phases of experiencing taboo, disrupting taboos, and harnessing support. For instance, particularly among those living in rural areas, conservative social and familial roles tended to render discussion of sexual-related matters across parents and children as taboo. However, upon becoming pregnant, some teenaged mothers reported they perceived themselves as having obtained adult status and felt more open discussions about sex with children, thus being able to disrupt traditional taboos. Some also reported that upon becoming a mother, they were more able to engage with their own
mothers about SRHR matters in order to garner support in their parenting. Some revealed perceptions that their mothers were open to providing this support, in order to facilitate the teenaged mothers to return to study, citing the recognition of the value of education in the context of poverty and rurality. Mkhwanazi (2014) contended that older-generation mothers (mothers of teenage mothers) navigate a contested space of upholding social norms and expectations regarding the taboo of discussing sexual matters with children, and wanting to impart family planning and parenting advice and support upon their children to protect them and promote positive sexuality and parenting. Thus, it is apparent that young peoples’ experiences of intergenerational relationships as supportive or contested social spaces, specifically with regards to SRHR matters like family planning, are diverse and contextual and shaped by intersections of gender, race, age, class and sexuality (Mkhwanazi and Bhana 2017).

The findings discussed above highlight the variability and contextuality of the role of intergenerational relationships, and that intergenerational communication about SRHR matters may be influenced by socially constructed norms and expectations about life-course social roles (such as being considered adult).

However, while the literature discussed above reveals some evidence of a positive role of intergenerational relationships in SRHR promotion, other evidence has shown that intergenerational relationships are a barrier to SRHR-related communication and health promotion. Abrahams and Jewkes (2012) found that the reasons these relationships pose a barrier, particularly in relation to HIV and AIDS issues, are variable however. Reasons reported by participants in their study included young people fearing being blamed as a result of their personal behaviour, fear of being controlled by an elder, a desire to spare parents hurt or further burden, or a perception among the young people that their parents were lacking accurate knowledge about HIV and perceived it as fatal. Mkhwanazi (2010) also suggested that parental avoidance of discussions with young people about sexual matters may be a strategy employed by parents to hide their own lack of knowledge and awareness on the topic. Some of these perspectives were expressed by participants in the present research, such as Sindiswa, Brenda, and other participants in focus group three (see section 6.2.2).

Cultural norms about familial roles and parenting, such as an authoritative parenting style, have also been reported in other literature. Research conducted in the Western Cape identified
community-held beliefs that a child was considered a reflection of not only the individual’s family but of the broader community also, and that there was a social expectation upon parents to teach children about socially acceptable and appropriate conduct (Mkhwanazi 2010, 2014). Thus, it is conceivable that any transgression of community norms would be viewed as a negative reflection of community, while socially acceptable or appropriate sexual behaviour would be viewed positively. This draws links to the conceptualisations of community engagement revealed through this present research, in which community connectedness and oneness, and the wellbeing of the whole community, were central to community engagement and underpinned by Ubuntu values (as discussed in chapter four). However, an interesting point of tension then arises between this position of connectedness and oneness, and the readiness of communities to construct social distance from issues perceived as socially undesirable, through actions such as shaming and stigmatising. This highlights the complexity and contextuality of community engagement in SRHR promotion.

Other literature has also reported that intergenerational communication about SRHR issues occurs in relation to broader socio-cultural influences and contexts, such as broader family and social structures. For example, Wilbraham (2008) conducted a Foucauldian discourse analysis of how parents positioned themselves with regards to communication with their children about matters of sex. She posited that South African familial structures have altered from traditional kinship-based models toward more nuclear-based models, reflective of colonial and Christian influences. Furthermore, these shifts were also linked to social policies and patterns of labour-migration during the apartheid era. Wilbraham argued that the family units then became ‘fragile’, ‘strained’ and ‘damaged’ (p.95), and female headed, with subsequent implications for the feminisation of parenting. In this context, communications about sexual matters were commonly gendered, being constructed and influenced by mothers (Wilbraham 2008). In addition to being gendered (feminised), Wilbraham also found that such communications were also raced, classed and temporal. That is, discussions that were considered liberal and ‘enlightened’ were associated with white middle-class colonial culture, while hidden or avoided discourses were associated with traditional Black cultures. Wilbraham also introduced the notion of a ‘negotiated’ position in which discussions were based on Christian values, thereby facilitating some – but limited – discussion promulgating abstinence and avoidance of sexual behaviours. Discussions were also temporal in that they were influenced by parents’ own
experiences of sex-related communication in their upbringing ‘then’, being during the apartheid-era, compared to ‘now’ in the post-apartheid social and familial contexts. The research highlighted the contextual nature of intergenerational communications about SRHR matters, dependent on multiple and intersecting contemporary and historically embedded socio-cultural and socio-economic factors. The influence of these broader contexts in community engagement in SRHR promotion is returned to in chapter eight, where the ‘relational environment’ is discussed as a key theme influencing community engagement.

The influence of intergenerational relationships was just one aspect of social connectedness and issue-connectedness raised in this research. Other types of relationships also influenced social connectedness and issue-connectedness, and subsequently community engagement in SRHR promotion both positively and negatively. These relationships included other familial relationships (for instance, sibling relationships) and peer relationships. In this study, it became apparent that a key mediating factor in the influence of these relationships on connectedness and community engagement was perceived or actual social distance from others. Multiple examples of the peer influence were highlighted, as well as the influence of community ‘insiders’ and ‘outsiders’ (refer to comments by Paki, Gugulethu and other members of focus group three in section 6.2.1). Examples of sibling relationships were particularly discussed by Lwazi and Paki in section 6.2.1. Similarly, an ethnographic study of teenage pregnancy among a community in the Western Cape found that while discussions between parents and children about sexual matters were commonly avoided, so too were discussions between young people when there was a close relationship involved (such as between siblings or peers) (Mkhwanazi 2010). This suggests that it is not only socio-cultural norms about age, but rather the degree of closeness or distance of relationships, which may influence interpersonal communication and thus connectedness and engagement in SRHR promotion. However, other literature advocates peer-based approaches as effective for SRHR promotion under some circumstances, as discussed in chapter two (see sections 2.3.3 and 2.5.2). This once again highlights the variable and highly contextual nature of influences on experiences of connectedness and subsequent engagement in SRHR promotion.

Social connectedness is influenced by perceptions of social group identity, and the related underpinning concepts of self-categorisation within a constructed group, and inter-group
comparison (described further below) (Abrams and Hogg 1990, Hogg and McGarty 1990). These factors subsequently influenced engagement in SRHR promotion in this research. This was most evident in participants’ discussions about perceived vulnerability and attribution regarding SRHR issues, and engagement in SRHR promotion. The purpose here is not to provide an in-depth or critical discussion of social group identity theories or related theories such as self-categorisation theories; for this, see Tajfel (1978, 1982) or Abrams and Hogg (1990). These bodies of work are vast, multifaceted and nuanced, and indeed, could reasonably provide one lens through which to examine these research findings. The purpose here is to broadly highlight the concept of social group identity constructions as a relevant consideration in relation to social connectedness and issue-connectedness as influences on community engagement in SRHR promotion.

Social group identity refers to the recognition of the differences between socially-constructed groups, and the nature of inter-group relations. Underpinning this are the essential elements of self-categorisation, being how individuals identify as belonging to certain socially-constructed groups, and social comparison, which establishes perceived ‘in-groups’ and ‘out-groups’ (Abrams and Hogg 1990, Hogg and McGarty 1990). Through these processes, one tends to attribute positive traits or characteristics to their own group (the ‘in-group’) while negative characteristics tend to be ascribed to an ‘out-group’ in a desire to maintain symbolic separation from those undesirable traits and create a positive social identity (Hogg and McGarty 1990, Hinkle and Brown 1990). This tends to accentuate differences between groups in a way that enhances the status (a form of symbolic capital) of the in-group, and thus helps to maintain and perpetuate those categorisations. The attribution of negative traits to particular groups based on their characteristics gives rise to stigma (Goffman 1963). Hence, links can be drawn between the social group categorisations and experiences of social connectedness discussed in this chapter, and the influence of stigma discussed in the previous chapter, as interacting influences on community engagement in SRHR promotion.

Participants in the present research revealed social identity group constructions and inter-group comparisons related to constructions of class (Bourdieu 1984). That is, the constructions were based on the value of intersecting properties such as ethnicity, educational status, socio-economic status and locality. However, Hinkle and Brown (1990) stressed the multi-
dimensionality of inter-group relations, and that the in-group and out-group can be favoured in different circumstances, depending on a range of contextual factors (such as the relative importance of particular traits, and the size of the group). This may be reflected in the diverse perspectives of participants in this research regarding attribution of SRHR issues to particular groups.

Participants’ experiences of connectedness (both social connectedness and issue-connectedness) as an influence on community engagement in SRHR promotion also revealed links to various forms of capital. Social connectedness has previously been linked to various forms of capital such as bonding and bridging forms of social capital, as well as symbolic capital through increasing community members’ opportunities and capacities for civic engagement (Samuel and Bagwiza Uwizeyimana 2017). Symbolic capital helps to construct and maintain the status of a socially constructed ‘in-group’ relative to the ‘out-group’, as briefly mentioned above. Bonding and bridging forms of social capital were implicitly evident in this research in participants’ narratives about engagement. For instance, several participants spoke of their own, or others’, experiences of connectedness in relation to socially constructed groups in the community. Examples include Lwazi’s and Paki’s views that commonalities between peers (such as language or background) could help to build a sense of connection, thus highlighting a role for bonding social capital between peers to enhance engagement. Several others shared perspectives that building connectedness across different groups, such as across different generations, or between those directly affected by an SRHR issue and those not directly affected, could help to enhance community engagement, thus highlighting a role for bridging social capital. For example, Brenda shared these views in relation to bridging links between older people and younger people, and between groups with diverse sexuality identities (sections 6.2.2 and 6.4 respectively). The ways in which groups were socially constructed, including individuals’ and communities’ constructions of ‘insiders’ and ‘outsiders’ or ‘others’, were revealed through participants’ discussions of inter-group and intra-group connectedness.

6.6 Chapter summary

Experiences of connectedness influence community engagement in SRHR promotion in multiple ways. Connectedness in this context took two forms, being social connectedness and issue-connectedness. These forms of connections could be either direct or indirect, and the
influences of the different forms of connectedness on community engagement in SRHR promotion could be either positive or negative. Positive experiences of connectedness and subsequent engagement reinforced the conceptualisations of community engagement discussed previously in chapter four (for example, the desire to contribute to the wellbeing of others and the community overall). Experiences of connectedness as a negative influence on engagement interacted with other factors discussed in the previous chapters, such as knowledges, gaps in knowledge, fatalism, stigma and assumptions. However, the relationships between these factors and their varying influences on community engagement should not be oversimplified or considered in a linear way, but rather as interactive and multidirectional across the individual and community levels. Experiences of connectedness which occurred at the individual level were influenced by multiple other factors at the individual and community levels. In turn, individual-level experiences contributed to, and reinforced, community-level socio-cultural norms which influence community engagement in SRHR promotion.

Interactive factors at the individual level included one’s own knowledge or knowledge gaps, the type of relationships, age, perceived social distance, one’s own previous experiences with regards to SRHR matters, and self-perceived vulnerability for SRHR issues. At the community level, factors included some of those which were present at the individual level but also operate at a community level (such as forms of knowledge), as well as others such as socio-normative perceptions of fatalism and stigma regarding SRHR issues, normative social roles and expectations, and social group constructions. All of these factors interact uniquely within any context. Furthermore, the influences of connectedness were not fixed, but could change over time depending on the changing context.

Intergenerational relationships, both familial and non-familial intergenerational relationships, were a particular form of social connectedness discussed as an influence on engagement. Overall, the influence of these relationships on community engagement in SRHR promotion was highly variable. Data suggested intergenerational relationships interacted with a range of other individual and community-level factors including knowledges, stigma, and embarrassment, to pose a barrier to community engagement in SRHR promotion; this was particularly strongly and consistently found to be the case for familial intergenerational relationships. However, this influence of non-familial intergenerational relationships on
engagement was more variable, as the contrasting experiences of Thotyelwa and Guglethu demonstrated. There was some evidence that a negative influence of intergenerational factors could be partly mitigated in some situations, or under certain circumstances, for example if there was a degree of social distance between parties. Furthermore, the influence of intergenerational relationships on community engagement in SRHR promotion occurred within, and was influenced by, the socio-normative context of everyday community life. That is, intergenerational relationships play out in relation to extant existing socio-cultural norms and values regarding family roles and relationships, such as what society considers acceptable age-appropriate interactions, the socio-historical context of access to information and education, and the emergence of more contemporary SRHR issues which may be unfamiliar to older generations. Younger and older generations experience their engagement in SRHR promotion in relation to this context.

The social construction of individual and group identities also influenced experiences of connectedness and subsequent engagement in SRHR promotion in varying ways. On one hand this has potential for bridging social capital to be developed to enhance social connectedness, and subsequently enhance community engagement; on the other hand, it has the potential to pose a barrier to community engagement by contributing to segregated group identities and negative attribution of stigma to particular groups, rather than the promotion of inter-group connectedness and unity. Furthermore, devolving concern regarding SRHR issues and engagement in SRHR issues to ‘others’ contributed to a decreased sense of issue-connectedness, and subsequently a depleted sense of relevance of SRHR promotion among some community members. A low perception of relevance posed a barrier to community engagement in SRHR promotion and is discussed further in chapter eight. Relatedly, various forms of social capital, including bonding social capital, bridging social capital, and symbolic capital were intertwined with social group construction and social connectedness.

The chapter highlighted multiple interactions of a range of factors influencing connectedness, and subsequently, community engagement. Two other concepts that interacted with experiences of connectedness and engagement were the related factors of acceptance and denialism. These concepts form the focus of the following chapter (chapter seven).
CHAPTER SEVEN

ACCEPTANCE AND/OR DENIAL
7.1 Introduction

This chapter discusses the fourth factor that emerged from the research as a key influence on community engagement in SRHR promotion; acceptance and/or denial. Like the factors discussed in chapters four to six, this factor also interacted with a range of other influences at both the individual and community levels. The chapter begins by unpacking multiple aspects of acceptance with regards to SRHR issues (section 7.2), including self-acceptance (section 7.2.1), acceptance of others (7.2.2), and acceptance of the reality of SRHR issues (7.2.3). The interactions of acceptance with other factors are discussed in section 7.2.4. Following the discussion of acceptance, attention turns to discussing the role of denial as a barrier to SRHR promotion (section 7.3). Interactions with other previously discussed factors are considered. The state of acceptance/denial is not static, but rather shifting, depending upon interactions with other factors. This is discussed in section 7.4. The points made about acceptance/denial were predominantly discussed in relation to HIV, but also matters of sexuality to a lesser extent.

7.2 Acceptance influences community engagement in SRHR promotion

Throughout the research, multiple aspects of ‘acceptance’ regarding SRHR issues were frequently discussed by participants as a generally positive influence on community engagement in SRHR promotion. Different aspects of acceptance were revealed, including acceptance of oneself and one’s own SRHR status, and acceptance of others living with SRHR issues. Related to both of these aspects was acceptance of the existence of SRHR issues. All of these aspects of acceptance were closely related to the key factors discussed in previous chapters: knowledges, stigma, and connectedness (both social connectedness and issue-connectedness).

7.2.1 Self-acceptance is important for broader community engagement

Several participants discussed the importance of self-acceptance of one’s own health status for engagement in SRHR issues, particularly in relation to diagnosis of a HIV positive status. Some shared their own experiences:

_They [an SRHR organisation] made me to take out what was a burden in me, I would say, a burden in the sense that I used it [HIV positive status] to stand up among a lot_
of people and say, “the disease is here, and it’s here to stay, and it’s mine”, and I decided to own the disease and after owning the disease I knew that some people would know that there are some people like me that can stand and say, “If you know your status then you are responsible. If you don’t know your status then you are not responsible”

(Gugulethu, adult female: focus group 3)

Others discussed self-acceptance they observed practiced by others in the community:

[She] was like, “okay, it is me, but it’s just me, it’s [HIV] not gonna control my life; it’s not, I’m not gonna live like, ‘okay now I’m dying’. I’m just gonna accept it and move on with life and I’m gonna keep making other people aware that thing lives, it’s around, you should be aware of it”.

(Nolusindiso, female youth: focus group 6)

While these accounts discuss self-acceptance practiced by individuals, Gugulethu and Nolusindiso linked these individual experiences to broader community engagement when they then discussed the benefits to the community of self-acceptance. These benefits included increasing community awareness and understanding of SRHR issues, and being a positive role-model to others in the community. These benefits reflect participants’ understandings of community engagement discussed previously in chapter four, being that community engagement is about contributing to, and enhancing, community wellbeing. Similar perspectives were shared by several other participants.

Several participants expressed a firm view that self-acceptance was an important precursor for broader community acceptance. Broader community acceptance included two aspects: individuals being accepted by others in the community, and individuals being able to accept others in the community. Participants thought this helped to promote social connectedness, and thereby community engagement in SRHR promotion:

[They teach] in the support group, accept yourself before you are accepted by the people.

(Thandiwe, adult female: interview 17)
Even now, even here, HIV positive people must accept yourself before you are accepting the other people.

(Bukelwa, adult female: interview 17)

The above examples highlight participants’ perceptions that self-acceptance was a necessary facilitator of community connectedness and community engagement. Interestingly, Thandiwe also discussed the inverse perception, that acceptance by others (individuals and groups) was an important facilitator of self-acceptance:

And even I, it was difficult for three days .... I get [got] my [HIV] status but I don’t accept it. So she [Bukelwa] laughed at me [participant laughs] and she said, “You’re okay, you are a bright woman because you know your [HIV] status and you are not ill before, so you take yourself as you are bright. So just take your CD4 count [a biological marker of HIV status] and you accept ...”. So, it was easy because there is Bukelwa; someone there.

(Thandiwe, adult female: interview 17)

The various perspectives highlight the multidirectional relationships between self-acceptance, community acceptance and community engagement. Some participants provided examples of the ways in which they, or others in the community, actively demonstrated self-acceptance of a HIV positive status, often through public disclosure:

But once I attend the trainings of HIV, they [the support group] build our dream, they build myself, they build my [self-esteem. So they [people with HIV who join the group] are shy at first, shy to disclose. But eh! [Now] I’m so powerful, so I try to disclose all these things to say how I feel. It’s to show people now, who want to disclose.

(Bukelwa, adult female: interview 17)

People have decided to start disclosing. Like, more than in the older days because then [in the past] – it was like... you’re an alien because you have HIV. It’s like you’re the only one to disclose about.
Participants’ discussions about self-acceptance and public disclosure pertained predominantly to HIV, but there was also some limited discussion about acceptance and disclosure related to sexuality. Participants described how the topic of sexuality, and disclosure of homosexuality, was sensitive, taboo and stigmatised in the community. The participants believed that demonstrating self-acceptance of sensitive or stigmatised SRHR issues through public disclosure helped promote community awareness and understanding of the issues. They perceived this contributed to breaking down silences and stigma surrounding issues such as HIV in particular, and to a lesser extent sexuality. They also considered it contributed to establishing interpersonal connectedness, the provision of support to others, and the promotion of a more positive climate in the community regarding acceptance of the reality of SRHR issues. Thus, these examples highlight how self-acceptance was not only an influence on community engagement, but was itself a way of practicing community engagement.

7.2.2 Acceptance of others

Acceptance of others in relation to SRHR matters was also considered by participants to be important for community engagement. Participants’ narratives revealed how acceptance of others could be a facilitator of community engagement, as well as an outcome of community engagement. This topic was discussed most often with regards to the acceptance of others’ HIV positive status, but not exclusively. There was also some discussion about acceptance of others in relation to other SRHR matters such as sexuality and gender identity, for instance:

*Even in my township, there are some gay guys and some lesbians. I treat them like me. I see no difference. It’s something that’s inside.*

(Gugulethu, adult female: focus group 3)

This relates to, and builds on, the earlier findings about conceptualisations of community engagement presented in chapter four. That is, acceptance of others reinforces the centrality of community connectedness and inclusiveness to community engagement in SRHR issues. It is noteworthy, however, that these attitudes were shared by research participants who were mostly already engaged with SRHR promotion organisations or initiatives. A few participants were not engaged at the time of the research but expressed an openness to engaging with SRHR promotion issues (either explicitly during discussions, or implicitly by their voluntary
participation in this research). Thus, perspectives about acceptance of others may be somewhat skewed among participants in this study compared to the broader community, and may warrant further exploration among a wider population, particularly those who are disengaged from community-based SRHR activities.

7.2.3 Acceptance of the reality of SRHR issues

Participants spoke of the need for broader community acceptance of the existence and reality of some SRHR issues, particularly regarding HIV. For instance, in discussing self-acceptance (at the start of this chapter), Gugulethu and Nolusindiso revealed their acceptance of the reality of HIV in community life through comments like, “the disease is here, and it’s here to stay” (Gugulethu), and “…it’s around, you should be aware of it” (Nolusindiso). Others spoke of community acceptance of other SRHR issues too, such as teenage pregnancy, youth sexual activity, sexuality, and STIs. Participants perceived such acceptance was particularly lacking among older generations. Zandile posited that acceptance among young people and adults needed to begin in schools:

You just have to accept that everyone is having sex... They're [teachers] are not supposed to judge them [young people], you know. Yeah, just have to accept that people are having sex.

(Zandile, female youth: interview 2)

She discussed how acceptance of this reality would help to create a more open and positive environment for intergenerational interactions related to SRHR promotion. She also thought that information about SRHR issues and current SRHR promotion initiatives should be integrated with the context of everyday life, rather than delivered as silo initiatives in limited contexts, in order to deepen acceptance and engagement. To highlight her point, she gave the example of school-based programs which teach SRHR issues within the school curriculum:

So to them [learners who don’t engage], they are taking it [SRHR promotion messages] as something they have to know, and write [a] test about it. They don’t put [take] it as in they have been taught to live like this. ... They don’t put it in their minds, you know?

(Zandile, female youth: interview 2)
Here, Zandile is postulating that SRHR promotion initiatives which are isolated in delivery and context-bound, such as in school-based subjects or programs, exert little influence as they lack relevance for program recipients. She posited that this model was perceived by learners as a component of formal school curriculum like any other subject (such as mathematics or science) rather than a life-lesson which can be translated beyond the school context. Her example highlighted her view that SRHR promotion should be integrated with daily community life in order to enhance deeper acceptance and community engagement.

Several participants, such as Ntombi, discussed a role for themselves in promoting broader community acceptance:

*Some people are still in denial. Like, "No it can't be me." Like, "No". Such stuff, such stuff. But some they do want to know, they do want to learn. Like some people, like myself. I would like to be part of them, in that group whereby we could teach them and let them learn and let them, um, understand that this [HIV and AIDS] is alive and this is there. And it can be treated, you see. You can't, you see if it's there you have it now. So what can you do? You must do this, and this, and this.*

(Ntombi, young adult female: focus group 4)

The desire to contribute to enhancing community acceptance for the wellbeing of others is supportive of participants’ conceptualisations of community engagement presented in chapter four.

### 7.2.4 Acceptance is influenced by other factors

While acceptance emerged as an influence on community engagement in SRHR promotion, acceptance was itself influenced by a range of other factors. These factors included some discussed in previous chapters, such as forms of knowledge, knowledge gaps and misinformation (discussed in chapter four), stigma and fear of discrimination (chapter five), social connectedness, issue-connectedness and attribution of SRHR vulnerability or risk (discussed in chapter six), as well as cultural norms and extant community engagement. Some of these factors posed barriers to acceptance of the self, acceptance of others and acceptance of SRHR issues, and to subsequent community engagement in SRHR promotion. These factors will not be discussed at length here as they are the focus of the previous chapters. However, some examples are included here to briefly highlight their relevance to
the discussion of acceptance in this chapter. For example, Veliswa and Viwe provided an example of the multiple interacting factors influencing acceptance. They linked acceptance to issue-connectedness, social connectedness, perceived vulnerability based on social-class constructions, and attribution of SRHR issues as the concern of ‘others’ as was discussed in the previous chapter. The influence of these interacting factors was considered by participants to inhibit acceptance of the reality of SRHR issues and acceptance of others, and thus inhibit community engagement:

Veliswa: I don’t think [people] accept it [HIV] in the township because people in the suburbs don’t interact much as in the townships. They don’t hang around each other much. In the townships, you don’t care who does what. You just do this, and, if you’re happy and the person next to you is HIV positive and you guys are having a good time, that’s it. Whereas if you live in the suburbs you won’t exactly be so comfortable because you don’t see each other every day. This person lives in their house the whole week, you live in yours the whole week; you don’t see each other.

Viwe: No, I know that she [Veliswa] is saying that people live in their house for the whole week, but I’m saying the whole year!

Veliswa: That’s the suburbs for you. That’s why it’s hard to like, accept it [HIV] in the suburbs. Because people just don’t see each other much and they don’t interact with each other.

(Veliswa, female youth; and Viwe, male youth: focus group 6)

Relatedly, participants in focus group six provided the following example linking acceptance and denial to social connectedness (in particular, intergenerational relationships), and fears of social stigma:

Nomphelo: It’s hard for us to accept that our parents are infected. But now if we talk about our peers, and in our age group, it’s fine to like – we’re not embarrassed if our friend is [HIV positive]. But if it comes to family, now it’s like, wow, it’s not good.
Nolusindiso: And, and I think that it’s because most of the time, [you’re] always worried about how it’s going to impact us, like the family or children …. It’s just, it’s all about the image –

Akhona: Yeah –

Nolusindiso: - and what other people would think.

(Members of a youth group associated with an SRHR organisation; focus group 6)

Nomphelo’s comment reveals the fluid nature of acceptance, and that acceptance and non-acceptance can co-exist depending on the circumstances. Nolusindiso raised the topic of acceptance again later in the focus group discussion. She reinforced her view that acceptance was influenced by wider social attitudes, concern about others’ thoughts and reactions, and perceptions about how SRHR issues would reflect upon or impact oneself. She implied that stigma, judgement and the role of close social connections were barriers to acceptance:

I think that the daughter [of a HIV positive woman] is more affected, rather, by the issue because emotionally and socially, you can’t possibly go out because, firstly, the friends - she’s lacking friends. Every time she makes a friend – “my mother… [is HIV positive]”; [and people will say] “stay away with your mother”…. her friends don’t really accept it.

(Nolusindiso, female youth: focus group 6)

Her comment also revealed the negative consequence for community engagement that can be experienced because of lack of acceptance, such as social isolation.

Stigma as a barrier to acceptance was interconnected with other factors such as societal beliefs and understandings, intergenerational factors and socio-cultural values regarding gender. This was also discussed by Derek:

We used to work in [a] community where we mobilised the community working with clinics, talking about HIV, about stigma, and also trying to give information to more especially to parents because at that time a person who is infected with HIV was stigmatised. They think that maybe she is sleeping around and she don’t know how to
handle herself. And the thing was that time they say HIV was a woman’s disease. They didn’t want to accept that if you’re a man can be HIV positive. If you remember at that time, when you are a man, there was no problem if you have ten to eleven women. They say, “No, you’re supposed to be like that because you are a man”. You see? But as time goes by, people changed.

(Derek, adult male: focus group 2)

7.3 Denial influences community engagement in SRHR promotion

While acceptance was widely discussed by participants as a positive influence on community engagement, the contrary process and outcome of denial was widely discussed as a barrier to community engagement in SRHR promotion. As with discussions about acceptance, participants’ discussions of denial were predominantly related to HIV and AIDS, but with some limited discussion related to issues of sexuality. Participants discussed multiple aspects of denial, including denial of the existence or reality of some SRHR issues, denial of one’s own HIV status, and denial of the HIV status of a close friend or relative. Like acceptance, denial was interdependent with other individual and community-level influences previously discussed including knowledges, stigma, social connectedness and issue connectedness.

Some participants discussed their own experience of denial:

_Eh, in 1995, I have [gave birth to] a baby. So after another two years, then I was diagnosed with HIV. Then found out that I was HIV positive. Then all along I’m trying my best to understand that HIV’s [real and present], and deny all the challenges I am facing [faced] with…Yoh! You [I] have the denial. .. [But] because of her [Thandiwe], I won’t get scared about “Hey, I am HIV positive”._

(Bukelwa, adult female: interview 17)

Bukelwa shared her experience of her own initial denial which she described was initially driven by fear of negative social perceptions, judgement and stigma. However, she went on to describe how close interpersonal relationships and support (for instance, from Thandiwe) facilitated her to overcome her denial, accept her HIV positive status, and then contribute to broader community engagement by becoming a community activist for SRHR promotion and supporting others in the community, thereby practicing and contributing to community engagement.
Several participants described widespread instances of denial they had witnessed in the community more broadly which negatively impacted community engagement in SRHR promotion. For example, Ntombi shared her account:

**Ntombi:** Like, I for instance, I had two brothers that passed away. They passed away because of AIDS. I didn't know that they were positive. My mother hid [hid] that from me. I only knew after. First, the first one, he died of AIDS. My mum lied. But she knows that I can, I know how to deal with a sick person. She lied to me; “Ok, well that's fine. But now everyone at home is well”. The second [brother], he is staying with her in [city]. He passed away again. I asked what was the problem. And, "No, he had only cold inside." I said, "No, that's impossible." I know that he was taking pills. He was taking pills. Well that's fine. I tried to take him apart [aside, to ask], "Please tell me the truth, what's going on. …… But, that was the denial to [off] my mum.

**Cebisa:** So what is it, its parents' denial?

**Ntombi:** Maybe she doesn't want to take it serious that “It can be my child who is sick”.

**Cebisa:** But why?

**Ntombi:** I don't know. But I told her that I do get tested every three months, but I tell her that, when I am positive, please don't hide it. Like, don't hide it to my sister that I'm positive. Tell my sister that I am positive so that she will know what that is, she will know not to fear of me, or maybe she [mother] fears so much for herself that “I am going to lose my baby because of this”. Maybe it's that, I don't know. But if, we as a family, we know that [sister] is sick, and is sick this way, maybe we will have much time or much way of caring for her or for him. Much way.

(Ntombi, adult female; and Cebisa, female youth: focus group 4)
Ntombi’s account provides insight into the nature and enactment of denial. While Ntombi could not specifically say why the denial arose in this circumstance and could only speculate, her comments suggested a climate of shame and secrecy existed regarding a HIV positive status, which she thought contributed to denial. Interestingly, her comment above also suggests that through this instance of denial, which was considered to pose a barrier to community engagement, the opportunity arose for her to enact and promote community engagement through disclosing her HIV positive status to, and encouraging acceptance by, her mother and sister.

Cebisa provided her own opinion about why denial arises in the community, linking denial to community-level assumptions and judgement:

Another thing that enforces denial is us. We people judge people...

(Cebisa, young adult female: focus group 4)

Cebisa’s views were consistent with, and reinforcing of, the views presented about the negative influences of judgement on stigma on community engagement discussed previously in chapter five.

Denial was also linked to interconnections of forms of knowledge (including lay knowledges and beliefs, and gaps in factual knowledge as discussed in chapter four), and fatalism (discussed in chapter five):

Brenda: I would say it’s ... that [rural] areas, it’s like people are so very uneducated when it comes to HIV. I would say that they still don’t know what it is [HIV specifically] and if they drink alcohol maybe they’re not going to feel the pain. I don’t know. It’s just most of them that I see now. They drink. And I [sigh] - because .... I would say that most of them that are drinking they are still in denial.

Researcher: Denial?

Brenda: I would say that. Because some of them they, maybe they don’t accept it, or some of them as that may be, ‘I am gonna die’, but, or – you know what? There’s a lot of stories going around saying that if you are
HIV positive you’re gonna die this bad, or it’s gonna be this painful, or in two months you’re gonna be dead. So, with all these myths going on, I mean ... they, to me it seems like [people think] ‘I’m human, so it’s just gonna happen to me’.

(Brenda, adult female: focus group 3)

Other participants discussed how denial linked to knowledges (and knowledge gaps), beliefs and fatalism could contribute to active disengagement at the individual level, and have negative health and wellbeing consequences:

She [friend] was using the ARVs. I think maybe it's because she knows that it [HIV] is not cured. Maybe the ARVs are just helping out. She knows that at the end of the day, “I'll be dead”. But I tried to tell her that, “You won't die now. If you eat healthy, if you don't do some such stuff like drinking and all that stuff, you will stay well for a long, long time”. But it's the denial that they have.

(Ntombi, adult female: focus group 4)

These examples highlight an association between denial and the concept of ignorance (discussed in chapter four). That is, the examples describe instances in which the participants perceived people were informed about SRHR issues, but owing in part to denial, they acted counter to information and advice given, thus demonstrating ignorance. While discussion about denial often involved examples of denial practiced at the individual level, the accounts revealed how individuals’ denial interacted with other community-level factors such as the forms of knowledge which are privileged in communities.

7.4 Acceptance and denial are dynamic processes

The state of acceptance/denial of the reality of SRHR issues or of one’s SRHR experiences or status could be dynamic and change over time. An example from Nomphelo provided above highlighted this when she described how a person could accept a friend’s HIV positive status, while simultaneously find it challenging to accept a parent’s HIV positive status because of differing relationships with each of these people. Derek also clearly articulated the dynamic state of acceptance with his comment above that, “as time goes by, people changed” with regards to the influence of gender-based perceptions related to acceptance.
Other participants discussed the dynamic nature of acceptance as a process of moving through various stages of poor engagement, to acceptance and then active demonstration of acceptance which helped promote community engagement, as the conversation between participants in focus group six captured:

**Nolusindiso:** Because once you have HIV and you tell yourself ‘I’m gonna die, I’m gonna die’, you’re gonna die in two years’ time. That’s why she [a person with a HIV positive status] is still living and drinking. If you drink every day with your stressors, and smoke drugs, you’re gonna die.

**Bukeka:** Stress makes you gonna die.

**Madoda:** So, you have to try to accept it?

**Nolusindiso:** Yeah, ... accept it.

**Madoda:** And once you accept, you can disclose.

**Chorus:** Yeah.

**Viwe:** - and if you’re HIV positive, doesn’t mean that when you come from the clinic you should stay in your house and not go out.

**Madoda:** HIV’s not a death sentence. You should be able to live your life.

(Members of a youth group associated with an SRHR organisation: focus group 6)

A similar view was also expressed by Paki:

**Paki:** When someone has tested HIV positive, it’s not easy for them to go out and speak about it. But when they started to accept it, their status, and then they can go and disclose. They can go public and talk about it.

**Researcher:** So it takes disclosure?

**Paki:** Yes, yes, they can talk about it. Even, even the experiences about, about sex, difficulties maybe, or their, their experience about sex, it’s
not easy to talk about it when maybe the bad thing happened. Until you accept it yourself and then we can go out and share it.

(Paki, male youth: interview 16)

Bukelwa discussed her own experience of moving through different stages of denial and acceptance. Some of her comments relating to this experience are provided above (section 7.2.1 and section 7.3). She also described how this experience of change facilitated other positive outcomes for herself and others:

*I just hid it in this [initial] stage of HIV, so angry. Although, I was so angry because I, the problem I was so angry, I don’t get [have] many boyfriends, as the people [think] - they thought if you are having HIV positive you have many boyfriends.... I was so worried [people would ask], “where do you get this?” [HIV] ... I was so angry, really. I was shy to disclose. And embarrassed – [for] my family. But I disclosed with my family .... I want [them] to understand. I want to work with my family and I want to educate my family about HIV so that they are not ashamed about me ... Others they can understand me and they accept me, really. [They are] supporting, really, supporting. Although I want to educate them ... they were uneducated, but the way they were supporting me – yoh! – it was so very very very supportive.*

(Bukelwa, adult female: interview 17)

Here Bukelwa’s description of her experience again highlights that attitudes and practices regarding denial and acceptance can change over time, from initial anger, denial and secrecy, fears or lived experiences of rejection by others, through to sharing by disclosure, connectedness and close support which are enactments of community engagement (as previously outlined in chapter four).

Each of the narratives provided above highlights the changing state of acceptance/denial. In each account, participants linked acceptance to community engagement as they discussed the positive outcomes for the community of acceptance. These outcomes included positive role-modelling and increasing understanding and awareness about SRHR issues among the community, and decreasing stigma and rejection among the community.
7.5 Discussion

The findings presented in this chapter illuminated multiple aspects of acceptance/denial which influence community engagement in SRHR promotion in South Africa. With regards to acceptance, disclosure was widely discussed as an important process in, and outcome of, acceptance. The literature about ‘acceptance’ related to SRHR issues in South Africa spans a breadth of topics reflecting contemporary SRHR matters. A good deal focusses on acceptance of interventions and/or treatments particularly for HIV and AIDS, such as voluntary counselling and testing or microbicides (Johnston et al. 2010, Madiba and Mokgatle 2015, Govender et al. 2017, Sabapathy et al. 2018). However, other topics covered to a lesser extent include acceptance of gender norms and attitudes linked to gender-based violence (Kalichman et al. 2007), and self-acceptance following experiences of sexual abuse (Kheswa 2017). Discussions about acceptance in this present research included some (limited) discussion of matters related to sexuality (including acceptance of diverse sexual identities and youth sexual activity). However, participants’ discussions tended to focus predominantly on acceptance of one’s own HIV status, acceptance of others’ SRHR (particularly HIV) status, and acceptance or denial of the reality of SRHR issues.

A study conducted by Watt et al. (2017) with HIV positive women in Cape Town who had experienced sexual trauma revealed insights into their experiences of acceptance regarding HIV status. Their study explored participants’ engagement in HIV care, and as part of this explored their acceptance of their HIV positive status. The research revealed a sense of connectedness and solidarity with others could facilitate acceptance of a HIV positive status. Most participants in that study reported that acceptance of a HIV positive diagnosis was helped by knowing that they were not alone in their experience. For some of the participants in Watt et al.’s study, acceptance of a HIV positive status was contextualised relative to other factors or experiences in their lives. For instance, participants reported that they found acceptance of their HIV positive status, including talking about and living with HIV, had been easier to cope with compared with accepting, talking about and living with their histories of sexual trauma, as they perceived HIV was relatively less stigmatised or shamed in communities compared to sexual trauma. This highlights the complexity of factors influencing acceptance of SRHR matters, including the relational experiences or context in which SRHR issues arise. The relational environment is discussed further as a theme influencing community engagement in SRHR promotion in the next chapter.
Literature about acceptance of one’s own, or others’, HIV status and the lived reality of HIV tends to concentrate on the issue of disclosure (for example, Wouters et al. 2009, Dageid et al. 2012, Mfecane 2012, Judgeo and Moalusi 2014, Maman et al. 2014, Iwelunmor et al. 2015, Katz et al. 2015, Bhatia et al. 2017), which is arguably one manifestation of acceptance. Participants in the current research viewed disclosure as a demonstration of self-acceptance, and a desire to promote community engagement in SRHR promotion through seeking to enhance acceptance among the broader community. For participants in the present research, their own disclosure was often voluntary. However, in some instances disclosure could be involuntary or inadvertent, such as through commencing ART treatment, being seen at the clinic, or through visible physical signs such as changes in body shape which were perceived among the broader community to be due to ARV treatment; this was discussed previously in chapter 5 (section 5.3). These instances were often linked to community-based stigma, knowledges (including lay knowledges and beliefs) and assumptions.

Participants in the present research shared mostly positive experiences of acceptance and disclosure. Disclosure of one’s HIV status has been associated with positive individual and community health benefits including increased engagement in health promoting behaviours (such as condom use and treatment adherence), a feeling of attaining respect from others in the community, and improved social and emotional health outcomes such as increased social support seeking and access to social support, enhanced coping, and access to practical and material support (Wouters et al. 2009, Mfecane 2012, Bhatia et al. 2017). However, some literature does reveal negative ramifications associated with disclosure in some situations, including anticipated or experienced stigma, discrimination, social and familial rejection, social isolation and violence, and a desire to stay connected with the community (Wouters et al. 2009, Mfecane 2012, Judgeo and Moalusi 2014, Maman et al. 2014, Katz et al. 2015, Bhatia et al. 2017).

Disclosure is not a static event, but rather, is a complex process (Bhatia et al. 2017). It is influenced by a range of individual and community-level factors, including individual experiences of social support, stigma (at the individual or community levels) and the community socio-cultural context. In their study among HIV positive men in Cape Town, Iwelunmor et al. (2015) found that acceptance was paramount for enabling disclosure, and that time and social support could assist acceptance. The authors concluded that behaviours regarding disclosure were strongly influenced by broader socio-cultural factors and
community contextual factors. For the male participants in the study, disclosure was linked to their perceptions about male identity. Further, these perceptions of masculinity were linked to broader sociocultural norms, and a complexity of underpinning social, political, cultural and historical factors. The authors articulated, “…in the South African context, the HIV disclosure experiences of men cannot be separated from the historical, social, and cultural factors that shaped notions of what it means to be a man” (p. 198). Examples cited by the authors included shifting male identities during apartheid era labour migration, which undermined traditional male roles and identities. Additionally, perceptions of masculinity alongside other enabling and nurturing factors, such as family systems (the presence of supportive family members, or unsupportive family) and community factors (such as community support groups or community stigma) influenced disclosure either positively or negatively.

A body of other research has also found that social support, and the nature of social or intimate relationships, were also important in acceptance and disclosure (Mfecane 2012, Maman et al. 2014, Iwelunmor et al. 2015, Katz et al. 2015, Bhatia et al. 2017). Iwelunmor et al. (2015) found that acceptance was paramount for enabling disclosure, and that time and social support could assist acceptance. Similarly, Katz et al.’s (2015) research with HIV positive people and health care workers in Soweto, Gauteng, revealed that a sense of social connection and social support was a facilitator for disclosure among those who accepted their HIV diagnosis and treatment. Notable among a cohort who refused to accept treatment was an expressed desire for greater social support to facilitate their engagement in disclosure, treatment and health promotion. However, paradoxically, they also found that social connectedness could be a barrier to disclosure, as fear of losing existing connections and becoming socially isolated prevented some people from disclosing (Katz et al. 2015). A similar phenomenon was also noted by Judgeo and Moalusı (2014), who found that fear of stigma prevented disclosure among some participants in their study with a HIV positive population in the Western Cape, and that the nature of relationships was central to this. This demonstrates the complex interconnections of factors including stigma, connectedness, acceptance and denial, and disclosure.

These findings about the influences of social support and social connectedness in acceptance and disclosure also suggest links to the concept of social capital, in particular bonding and bridging forms of social capital. In one of the few studies to empirically test the relationship
between social capital and SRHR health behaviours and outcomes, Wouters et al. (2009) examined the effects of bonding and bridging forms of social capital on disclosure among people living with HIV and AIDS who were undergoing anti-retroviral therapy (ART) in the Free State province of South Africa. Using cross-lagged regression analysis, they concluded that bonding social capital (such as support from family and friends) had a consistent, positive association with disclosure, and that over the longer-term, bridging social capital also positively influenced disclosure. Additionally, they tested the hypothesis that in disclosing, people living with HIV and AIDS would compensate for a lack of one form of capital (for example, limited bonding capital, such as feeling unable to disclose to close family and peers) with other forms of capital (for example, greater bridging capital, such as being more likely to depend on health services and community support groups in disclosing). They found that bridging social capital was particularly important for those who lacked bonding capital to facilitate disclosure. Similarly, Masquillier et al. (2015) found that having external support such as through a formalised peer-support program could enhance the initiation and uptake of support from closer ties such as a direct relative, partner or close friend. This again suggests positive influences of bridging capital for bonding capital, and for disclosure and acceptance.

Participants in this present research considered disclosure could be a pathway to enhancing community engagement in SRHR promotion by increasing awareness about SRHR issues among the community, enhancing acceptance of SRHR issues and people experiencing SRHR issues among the broader community, and encouraging others to accept and disclose a positive HIV status for the benefit of the community. This is similar to findings of other research from South Africa which found reasons underpinning individuals’ disclosure were often oriented toward the benefit of others and the community, such as wanting to protect a partner, or encouraging a family member to get tested (Mfecane 2012, Maman et al. 2014, Bhatia et al. 2017). In contrast, some literature has also reported that non-disclosure was often practiced among South African communities for perceived benefits for the wellbeing of others, such as a desire to protect family members from anticipated stigma and discrimination (Judgeo and Moatusi 2014, Maman et al. 2014). However, Judgeo and Moatusi (2014) cautioned that non-disclosure does not necessarily infer denial of a HIV positive status; instead, non-disclosure may be due to an awareness and internalisation of societal stigma, and thus a coping strategy employed by discreditable individuals to avoid further harm such as social rejection or discrimination. Together, the multiplicity of experiences regarding
Disclosure reveals the complex and contextual nature of acceptance, denial and disclosure and community engagement in SRHR promotion.

### 7.6 Chapter summary

This chapter has discussed multiple aspects of acceptance and denial in relation to how they influence community engagement in SRHR promotion. Acceptance and denial are not diametrically opposed to one another, but rather are fluid processes that co-exist and interact with one another. These processes can operate as both a determinant of community engagement in SRHR promotion, and an outcome of community engagement in SRHR promotion by contributing to increasing awareness, inclusivity and connectedness, and ultimately the wellbeing of others and the community.

Participants’ observations of the community, and their own lived experiences, revealed that states of acceptance/denial can change over time as a result of interactions with other factors influencing community engagement. Some of these factors include stigma, knowledges, perceived or experienced risks and negative social outcomes, social networks and connectedness. The wider body of literature also reveals the interactive factor of the community context and socio-cultural norms. These factors interact in contextually unique ways to shape processes of acceptance/denial, and to influence community engagement in SRHR promotion.

Disclosure was a prominent topic of discussion in relation to acceptance among participants in this present study. Participants considered the practice of disclosure was an important demonstration of their own acceptance, as well as important for facilitating broader community acceptance through enhancing community awareness of SRHR issues. It was generally thought by participants that this would have benefits for the community by enhancing community knowledge, understanding and connectedness. Thus, disclosure facilitated and practiced community engagement as defined in this context (see chapter four), that is, a focus on community wellbeing.

This chapter is the final one focussing on one of the four key factors revealed by this research as influences on community engagement in SRHR promotion. The next chapter draws together the four key factors presented thus far (through chapters four to seven) to demonstrate how the interactions of these factors at the individual and community levels
contribute to three superordinate themes influencing community engagement in SRHR promotion in South Africa. The four underpinning factors presented thus far, and the three superordinate themes, are presented in a model of influences on community engagement in SRHR promotion in South Africa in the following chapter.
CHAPTER EIGHT
DISCUSSION
8.1 Influences on community engagement in SRHR promotion in South Africa: a conceptual model

This chapter presents the final findings from the analysis - a conceptual model for theorising influences on community engagement in sexual and reproductive health promotion in South Africa. The model draws together the four key factors presented thus far (in chapters four to seven) as influences on community engagement, into three superordinate themes which influence engagement. The chapter begins with a presentation and description of the model overall, and then goes on to describe in detail the three superordinate themes. Unlike the presentation of findings in the previous chapters (chapters four to seven) where discussion of literature was reserved for a separate section at the end of the chapter, in this chapter relevant literature will be integrated with the discussion of each theme through the chapter. Following this, a separate discussion section is presented in which other relevant social theory – particularly, Bourdieu’s theory of habitus - is drawn upon to demonstrate how the findings of this new research fit with existing social theory. While this theoretical framework was not initially used in conceptualising the research, several relevant aspects of this theory have already been introduced in previous sections of the thesis, including social capital (section 2.3.3), symbolic violence (section 3.5) and the construction of social group identities (section 6.5). Here, the discussion expands to demonstrate how the theory of habitus can be used as a lens for considering these current research findings.

8.2 A model for understanding influences on community engagement in SRHR promotion in South Africa

Based on the research findings presented throughout this thesis, a conceptual model for understanding influences on community engagement in SRHR promotion in South Africa has been derived. This model is presented below in figure 8.1.

The model represents the four factors revealed as key influences on community engagement in this context: i) knowledges; ii) stigma; iii) connectedness; and iv) acceptance/denial. Each of these factors has been discussed in depth in chapters four to seven, respectively. These four factors exist and operate individually, as well as in multiple interactive ways with one another. The interactions of these four factors contributed to the emergence of three superior central themes influencing community engagement in SRHR promotion in South Africa: i)
representations of SRHR issues; i ii) relevance; and iii) the relational environment. The first of these, ‘representations’, refers to the influences of discursive constructions of SRHR issues on community engagement. The second, ‘relevance’, refers to community members’ perceptions of the reality and relevance of SRHR issues and SRHR promotion, and how these influence engagement. The third, the ‘relational environment’, refers to how SRHR promotion, and community engagement in SRHR promotion, occur in relation to the normative social contexts of community life. These superordinate themes were derived from common threads across the four key factors, and/or from interactions of the four factors. These themes can also act independently or interactively with one another to influence community engagement. Simultaneously, these themes are themselves shaped by communities’ experiences and practices of engagement in SRHR promotion. Thus, processes and experiences of community engagement, and the factors influencing community engagement, are highly dynamic and contextual, and multi-dimensional. Each of the superordinate themes is discussed below, drawing on examples from the analysis to demonstrate them.
8.2.1 Representations

A deep analysis of the four key themes, and their interactions, revealed a central influence on community engagement was the way SRHR issues were constructed and represented in society through discourses and symbols. The representations, and their influences on community engagement, were found to be predominantly negative, posing a barrier to community engagement. Common discursive representations of SRHR issues, particularly HIV and AIDS, were as immoral and taboo, fatal, and gendered and classed. These discursive
and symbolic representations were constructed from the combined interactions of knowledges (including forms of knowledge and gaps in knowledge), stigma, experiences of connectedness (both social connectedness and issue-connectedness), and discourses or experiences of acceptance/denial. In turn the representations, and the local meanings ascribed to them, reinforced and perpetuated existing understandings, beliefs and stigma.

The construction of SRHR issues as immoral and taboo arose from combined influences of knowledges (including traditional lay forms of knowledge), community members’ experiences of connectedness to SRHR issues (either directly or indirectly), and stigma (including judgement, assumptions and shame). For instance, in chapter seven (section 7.4), Bukelwa discussed her experience of false community perceptions that she must have become HIV positive through having multiple partners. This suggested a community belief that one who obtains HIV is promiscuous, regardless of any interpersonal connection they may or may not have had with Bukelwa, and with limited understanding of Bukelwa’s own personal circumstance. Esihle and Thandiwe also explicitly spoke of the community perceptions of SRHR issues generally being considered taboo and immoral, based on community knowledges, attitudes and stigma (section 5.2). This construction was particularly strong in the context of intergenerational relationships (discussed at length in chapter six, section 6.2.2), and so linked to aspects of connectedness. Further, the construction of SRHR issues as taboo was linked to the broader socio-normative environment of community knowledges, beliefs, stigma and relationship norms, and in-turn perpetuated socio-cultural norms of taboo, silence and shame regarding SRHR issues. The broader relational environment as an influence on SRHR promotion is discussed further in section 8.2.3 below.

Another dominant representation in the community of HIV and AIDS specifically was as a fatal illness. Fatalism was specifically discussed in chapter five (section 5.4). The combined influences of knowledges (in particular lay forms of knowledge informing community attitudes and beliefs about SRHR outcomes), social connectedness (community members’ experiences with people affected by SRHR issues, particularly HIV and AIDS), and stigma contributed to the community-held representation of HIV as fatal. Stigma was particularly linked to physical appearances and the local meanings ascribed to physical appearances, which were informed by community knowledges (including lay knowledge, and gaps in factual knowledge) and experiences of social connectedness. Representations of HIV as fatal based on physical appearances revealed in this research reflect findings of other research
which also found stigma was associated with discursive interpretations of physical signs of weight loss (Cloete et al. 2010).

Community members’ lived experiences of social connectedness contributed to reinforcing or challenging this representation as fatal. For instance, several participants perceived that many community members had experienced the death from HIV and AIDS of somebody they knew, thus reinforcing the view of the illness as fatal. However, most participants in this study did not necessarily subscribe to the fatalistic representation themselves, and some even directly challenged this representation (for example, see sections 5.5 and 7.2.1). This was perhaps due to their involvement with SRHR promotion and the factual knowledge they had gained through that, and/or their own experiences of connectedness (for instance, to people they know who are managing their HIV and ‘living positively’), and acceptance of the reality of HIV and AIDS as a present yet manageable illness in the community.

The dominant representations of SRHR issues, particularly HIV and AIDS, as taboo and fatal are not necessarily separate, but may be linked. Existing literature has discussed how matters of death and dying in themselves are taboo and silenced in South African culture (McNeill 2009). Thus, representations of HIV and AIDS as fatal could possibly compound the taboo associated with the illness. Understanding this broader cultural context regarding death and dying, and the place of SRHR issues within that context, is an important consideration for future SRHR program planning and implementation, and community engagement in SRHR programs.

Representations of SRHR issues (predominantly but not exclusively HIV and AIDS) were also as classed and gendered issues. With regards to being class-based, participants raised community-held beliefs that HIV in particular is a disease of ‘poor people’ and of ‘Black people’, where race (African race, or Black identity) was considered an indicator of class, based on the socio-economic legacy of apartheid. Perceptions of HIV and AIDS being related to class was particularly discussed in section 6.4. Such a representation was derived from interactions of lay knowledges about illness aetiology and attitudes about vulnerability for HIV and AIDS, and underpinning influences of connectedness (both social connectedness and issue-connectedness), whereby community members perceived particular issues as relevant to particular social groups based on their experiences and exposures to HIV or people with HIV. This representation may be reinforced by factual knowledge about patterns
of the epidemiology of illnesses such as HIV which predominantly affect the majority Black population (SANAC 2011).

Representations of SRHR issues as gendered were also somewhat evident throughout this research. This was explicitly articulated by one participant (Derek, in section 7.2.4) who stated his understanding that that HIV was once conceptualised among the community as a women’s disease. This perception is underpinned by stigma, and lay knowledges including normative socio-cultural attitudes and beliefs regarding gender, resulting in gender-based stigma. A body of literature over time has consistently reported the presence of gender-based stigma attached to SRHR issues in South Africa which disfavours and negatively impacts upon females (Petros et al. 2006, Cloete et al. 2010, Abrahams and Jewkes 2012). Abrahams and Jewkes (2012) highlighted the gendered nature of HIV-related stigma; from a male perspective, stigma, fear of stigma and subsequent acts like non-disclosure are underpinned by perceptions of masculinity, machoism, independence, and a fear of not wanting to be seen as weak and not wanting to lose independence. From a female perspective, stigma, fear of stigma and subsequent acts like non-disclosure of SRHR status are underpinned by perceptions of morality, immorality and promiscuity (Abrahams and Jewkes 2012). This suggests that representations of SRHR issues, in particular HIV, as gendered may also be linked to representations of the issues as immoral and taboo. Further, the representation is linked to the superordinate theme of the relational environment through the gendered socio-cultural norms which operate and influence everyday community attitudes and practices. This is discussed further in section 8.2.3 below.

8.2.2 Relevance of SRHR issues and SRHR promotion

A second superordinate theme arising from this research was the influence of the perceived relevance of SRHR issues and SRHR promotion by the community. The development of this theme was informed by interactions of all four of the underpinning factors of knowledges, stigma, connectedness, and acceptance/denial. The sense of relevance could be either positive or negative in relation to community engagement in SRHR promotion. That is, having a sense of relevance about SRHR issues tended to positively influence community engagement, while conversely, a low sense of relevance posed a barrier to community engagement.

A sense of relevance about SRHR issues, particularly HIV, was strongly linked with a sense of reality about the issues, the perceived sense of vulnerability regarding the issues,
underpinning experiences of connectedness (both social connectedness and issue connectedness), and knowledges (including factual knowledge, lay knowledge, and the concept of ‘ignorance’). There were many instances of this presented in chapter six (connectedness), such as the narratives of Gugulethu, Lindani and Nikelwa (see sections 6.3.1).

Acceptance/denial was also interactive with connectedness (social connectedness and issue-connectedness), knowledges (including ‘ignorance’) and stigma to contribute to a sense of relevance. Acceptance implicitly requires and infers acknowledgement of the lived reality of an SRHR issue, and so was key in contributing to a sense of relevance regarding SRHR issues and SRHR promotion. Denial may implicitly infer poor or no recognition of the reality of an SRHR issue, and so little sense of relevance regarding SRHR promotion. Participants narratives revealed that through practicing acceptance, for example through actions like disclosure of one’s HIV status or supporting others experiencing SRHR burdens, they were contributing to an environment which promoted the reality of SRHR issues in the community, the concept of connectedness in the community, and hence the relevance of SRHR issues and SRHR promotion to the community at large. This was demonstrated through comments such those by Gugulethu and Nolusindiso in section 7.2.1, and Bukelwa in section 7.4. This also links to the concept of community engagement as understood in this context as being about connectedness, inclusion and community wellbeing (discussed in chapter four).

In contrast, a low sense of relevance could inhibit community engagement in SRHR promotion. A low sense of relevance could arise from interacting factors including limited experiences of connectedness (social connectedness and issue-connectedness) and particular forms of knowledge (including lay beliefs about candidacy of particular groups, and ignorance). This was eloquently expressed by Esona in discussing her perceptions of the broader community, when she stated, “maybe because they are not HIV positive they think it’s got nothing to do with them” (section 6.3.2); and also expressed by Viwe in relation to his own experience, through comments such as, “I don’t know of anyone who has HIV and AIDS, so I don’t see myself as involving myself in HIV and AIDS”, and, “I don’t think that I should know much about it cos I don’t know anyone who does have it, and I can’t help anyone about it” (section 6.3.2).

The theme of relevance is also linked to the other two superordinate themes of representations (discussed above in section 8.2.1) and the relational environment (section
For instance, representations of SRHR issues (notably HIV and AIDS) as classed and gendered may influence community members’ perceptions of their vulnerability to the issues, and hence their sense of relevance regarding the issues and SRHR promotion for themselves. Relevance was linked to the relational environment, for example, through the normative social group constructions present in society, which also influenced perceptions of vulnerability, and thus relevance. That is, socially constructed groups (constructed on the bases of location, class and race, for example) form part of the normative socio-cultural environment (the relational environment) in which SRHR promotion occurs. This interacted with individual and community-level beliefs about vulnerability for particular SRHR issues, or attribution of particular SRHR issues to particular groups, and experiences of social connectedness and issue-connectedness to contribute to a sense or relevance (or lack of sense of relevance), and subsequent engagement (or non-/low- engagement) with SRHR promotion.

Perceived relevance of SRHR issues and SRHR promotion are critical for engaging members of a desired population group in any given intervention. Particular attention to this is needed when seeking to apply existing evidence-based SRHR promotion initiatives in new contexts, to ensure the initiatives are adapted for the new demographic, social and cultural contexts to ensure relevance (Nöstlinger et al. 2016). Nöstlinger et al. (2016) outlined a systematic approach for adapting existing programs for context, involving participatory qualitative research, and process evaluation, to ensure content and delivery methods were relevant to the target populations. They concluded that while underlying program objectives and pedagogy may remain the same, content adaptation is needed in order to ensure the messages delivered are relevant to the particular social identities and social roles (such as relevant to age and life-stage) in any given context.

Similarly, Quinlan and Bute (2012) contended that the framing of SRHR messages can influence the way SRHR issues are perceived by particular population groups, and thus influence the engagement of particular populations. For instance, they argued that SRHR issues have often been framed as women’s concern, and thus, this framing has marginalised men. Similarly, as previously mentioned in section 2.5.2, Wilbraham (2008) has argued that in the South African context, the framing of SRHR promotion messages needs to take account of gender, race, culture and class in order to be relevant to population sub-groups and engage them appropriately in SRHR promotion.
A systematic review of process evaluations of school-based STI prevention programs internationally found that relevance and appeal were crucial factors for engaging schooling youth in the interventions (Shepherd et al. 2014). Factors which contributed to relevance and appeal were the use of peer-educators who the schooling youth regarded as sharing a similar language and similar values about SRHR issues; and characters, case studies or vignettes used in the program which were relatable for the young people. The findings of the present research echo these findings of Shepherd et al. (2014). Conversely, Shepherd et al. (2014) reported that the omission of topics from the program which the young people deemed relevant and important to themselves was a barrier to their engagement. However, only one study included in the review was conducted in South Africa (Karnell et al. 2006) and that study is now over a decade old; the other eleven studies included in the review were conducted in the United States, United Kingdom and Italy. Thus, this present study provides a more current and contextually specific understanding of factors influencing perceived relevance, and subsequent engagement in such SRHR promotion interventions in South African communities.

However, relevance relates to more than programmatic factors such as messages and content, and is also linked to the broader social context. Gibbs et al. (2010) provided an example from South Africa in which a community-based SRHR program failed to resonate with the social identity constructions of young people, or their aspirations for the future. For example, the authors highlighted how the program retained culturally adult-oriented views of sexuality issues (such as the promotion of abstinence only discourses) which did not concord with youth sexualities. The program also retained a local focus despite many of the young people in the target population having aspirations to migrate to urban areas for work or study and so was not perceived as relevant to the context of their aspirations. Similarly, the program was voluntary and so did not meet the relevant needs the young people identified for themselves. For instance, it did not provide opportunities for income-generation which the young people sought, nor create opportunities for networking which would be relevant to facilitating their aspirations. The barrier posed by the voluntary nature of the program was compounded by competing priorities such as school or other work, so the program did not cohesively fit with the broader community context of the young peoples’ lives. This suggests that the perceived relevance of SRHR promotion interventions for population groups is interconnected with the relational environment, for instance in this case, young peoples’ lived experiences of their
socio-economic conditions. A similar finding was also revealed through this present research, as highlighted above.

**8.2.3 Relational environment**

The third superordinate theme revealed through this research as an influence on community engagement in SRHR promotion in South Africa was that of the relational environment in which SRHR issues arise and SRHR promotion is conducted. The relational environment includes the contemporary and historical social, cultural, political and socio-economic contexts of the broader community which influence daily life in the community. That is, community conceptualisations and experiences of, and influences on, engagement in SRHR promotion were strongly embedded within the context of individuals’ and communities’ everyday lived realities. This was first articulated in chapter four, where meanings of community engagement in SRHR promotion were discussed. Participants’ narratives presented there revealed that influences on community engagement in SRHR promotion do not occur as an isolated undertaking, but rather, in relation to other decisions and actions carried out as part of everyday life. This was highlighted by examples such as Thandiwe and Esihle who engaged with SRHR promotion as part of broader activities such as computer classes, or Ciko’s experience where he joined an organisation with the aim of seeking support for his disability (see section 4.2). Through engaging with these life skills initiatives as part of their usual community living, these participants became exposed to SRHR promotion. The example of decision making regarding condom use, and the relative priority placed on sexual pleasure compared to sexual health (see participants’ discussion in section 4.4), also revealed how decisions about engaging with SRHR promotion are made in relation to other competing priorities of everyday life.

Engagement in SRHR promotion also occurs in relation to, and is influenced by, the normative socio-cultural environment of the community. This includes community beliefs and values, such as the stigma associated with sensitive SRHR topics, and the taboo regarding discussing death and dying generally (as discussed previously in sections 2.5.2 and 5.2). Other aspects of the relational socio-cultural environment include relationship norms, social group construction and hierarchies, and gender norms. These are discussed further in the following sections.

*Relationship norms*
Traditional socio-cultural relationship norms have a considerable influence on shaping the relational environment in which community engagement in SRHR promotion occurs, particularly through the construction of intergenerational roles and hierarchies. Intergenerational relationships as an influence on community engagement in SRHR promotion were discussed in detail in chapter six (section 6.2.2). These relationships are socio-culturally embedded, as discussed in section 6.5. Norms governing intergenerational relationships interacted with other socio-cultural norms in the relational environment such as norms about taboo topics, and embedded cultures of silence and shame regarding SRHR issues in society. This was discussed in chapter four (section 4.3.3), with Nokwanda’s example highlighting how intergenerational factors interacted with socio-normative cultures of silence, shame and embarrassment surrounding SRHR issues, to contribute to knowledge gaps.

Other types of relationship norms formed part of the relational environment influencing community engagement in SRHR promotion, such as sibling relationships, peer relationships and community insider-outsider relationships (see discussion in section 6.5). These relationship norms interacted with other community norms in the relational environment to influence engagement. For one example cited in section 6.2.1, Paki discussed the role of community ‘insiders’ and ‘outsiders’ as program facilitators delivering SRHR promotion programs. Their relationship status with the community interacted with other community context factors, such as the socio-economic context and the state of community knowledge. Paki discussed issues of mistrust of local community insiders as program facilitators, based on community knowledge about the normative community socio-economic context regarding access to education, training and other opportunities. Often, according to Paki, community perceptions of this context contributed to negative perceptions about the credibility of the local person and/or program, and a subsequent reservation among community members to engage with SRHR promotion.

These examples reveal that relationship norms interact with other community contextual factors to form part of the everyday community relational environment in which SRHR promotion is situated, and which influences community engagement in SRHR promotion.

*Social group construction*
Another aspect of the relational environment which influenced community engagement in SRHR promotion was the context of social group construction and group identities. Participants identified various class groups conceptualised based on the intersections of location of residence (those in suburban, township and rural areas), socioeconomic status (high or low educational status; poor or rich), age (older generations and younger generations) and ethnicity (Black people, Coloured people and White people). The influence of social group constructions on community engagement in SRHR promotion was discussed previously in section 6.4. These various class groups are not fixed but rather are constructed from the intersections of objective and subjective structures in society and are thus malleable and contextual, and are associated with varying forms of capital (such as symbolic capital or cultural capital) in any given social system (Bourdieu 1984, 1989).

In particular, vulnerability for SRHR issues (particularly HIV) and the relevance of engagement in SRHR promotion was often associated with particular social groups based on race and class (whereby perceptions of class were constructed on the basis of interactions of race, education level and geographic location). This was discussed in chapter six. Participants in this study differentiated between groups (sometimes including or distancing themselves) on these race, education and location characteristics. Participants commonly stated and reiterated perceptions (their own and those they believed were held among the wider community) that factors underpinning community engagement (such as knowledges and perceptions of vulnerability to SRHR issues) differed across communities in different locations. Specifically, a strongly posited view across the cohort was that rural areas were associated with lower class and had poorer factual knowledge regarding SRHR issues compared to their urban counterparts.

The common and repeated references to such structures across research sites may suggest that the social construction of different groups is common in society generally, and so community engagement in SRHR promotion is understood and occurs in relation to this broader normative social structure and organisation. Thus, participants’ views about group identities with regards to SRHR promotion, and community engagement in SRHR promotion, were formed in relation to the broader context and lived experience of community life, and community social structures and hierarchies they experienced and operated within as part of everyday community life.
The emergence of this final superordinate theme, the relational environment, demonstrated that community engagement in SRHR promotion does not occur in isolation from the broader socio-cultural or socio-economic contexts of everyday community life; rather, community contextual factors are considerable influences on community engagement in SRHR promotion. The relational environment includes the interactive factors of socio-cultural norms and values (for instance, regarding family and social roles), sexuality discourses which are informed by dominant community knowledge and belief systems, the construction of social groups and identities, and individual and communities’ historical and contemporary experiences of SRHR issues and health promotion, among a range of other contextual factors. These findings are consistent with other research which has identified the relational environment as an important consideration in SRHR promotion (Ransom and Johnson 2009, Campbell and Cornish 2010, Angotti et al. 2018). Campbell and Cornish (2010) identified the role of the symbolic context and relational context in community mobilisation to enhance HIV interventions. In their research, they defined the symbolic context as including things such as community ideologies, while the relational context included factors such as community leadership hierarchies and decision making processes. In this present research, the ‘relational environment’ includes the symbolic factors that Campbell and Cornish distinguished from their relational context, such as normative community beliefs and values.

Prior research conducted in KwaZulu-Natal and Gauteng provinces in South Africa by Ransom and Johnson (2009) also found that the broader social conditions in which people live, including the socio-economic context, or conditions of poverty, social and cultural isolation, influence community beliefs about SRHR and engagement in SRHR related-behaviours, including risk behaviours and engagement with health promoting messages and services. However, these findings were based on data collected some time ago (2002-2003). The present study reveals that the socio-economic and cultural contexts of peoples’ lives remains a relevant influence on community engagement in SRHR promotion among communities in the Eastern Cape Province.

Most recently, a study by Angotti et al. (2018) to understand how older South Africans who are living with HIV make health-related decisions affirmed the importance of the normative environment, or the “wider relational dimensions of social life” (p. 263) as relevant for understanding their experiences. The study identified socio-normative expectations of age-appropriate behaviour and respect as one key aspect of the relational environment which
influenced health decision-making and actions. The authors explain that regarding the life course and ageing, “the social expectations accompanying these roles vary, notably by age and gender, and are circumscribed by cultural norms and structural realities” (p.266), thereby explicitly linking to the relational social and structural environments. This reflects the findings of the present study that socio-cultural norms governing intergenerational expectations, behaviours and interactions were key influences on community engagement in SRHR promotion.

In Angotti et al.’s (2018) study, this age-related dimension was also gendered, with expectations and experiences differing for men and women. Furthermore, the influence of persistent gender norms, values and practices has been found to be structurally embedded. For instance, Jewkes et al. (2009) discussed how a “gendered social environment” (p.676) has influenced male and female roles in women’s SRHR experiences. Further, this “gendered social environment” has also influenced the structural environment in which SRHR issues occur, for instance, by influencing policy development (Jewkes et al. 2009). In the present study, the gender dimension was raised by participants, albeit sparsely, so would warrant greater specific exploration in this context.

8.3 Discussion

This research has revealed that a complex interplay of multiple factors contribute to three superordinate themes influencing community engagement in SRHR promotion in South Africa. These factors and superordinate themes also demonstrate that community engagement is influenced by interactions of people and the community environment. Thus, Bourdieu’s theory of habitus (Bourdieu 1977) may be useful for considering these findings to further theorise and develop understanding about community engagement in SRHR promotion in South Africa. This section will discuss the present research findings in relation to constructs of habitus.

Bourdieu’s theory of habitus posits that human beings are social beings, and their attitudes and behaviours are shaped by their experiences of their objective and social worlds. It is the interactions of the objective and social worlds, and their interpretations, which shape social norms and values that guide individual attitudes and behaviours. Thus, Bourdieu (1989) referred to habitus as a “constructivist structuralism” theory (p.14), comprised of the objective structures in society alongside their socially constructed interpretations.
Furthermore, Bourdieu (1977) theorised that habitus is self-perpetuating as peoples’ experiences and their social worlds continuously shape and reshape one another. Similarly, Paulo Freire, in his influential work, “Pedagogy of the Oppressed” (1968), argued that people and the objective and social worlds do not exist independently, but rather interact, shape and transform one another. This was evident in the current research findings as individuals’ and communities’ engagement in SRHR promotion was influenced by the dominant factors and superordinate themes which emerged (for instance, by dominant representations of SRHR issues, or the relational environment regarding social and intergenerational interactions), but individuals and communities’ attitudes and behaviours also contributed to shaping and reinforcing those dominant norms. This was particularly evident in the emergence of the three superordinate themes of representations, relevance, and the relational environment. The interactions of objective structures and symbols (such as systems of classification by age or generation, sex, ethnicity or SRHR status), with socially constructed meanings (derived from, for instance, community knowledges and lived experiences), contributed to the four key factors underpinning community engagement. The interactions of these four factors further contributed to the emergence of the superordinate representations of SRHR issues, perceptions of relevance, and relational environment, and their interactions, which formed the habitus influencing engagement.

Habitus is shaped by multiple ‘fields’ (settings of interactions) – the social structures, including social groups and classes, and norms of knowledge, values, discourses and behaviour (Bourdieu 1989). Decoteau (2013, 2016), and Veenstra and Burnett (2014) highlight the possibility for individuals to experience multiple fields which may all influence habitus, and for ‘hybrid habitus’ to be engaged in. Fields are not static but rather, are dynamic, and individuals have the capacity to move across different fields. Thus, habitus is fluid. Individuals’ experiences of their field and habitus are informed by intersectionalities of factors such as gender, age, ethnicity, class, and level of education. Thus, habitus is also contextual, and can be established through the intersectionality of the unique factors operating in any given context. The highly contextual nature of multiple and sometimes shifting perspectives on, or experiences of, community engagement was strongly and repeatedly evident in these present research findings.

Within fields exist doxa; the established norms of knowledge and structures, which are often taken for granted and unquestioned, and so retain the status-quo of the social order (Bourdieu
1977). In this research, participant’ narratives revealed that the dominant doxa regarding SRHR issues in this context has generally been one of silence, shame and taboo, and class. With regards to the predominantly discussed the issues of HIV and AIDS specifically, the doxa has been one of stigma, and that HIV and AIDS are illnesses of “Black people”, of “poor people”, and fatal. Various forms of knowledge, including lay knowledge, scientific knowledge and gaps in knowledge contribute to forming the doxa, and these are shaped and reinforced by interactions with other factors including lived experiences of connectedness, stigma, and acceptance/denial. These factors constitute the ‘taken for granted’ state of the field and normative frame of reference for community engagement in SRHR promotion. The role of symbols in contributing to this doxa was evident through many examples. Some of the more prominent examples were the interpretations attached to the physical signs of illnesses like HIV, interpretations of vulnerability to SRHR issues associated with symbolic characteristics such as race or class or other personal trait, and interpretations of HIV-fatalism attached to experiences of connectedness. In turn, the representations and local meanings ascribed to the representations in the specific field helped to reinforce and perpetuate existing understandings, beliefs and stigma, thus reinforcing the habitus – the interpretations and meanings. That is, social and cultural symbols, and their interpretations, contributed to the socio-normative discourses and practices regarding SRHR promotion in this research context. These discursive symbolic factors perpetuated the representation of HIV as taboo and stigmatised, and something that cannot be spoken about directly. This helps to maintain the state of the illness as one that is silenced and unspoken about, thus maintaining the orthodoxy of the field. Thus, the interaction of symbols, and the local meanings ascribed to those symbols based on community-held knowledges, creates the orthodoxy in the field, and the reinforcement of the habitus.

Furthermore, the normative state of the ‘field’ in this specific research context is one of a community comprised of a majority Black-population, of low socio-economic status, with an extant high prevalence of HIV and AIDS in the communities, and high rates of mortality from HIV-related illnesses. For many community members, direct or indirect experiences with HIV and/or AIDS (or others living with HIV or AIDS) are common. Thus, community members in these contexts are experiencing lived realities of high HIV prevalence and mortality rates, as well as high rates of other SRHR issues such as sexuality-related discrimination, unplanned pregnancies and sexual violence. This context contributes to shaping community members’ familial and social experiences of their field in which SRHR
issues, and HIV in particular, are diseases of the Black population, diseases of the poor, and fatal, and contributed to formation and reinforcement of the doxa of their reality.

However, also evident in the research were challenges to the orthodoxy surrounding SRHR issues, in particular HIV and AIDS. Veenstra and Burnett (2014) argue that a relational approach to engagement in health promotion “sees opportunities for social change in the relationships formed between people, places, spaces, histories, dispositions, beliefs, meanings and events” (p. 212). This was evident in some participants’ narratives describing things such as challenging the representation of HIV through acts of disclosure in order to reduce stigma and demonstrate a reality of ‘living positively’ with HIV; practicing acceptance (of self and others) and inclusion to highlight the reality and relevance of SRHR issues to all; and advocating for the integration of SRHR promotion as part of the broader, everyday context of community life. These examples relate to each of the three superordinate themes influencing community engagement (representations, relevance, and relational context, respectively) to highlight how these components of the doxa may be challenged.

Furthermore, Bourdieu (1977) contended that people’s habitus is historically constructed. Decoteau (2013) suggested that as Bourdieu’s theory of habitus emerged from his early work in Algeria examining the structural disjunctures which arose during period of colonialism, it remains relevant in a post-colonial context for considering the effects of a colonial legacy. Thus, it is relevant to considering this research which was conducted in the post-colonial context of South Africa. In fact, it is arguable that it is not possible to consider contemporary South African objective and social structures, and their interactions, in the absence of the socio-historical context of colonialism and apartheid, and the legacies of those eras. Apartheid was a regime of government policy which enacted institutionalised structural and social segregation of the population on the basis of race (Msimang 2018). This entailed systemic oppression of the majority Black population, which intersected with stratifications of geographic location, class and deprivation (Burger et al. 2017) so that race and class became inextricably linked. It has been argued that this legacy has contributed to the current burden of disease impacting the majority Black population, particularly pertaining to HIV and AIDS (Hunter 2007). Thus, the legacy of apartheid could be viewed as contributing to shaping the normative state of the field and the relational environment in which SRHR issues arise and community engagement in SRHR promotion occurs.
However, others argue that in post-apartheid South Africa, social categorisations and subjectivities entwining ethnicity and class have become less rigid and rather more fluid (Burger et al. 2015, Khunou 2015). There is a growing body of literature which argues that the relationships between ethnicity and class are not fixed and categorical, but rather are contextual and fluid over time and place, and that the very notion of class in South Africa is contested (Burger et al. 2015, Khunou 2015). Understandings of class as a proxy for ethnicity, or ethnicity as an indicator of class, have been blurred and are now intersecting with other factors such as education level, employment and area of residence (Burger et al. 2015, Khunou 2015). Singh and Bhana (2015) also contend that notions of class associated with locality (rural compared to urban), whereby locality has also traditionally been strongly linked with ethnicity, are also breaking down. These factors contribute to individuals’ experiences of intersectionality, and to shaping the multiple and shifting fields and the doxa which influence those fields. Evidence of this is in the diversity of participants’ own identification of subjectivities. For instance, one view expressed by some participants was the perception of a community-held belief that HIV and AIDS were illnesses of Black people, and of the poor, rather than of the ‘high-class’ or educated (with ‘poor’ intricately linked with being Black), or of those in rural locations rather than in the suburbs (with rurality also again linked with being poor and Black), which constituted the traditional orthodoxy. However, the research also revealed heterogeneous and shifting identities within these groups. Some participants who were of the majority Black population self-identified as belonging to the ‘poor Black’ group, and perceived their own vulnerability to SRHR issues, most notably HIV. Some of these people were in rural locations and some in urban locations. Others among the majority Black ethnic population did not perceive their own vulnerability for HIV (or that HIV was not relevant to them) as they did not identify as poor, or as from a rural location. In some of these instances, participants would consider themselves or their networks to be of a different class, socio-economic or locational status. Some of these participants also spoke in hypothetical terms, such as “…if I was to know someone”. This highlights their lack of social connectedness and issue connectedness regarding HIV (directly or indirectly) to date, and reinforces their perceived social distance from ‘other’ Black populations in other locations or from other social groups whom may be regarded as vulnerable to HIV. Thus, the orthodoxy did not resonate with them, and this influenced their subsequent engagement (or lack of engagement) with SRHR promotion.
In other instances, participants did not subscribe to the doxa that SRHR issues (particularly HIV) issues were relevant to, or the concern of, only some social groups such as the poor or Black populations; instead, they challenged it with a new heterodoxy that SRHR issues, in particular HIV, was a community-wide issue. This alternative heterodoxy was underpinned by the notion of connectedness and *Ubuntu*, and so derived with respect to the relational environment of traditional community cultural values. This highlights that while historically-rooted constructs of race entwined with class may have helped shape the field regarding the SRHR issues, habitus is a fluid and individual construct. The diverse views of participants also highlights the malleable and contextual nature of identity construction, and the fluid yet ever-present influence of intersectionality in contributing to social identity, and sense of vulnerability and relevance regarding SRHR issues and SRHR promotion. Further, the contextual experiences of participants also support the idea that individuals can inhabit multiple habitus, such as the habitus shaped by a Black identity and associated experiences, and a habitus shaped by experiences of class. This indicates the need for consideration of how individuals construct their own identity, and that of others, and how this influences the habitus and subsequent community engagement in SRHR promotion.

Similarly, historically-rooted constructions and praxis of norms regarding gender, sexuality, ethnicity and social structures (such as familial roles) also contribute to shaping contemporary habitus’ and community engagement in SRHR issues. Several authors contend that the social context and lived reality of sexuality, and in particular of women’s sexual and reproductive rights, is gendered, raced and classed, and that this reality is underpinned by historically-embedded and traditional cultural norms and values pertaining to gender. For instance, a contemporary lens tends to cast perceptions of African sexuality as promiscuous (Jewkes et al. 2009, Bhana et al. 2012, Stern and Buikema 2013), and dominated by a “hegemonic masculinity” (Stern and Buikema 2013: 1041) which Stern and Buikema (2013) also argue is essentialist, and one with which men must conform or otherwise risk marginalisation. This contemporary sexuality is rooted in historically-derived, but persistent, socio-cultural gender norms and hierarchies which construct male sexuality and masculinity as associated with fertility and having multiple sexual partners. In this context, men are framed as invulnerable, while women are framed as vulnerable and their sexuality has been constructed to have a subordinate role that limits women’s sexual empowerment and agency (Dageid and Ducker 2008, Stern and Buikema 2013). In this context, many women may experience sexual violence and coercion, including coercive conception (Campbell et al.
Mkhwanazi (2010) discussed how from an early age, males and females receive differential information, and are subjected to different levels of parental monitoring, control and regulation regarding sexual behaviour, linked to the traditional constructions of masculinity. This includes young men having their own rondavels (traditional hut) constructed in the family yard to support and encourage their social development and masculinity, while girls remain in the family buildings under the close watch of parents (Jewkes et al. 2009). This highlights the role of traditional socio-cultural factors in shaping the habitus and specifically, in relation to this research, the contemporary relational environment (of socio-cultural norms regarding sexuality, gender and intergenerational factors), and representations of SRHR issues (for instance, as gendered), which form part of the habitus.

Another related aspect of Bourdieu’s theory of habitus which is relevant to consider in relation to this research is the concept of capitals. Bourdieu (1986) posited that individuals’ habitus informs the kinds of capital one has access to, including social capital, cultural capital, and symbolic capital (such as power and status), and this further influences individuals’ lived experiences. Various forms of capital repeatedly arose throughout this research as linked to community engagement in SRHR promotion. Most notably, social capital (bonding and bridging forms) was raised in each of the chapters discussing the key factors underpinning engagement (chapters four to seven). That is, social capital was related to meanings of community engagement (see section 4.6), stigma (section 5.6), connectedness (section 6.5) and acceptance/denial (section 7.5). Social capital was found to be both a positive influence on community engagement, and a perceived outcome of community engagement in relation to these factors.

Other forms of capital linked to community engagement in SRHR promotion were also evident throughout the findings. Cultural capital is described by Gale and Parker (2017) as “a resource on which people draw in order to navigate social spaces or fields: a knowledge of things valued by the field, including a knowing of how the field operates and how to operate within it” (p. 89). This form of capital was particularly evident in this research in relation to the integration of Ubuntu values into meanings of community engagement (chapter four), as well as in the opportunities that arose to challenge stigma and develop new, positive discourses, and environments of inclusiveness and acceptance regarding SRHR matters (as described by participants in chapter five). Symbolic capital refers to the status, prestige,
power and privilege one has. This was evident particularly in relation to the influence of connectedness and the social construction of identities and groups, and associated attribution of vulnerability to SRHR issues (see discussion in section 6.5). Symbolic capital is also linked to opportunities for civic participation, and so was evident in participants’ experiences of civic engagement (in either SRHR promotion, or broader community-based activities in which SRHR promotion was embedded), and the status they may gain through their civic engagement. Examples include experiences described by Ciko, Esihle, Thandiwe and Nonzukiso (section 4.2). Similarly, economic capital may also be linked to engagement as a facilitator or outcome. For instance, some participants expressed their views or experiences of their engagement in community-based SRHR promotion or community-based civic activities in the hope of gaining relevant skills and experiences for employment in future (such as Esihle and Thandiwe in secion 4.2). Thus, evidently, various forms of were linked to participants’ habitus’ and their experiences of community engagement in SRHR promotion.

Bourdieu’s theory of habitus has previously been applied to understanding community engagement in health promotion, yet not specifically sexual and reproductive health promotion. Veenstra and Burnett (2014) posit that engagement in health promotion behaviour is ‘relational’; that is, they contend, “Agency arises in practices that emerge in the interplay between field, capitals and habitus” (p. 212). Thus, actions (in this case, engagement in SRHR promotion) is contextual, depending upon the unique interactions of agency and structure in any situation. The present research has revealed that community engagement in SRHR promotion among communities in the Eastern Cape of South Africa is highly contextual, and influenced by unique interactions of a range of individual and community-level factors which constitute the doxa, fields and habitus influencing engagement in this context.

8.4 Chapter summary

Through a process of describing, interpreting and theorising from the data about influences on community engagement in SRHR promotion in South Africa, a theoretical framework has emerged. This framework encapsulates the four key factorsS arising from the data which may influence community engagement in SRHR promotion: (i) individual and community knowledges about SRHR; (ii) individual and community attitudes and experiences regarding stigma; (iii) social connectedness and issue-connectedness related to SRHR matters,
experienced at the individual and community levels; and (iv) individual and community acceptance/denial of SRHR issues. While these four factors are key influences on community engagement in SRHR promotion, analysis of the factors revealed links between them, and that these interactions of the four factors added a layer of complexity to community engagement in SRHR promotion. Thus, the framework reveals an additional level of three superordinate themes influencing SRHR promotion in South Africa; (i) representations of SRHR issues in the community; (ii) perceptions of relevance regarding SRHR issues and SRHR promotion; (iii) and the relational environment in which SRHR promotion initiatives are carried out. The research revealed the influences of these factors and superordinate themes are highly contextual in any given community setting or circumstance. The framework provides a tool to guide planning for SRHR promotion in South Africa to ensure these crucial influences are considered, in order to enhance community engagement in SRHR promotion interventions.
CHAPTER NINE
CONCLUSIONS
9.1 Introduction

The preceding chapters have presented the rationale for the research (chapters one and two), methods of the research (chapter three) and key findings of the research (chapters four to eight). This final chapter discusses the conclusions and implications of the research. The chapter begins by discussing the conclusions of the research in relation to the research questions, and the implications of the research findings for future public health and health promotion practice (section 9.2). However, the findings and implications must be considered within the scope of the strengths and limitations of this research; these strengths and limitations are presented in section 9.3. Finally, the chapter finishes by presenting implications for future research and practice (section 9.4).

9.2 Conclusions and implications of the research

9.2.1 New, contextual understandings of the meaning of ‘community engagement’

This ethnographic, constructivist research was undertaken across communities in the Eastern Cape of South Africa with the aim to understand and theorise about influences on community engagement in SRHR promotion in that context. The first research question sought to explore the meaning of ‘community engagement’ with regards to SRHR promotion among the communities. The findings revealed that community understandings of ‘community engagement’ with regards to SRHR promotion are multi-faceted, and culturally contextual.

Theoretical definitions of ‘community engagement’ in literature tend to define community engagement as a process or continuum, and emphasise the various steps involved (see box 2.1). However, meanings of ‘community engagement’ presented by participants in this study tended to emphasise outcomes achieved for the whole of community, such as wellbeing, inclusiveness and connectedness. The culturally contextual understandings presented appeared to be strongly linked to the widely held cultural concept of Ubuntu (defined and discussed previously in section 2.4.1).

The implications of this for health promotion practice are that organisations seeking to understand or promote community engagement in SRHR promotion in this context should consider framing community engagement in relation to Ubuntu. Previous research with South African communities has linked community engagement to Ubuntu (Schwartz 2013, Klemz et al. 2015), and Ubuntu with SRHR issues (Angotti et al 2018). However, the present research adds to these bodies of work by being the first to draws all three concepts –
community engagement, SRHR promotion and Ubuntu - together. Angotti et al. (2018) identified that among communities in South Africa, the concept of community and the values of Ubuntu are central aspects of the normative socio-cultural environment in which community members make health-related decisions. The present study supports Angotti et al. (2018), with specific regards to community engagement in SRHR promotion. Linking community engagement in SRHR, with the concept of Ubuntu (including the values of community connectedness, oneness and wellbeing), could help to reduce or overcome some of the barriers to engagement posed by stigma, discrimination and exclusion associated with SRHR issues. An explicit focus on Ubuntu in future SRHR promotion initiatives may provide a helpful foundation for effectively engaging community members in future SRHR health promotion practice.

9.2.2 Understandings of the contextual influences on community engagement in SRHR promotion

The second research question sought to explore factors influencing community engagement in SRHR promotion in communities in the Eastern Cape of South Africa. The findings revealed a range of factors operated independently and interactively, multi-directionally (that is, as influences themselves but also influenced by other factors), and at the individual and community levels to influence community engagement in SRHR promotion in South Africa. The nature of the influences of these factors on engagement could be either positive (that is, a facilitator) or negative (acting as a barrier to engagement). While the research sought to explore community engagement, it did so by exploring individuals’ perspectives and experiences. Participants shared their individual experiences and views, as well as their perspectives about the broader, normative community situation. Even in sharing individual experiences or personal views, these often (although not always) reflected views that were considered normative across the community. Thus, individual experiences of community engagement and community experiences of engagement are intricately linked, and underpinned and influenced by a multitude of factors at the individual and community levels.

Four key factors, present at both the individual and community levels, had prominent roles influencing community engagement: knowledges, stigma, connectedness (social connectedness and issue-connectedness), and acceptance/denial. Each of these factors was thematically constructed from a range of underpinning concepts, and was multi-faceted (for instance, knowledges included scientific forms of knowledge, lay forms of knowledge, gaps
in knowledge, and the concept of ignorance, among other components). Furthermore, these four key factors operated interactively with each other, rather than independently. Thus, the factors operated in multiple and contextual ways with varying influences on community engagement. It is from the various interactions of these four factors that three superordinate conceptual themes emerged as central influences on community engagement, operating at the individual and community levels: representations of SRHR issues; the relevance of SRHR issues and SRHR promotion; and the relational environment in which SRHR promotion occurs. The identification of the four key factors and three superordinate themes led to the development of a novel conceptual model theorising influences on community engagement in SRHR promotion in South Africa (presented in figure 8.1).

The findings of this research address a gap in current literature and practice regarding community engagement in SRHR promotion (see chapter two – literature review), as it is the first to specifically draw the concepts of community engagement and SRHR promotion together in a conceptual model. This model can be used as a resource for health promotion practitioners to help inform future health promotion intervention planning. For instance, in undertaking a situation analysis prior to intervention design, practitioners could seek to explore the community and health-issue contexts in relation to each of the four key underpinning factors, and three superordinate influences.

As community engagement is integral to the success and sustainability of SRHR promotion interventions (CDSDoH 2008; Attree et al. 2011, WHO 2011a), substantial investment should be made at the outset of any SRHR promotion program planning to engage community members as key informants. As there is no singular understanding or experience of community engagement, it is important to understand the unique context and influences in any given setting. Specifically, community members’ insights should be specifically sought regarding how a particular SRHR issue is framed and represented in that setting (representations), how relevant the community feels the issue is to them (relevance), and the broader context of their community at that time, including the socio-demographic context, the social and wellbeing priorities of the community, and other historical or contemporary factors which may shape how an SRHR issue is perceived and received in the community (relational environment). Understanding these broader contextual considerations may involve an exploration of the role of the specific factors of community knowledges, stigma, connectedness, and acceptance/denial with regards to SRHR issues in a community.
9.2.3 Experiences of community engagement are related to habitus

As discussed in the previous chapter (chapter eight), the key thematic findings from the research can be understood in relation to Bourdieu’s theory of habitus, fields and capitals (Bourdieu 1977). Multiple contextual influences interact to inform community understandings of engagement, and individuals’ experiences of their communities with regards to engagement in SRHR promotion. Bourdieu’s theory of habitus permits recognition of the role of intersectionality in community engagement. That is, the unique intersectionalities of individuals’ circumstances and lived experiences, shaped by historical and contemporary factors, contribute to habitus which influences engagement in SRHR promotion. Thus, experiences of, and influences on, community engagement are fluid and contextual. Further, a habitus lens acknowledges the interactive links between individuals, their environment(s), and broader society, which were integral to conceptualisations and experiences of community engagement uncovered in this research.

Bourdieu (1986) posits that individuals’ habitus informs the kinds of capital one has access to (for instance, social capital and cultural capital). Various forms of capital (social, symbolic, material and cultural) linked to participants’ lived experiences of their own habitus were found to be important influences on community engagement in SRHR promotion in this research. This was a common thread across the four key factors and three superordinate themes influencing community engagement. In particular, social capital – being the norms, trust and relationships in society – was central to conceptualisations of community engagement, and influences on community engagement. Bonding and bridging forms of social capital were regularly apparent as a mediating factor in the key factors and themes influencing engagement. Forms of capital – particularly bonding and bridging forms of social capital but also symbolic capital – were also linked to outcomes of community engagement in SRHR promotion.

Social group construction also had an important role in various influences on engagement, and this can be linked to one’s experience of their habitus. Bourdieu (1989) considered habitus as a scheme of both production and interpretation, but argued that interpretations are made by those with particular social and cognitive schemas to understand the social meanings in a particular context. This, he contended, requires an individual to have a sense of one’s own social position and of the relative social position of others. Thus, social groups are constructed in relation to experiences of habitus and environment. These social group
constructions influenced participants’ experiences of several factors and superordinate themes associated with community engagement in SRHR promotion, perhaps most notably the factor of connectedness (social connectedness and issue-connectedness), and the theme of relevance.

One final aspect of Bourdieu’s theory of habitus which has relevance to understanding the present research findings is the concept of the doxa. There do appear to exist dominant societal doxa (orthodox) or norms in relation to SRHR issues which bi-directionally influence, and are influenced by, community engagement (discussed in section 8.3). However, also present in the research findings are emergent doxa which interacts with fields to shape the habitus, and diverse responses of community members to engagement in SRHR promotion. The research also revealed examples of non-quiescence which sought to disrupt the dominant doxa. This was demonstrated by discourses and subsequent actions by community members to disrupt the ortho-doxa of SRHR issues, most prominently HIV and AIDS, as being stigmatised, shameful, fatal, and issues of the poor and Black population, and instead shape a new doxa of acceptance, ‘living positively’, inclusiveness and connectedness underpinned by Ubuntu values. Decoteau (2013) argued that “resistance is only possible if the subjugated recognize their own domination and engage in a symbolic struggle for recognition and legitimacy” (p. 281; original emphasis). In the present research, this resistance is best exemplified by those living with HIV or AIDS, through their acts of acceptance (of themselves and their HIV positive diagnosis) and disclosure. Thus, various aspects of Bourdieu’s theory of habitus can help to develop understanding about the meanings and experiences of community engagement in SRHR promotion in South African contexts, and may be usefully applied to help shape future SRHR promotion planning and intervention.

**9.2.4 Link to key charters and protocols**

The findings of this research can also be considered in relation to implications for current key national (South African), regional and global SRHR strategies. Some of these strategies are SRHR-specific, while others are broader development agendas to which SRHR issues, and the findings of this research, may have relevance.
National level

At the national level, these findings may inform action regarding current and future NSPs. The NSPs have evolved over the years from a focus on structural drivers of HIV and STIs in the previous plan, to the current plan which focuses on the implementation and impact of interventions through maximising reach and impact. Enhancing meaningful reach and impact of interventions will necessitate community receptiveness and engagement in the interventions. The findings of the present research provide a framework of key influences on community engagement in SRHR promotion interventions, which should be understood and addressed in order to achieve positive engagement. Furthermore, the principles underpinning the current NSP include a ‘people-centred’ approach, inclusivity, and participation. These principles resonate with the findings of the present research which emphasise the role of community connectedness and inclusiveness as central to achieving community engagement.

There are various specific goals and objectives of the current NSP (SANAC 2017a) for which the present research findings are relevant. For instance, to achieve Goal 4, “Address the social and structural drivers of HIV, TB and STIs”, this would require understanding the relational environment in which the interventions will occur. Within Goal 4, to achieve objective 4.1 (“Implement social and behaviour change programmes to address key drivers of the epidemics and build social cohesion”), program planners should consider the representations of relevant SRHR issues and how they are constructed, and consider the relevance of the issue and planned intervention to the group, and factors such as social connectedness and issue-connectedness. Similarly, addressing sub-objective 4.1.1 (“Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families”) should entail consideration of the perceived relevance of such programs to the target groups, the relational environment such as competing priorities of the target groups (for instance, for socio-economic security), and understanding of contextual intergenerational norms. Table 9.1 outlines several goals, objectives and sub-objectives of the current NSP for which the themes and key factors identified in the present research findings may have relevance.
Table 9.1: Examples of research findings relevant to the current South African National Strategic Plan for HIV, TB and STI 2017-2022.

<table>
<thead>
<tr>
<th>Goal/Objective/Sub-objective of the current NSP</th>
<th>Examples of relevant concepts from research findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 3: Reach all key and vulnerable populations with customised and targeted interventions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 3.1:</strong> Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities</td>
<td>Relevance&lt;br&gt;Relational environment&lt;br&gt;Connectedness</td>
</tr>
<tr>
<td><strong>Sub-objective 3.1.2:</strong> Support key and vulnerable population social capital by encouraging community networks that include advocacy agendas for equal health and human rights</td>
<td>Connectedness (social connectedness) &lt;br&gt;<strong>Ubuntu</strong></td>
</tr>
<tr>
<td><strong>Objective 3.2:</strong> To provide an enabling environment to increase access to health services by key and vulnerable populations</td>
<td>Knowledges&lt;br&gt;Stigma&lt;br&gt;Acceptance/denial&lt;br&gt;Connectedness&lt;br&gt;Relevance&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Sub-Objective 3.2.1:</strong> Enable increased access to tailored health information through differentiated service delivery approaches that are tailored for the populations served</td>
<td>Knowledges&lt;br&gt;Acceptance/denial&lt;br&gt;Representations&lt;br&gt;Relevance&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Sub-Objective 3.2.2:</strong> Enable increased access to health information and social and behaviour change communication interventions</td>
<td>Knowledges&lt;br&gt;Acceptance/denial&lt;br&gt;Connectedness&lt;br&gt;Representations&lt;br&gt;Relevance&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Sub-Objective 3.2.3:</strong> Expand the provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB</td>
<td>Stigma&lt;br&gt;Acceptance/denial&lt;br&gt;Connectedness&lt;br&gt;Representations</td>
</tr>
<tr>
<td><strong>Sub-Objective 3.2.4:</strong> Further train and sensitishe healthcare professionals in the identification and delivery of appropriate services for key and vulnerable populations</td>
<td>Knowledges&lt;br&gt;Stigma&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Sub-Objective 3.2.5:</strong> Integrate rights-based components in all health and social programmes to holistically serve key and vulnerable population clients and patients</td>
<td>Knowledges&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 4.1:</strong> Implement social and behaviour change programmes to address key drivers of the epidemics and build social cohesion</td>
<td>Connectedness&lt;br&gt;Stigma&lt;br&gt;Acceptance/denial&lt;br&gt;Representations&lt;br&gt;Relevance&lt;br&gt;Relational environment</td>
</tr>
<tr>
<td><strong>Sub-Objective 4.1.1:</strong> Reduce risky behaviour through the implementation of programmes</td>
<td>Intergenerational norms&lt;br&gt;Relational environment</td>
</tr>
</tbody>
</table>
that build resilience of individuals, parents and families

<table>
<thead>
<tr>
<th>Sub-Objective 4.1.2:</th>
<th>Comprehensive and age-specific and appropriate support for learners and out-of-school youth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge Intergenerational norms Connectedness Relevance Relational environment</td>
</tr>
<tr>
<td>Sub-Objective 4.1.3:</td>
<td>Strengthen the capacity of families and communities</td>
</tr>
<tr>
<td></td>
<td>Intergenerational norms Connectedness Relational environment</td>
</tr>
<tr>
<td>Objective 4.5:</td>
<td>Implement economic strengthening programmes with a focus on youth in priority districts</td>
</tr>
<tr>
<td></td>
<td>Relevance Relational environment</td>
</tr>
<tr>
<td>Sub-Objective 4.5.1:</td>
<td>Economically empower targeted groups of young people by increasing the availability of economic opportunities</td>
</tr>
<tr>
<td></td>
<td>Relevance Relational environment</td>
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</table>

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

<table>
<thead>
<tr>
<th>Objective 5.1:</th>
<th>Reduce stigma and discrimination among people living with HIV or TB by half by 2022</th>
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<tbody>
<tr>
<td></td>
<td>Knowledge Acceptance/denial Connectedness Stigma Representations Relational environment</td>
</tr>
<tr>
<td>Sub-Objective 5.1.1:</td>
<td>Revitalise community-based support groups to deal with internalised stigma</td>
</tr>
<tr>
<td></td>
<td>Knowledge Acceptance/denial Connectedness Stigma Representations Relational environment</td>
</tr>
<tr>
<td>Sub-Objective 5.1.2:</td>
<td>Reduce stigma through community education</td>
</tr>
<tr>
<td></td>
<td>Knowledge Acceptance/denial Connectedness Stigma Representations Relational environment</td>
</tr>
</tbody>
</table>

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

<table>
<thead>
<tr>
<th>Objective 6.1:</th>
<th>Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Meanings of engagement Ubuntu</td>
</tr>
<tr>
<td>Sub-Objective 6.1.4:</td>
<td>Ensure a central role for civil society and community groups</td>
</tr>
<tr>
<td></td>
<td>Meanings of engagement Ubuntu</td>
</tr>
</tbody>
</table>

Goal 8: Strengthen strategic information to drive progress toward achievement of the NSP goals

<table>
<thead>
<tr>
<th>Objective 8.2:</th>
<th>Rigorously monitor and evaluate implementation and outcomes of the NSP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledges</td>
</tr>
<tr>
<td>Sub-Objective 8.2.4:</td>
<td>Disseminate timely, relevant HIV, TB and STI information to the public</td>
</tr>
<tr>
<td></td>
<td>Knowledges Relevance</td>
</tr>
</tbody>
</table>
Additionally, the current NSP outlines a number of enablers for achieving the goals and objectives of the plan (SANAC 2017a). Examples of some of the enablers, for which the present research findings may have relevance, are presented in Box 9.1.

**Box 9.1: Examples of enablers from current South African National Strategic Plan for HIV, TB and STI 2017-2022**

<table>
<thead>
<tr>
<th>Enabler</th>
<th>Description</th>
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<tbody>
<tr>
<td>Enabler 1</td>
<td>A focus on social and behaviour change communication (SBCC) to ensure social mobilisation and increasing awareness.</td>
</tr>
<tr>
<td>Enabler 2</td>
<td>Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impacts of the epidemics.</td>
</tr>
<tr>
<td>Enabler 3</td>
<td>Effectively integrate HIV, TB and STI interventions and services.</td>
</tr>
<tr>
<td>Enabler 5</td>
<td>Ensure that the human resources required are sufficient in number and mix, trained and located where they are needed.</td>
</tr>
</tbody>
</table>

(SANAC 2017a)

For instance, Enabler 1 cites community mobilisation through developing social and behaviour change (SBC) programs as critical for achieving the goals of the Plan. The focus on social change is an acknowledgement of the influence of the social context on community-based SRHR promotion, and that this needs to be addressed in order to effectively engage the community in mobilisation. Similarly, the Department of Social Development (2015b) developed a decentralised model of HIV prevention among youth which considers the socio-relational context in which SRHR issues and engagement in SRHR promotion occur. The model centred on SBC to enhance youth active citizenship, and improve intergenerational communication between young people and their parents/guardians (among other goals and endeavours). The implementation of SBC programs under this model involved targeted interventions at the individual level, interpersonal level (with families), and community level (with community leaders and gatekeepers). This encompassing approach recognises the important roles of parents, guardians and community leaders in shaping or reinforcing normative community values, attitudes and behaviours regarding SRHR promotion. Thus, the
findings of the present research provide further theoretical support to underpin and strengthen such approaches. However, the Department of Social Development (2015b) acknowledged the varying contexts of communities, stating, “It is important to note that while the approach will provide a framework, each community is unique therefore factors that drivers [sic] HIV in every community should be dealt with is [sic] such a manner that the specific drivers are addressed depending on the peculiarity of that particular community.” (p. 4). Thus, the findings of the present research provide a complementary framework for helping to explore a setting’s unique situation.

Furthermore, the current NSP is also linked with the broader National Development Plan 2030 (National Planning Commission 2012) which sets out objectives and a framework for action to achieve social and economic development. With regards to this relationship between the two strategies, the Deputy President of the Republic of South Africa at the time (now current President), Cyril Ramaphosa, stated in the NSP, “These are mutually reinforcing efforts: progress in reducing the burden of disease contributes to development, while faster development improves our ability to address the social and structural drivers of HIV, TB and STIs.” (SANAC 2017a: x). Thus, the findings of the present research again provide further evidence to support this link between SRHR promotion and the broader relational environment of community social and economic contexts; in order to achieve engagement in SRHR promotion, the relational environment of social and economic circumstances and opportunities needs to be considered.

Two other current population-specific SRHR strategies for which the present research findings have relevance are the National Adolescent SRHR Framework Strategy (Department of Social Development 2015a), and the South African National LGBTI HIV Framework 2017-2022 (SANAC 2017b). This Adolescent SRHR Framework Strategy sets out five priority areas. Those which have particular relevance to the current research findings are presented below in Box 9.2.
Box 9.2: Examples of priority areas from National Adolescent SRHR Framework Strategy

| Priority 2: | Developing comprehensive SRHR information, education and counselling for adolescents; |
| Priority 3: | Strengthening adolescent SRHR service delivery and support; and |
| Priority 4: | Developing community support networks for adolescents |

(Department of Social Development 2015a)

Each of these priorities has a set of underpinning objectives. Achieving the objectives, and overall progress in the priority areas, would necessitate the effective engagement of young people who are the target of the strategy, as well as other groups in the community (for example, objectives under priority area four specify “buy-in” [p.31] from stakeholders including parents, caregivers, and community leaders). Thus, the findings of the present research may provide a framework for exploring influences on community engagement to address the priority areas. For instance, concepts from the research which are relevant to the priorities outlined above (and the objectives within them) include knowledges, stigma, representations, acceptance/denial, connectedness, intergenerational relationships, perceptions of relevance, and the relational environment.

The National LGBTI Framework (SANAC 2016) sets the goal of reducing the burden of HIV, TB and STIs among the LGBTI community of South Africa, and promoting a rights-based and evidence-based environment to support the LGBTI community. In articulating the need for a rights-based environment for LGBTI people, the framework is recognising the role of the broader relational socio-cultural-political environment in which LGBTI people experience SRHR. The framework specifically highlights the role of stigma and discrimination in contributing to SRHR inequities for this group, and advocates the need for an enabling environment in which “all role players, such as health and social care workers, law enforcement officials, legal representatives and community members, contribute to LGBTI wellbeing” (SANAC 2016:15) in order to reduce the burden of HIV, TB and STIs among this population. Thus, the framework is implicitly highlighting the role of Ubuntu values, bridging social capital and social connectedness to achieve this goal. To help achieve
engagement of the many diverse stakeholders in LGBTI SRHR issues, and ultimately achieve the goal of the framework, the findings of the present research could be used to explore the context for community engagement, in particular issues related to stigma, connectedness, acceptance of others (and bridging social capital), and the relational socio-cultural-political environment.

**Regional level**

As well as having relevance to various current South African strategies, the findings of this research are also relevant to several regional and global SRHR strategies and broader development agendas.

Regionally, the Maputo Plan of Action 2016 – 2030 (African Union Commission 2016) sets out a plan for operationalising the Continental Policy Framework on Sexual and Reproductive Health and Rights (herein, the Continental Policy Framework). The Continental Policy Framework was developed to address issues of universal access to SRHR in Africa by mainstreaming SRHR into primary health care and strengthening the health sector (African Union Commission 2005). Despite this framework first being adopted in 2005, it remains a relevant regional framework for addressing SRHR issues in Africa (African Union Commission 2016). The Maputo Plan of Action aims to achieve a collaborative effort between governments, civil society and the private sector to implement the Continental Policy Framework, and contribute to sustainable development and prosperity in the region. The Maputo Plan explicitly states the bi-directional link between SRHR and sustainable development, noting, “It is generally recognized that health, especially sexual and reproductive health and rights (SRHR) is a precondition for and an outcome and indicator of all aspects of sustainable development” (African Union Commission 2016: 5). Thus, the goal of The Maputo Plan recognises the links between SRHR promotion and the broader relational socio-economic environment.

The Maputo Plan outlines a number of key strategies including a substantial focus on SRHR information, education and communication (IEC) initiatives, including targeted gender and age-appropriate initiatives, and involving parents and peers. Many of the target indicators for monitoring and evaluation of the plan are quantitative measures, such as the percentage of a population reached or involved in initiatives. In order to successfully achieve desired increases, the findings of the present research would suggest focus needs to be given to
understanding influences on the effective engagement of the community members in the initiatives. Specifically, this would include developing a contextual understanding of current knowledges, openness to acceptance of new forms of knowledge, intergenerational relationships and the influences of these relationships on the engagement of populations with the IEC initiatives, representations of SRHR issues (including factors related to stigma), understanding the perceived relevance of the IEC initiatives and their content for specific groups, among other factors.

One other key strategy of the plan is to enhance uptake of SRHR services, particularly among vulnerable groups including youth and the elderly. Once again, many of the monitoring indicators are quantitative measures, and so to achieve desired measures would require understanding the influences on the engagement of these groups in any given setting, including the role of knowledges, stigma and the representations of SRHR issues, acceptance/denial, and the perceived relevance of services to an individual or group.

The current Maputo Plan of Action also aligns with the strategic pillars of the African Union Commission’s Agenda 2063 (African Union Commission 2015), and the Common African Position on the Post-2015 Development Agenda (African Union Commission 2014). Both of these agendas are focused on broad development objectives such as socio-economic development and sustainable development, but do recognise the links between sustainable socio-economic development and achievements in SRHR promotion and wellbeing. They both recognise the need for civic involvement and community-centred approaches, and enhanced uptake of health services, but do not provide discussion or guidance on how to achieve community engagement in community-based interventions or health services utilisation. Thus, the findings of this present research could provide a complimentary framework for undertaking community engagement to achieve the SRHR objectives, and thereby broader development objectives.

Global level

At the global level, the findings of this research may be relevant for key agendas such as the SRHR-specific, ‘Treatment 2.0 Framework for Action’ (WHO 2011b). The UNAIDS/WHO framework, ‘Treatment 2.0 Framework for Action’ outlines a global strategy for the scale-up of universal access to diagnosis, treatment (including ARV drug therapy), care and support for people with HIV (WHO 2011b). The framework comprises five key priority areas,
including delivery and uptake of ARVs, and community mobilisation. Achievements in these key areas are guided by a set of principles, including community involvement. The framework recognises, “The full engagement of people living with HIV and their affected families and communities is essential to the success of Treatment 2.0” (WHO 2011b: 18). Thus, in order to achieve this, a specific emphasis on community engagement is needed. The findings of the present research can provide a relevant framework for exploring the factors influencing community engagement among communities in South Africa and potentially other similar settings, in order to inform community engagement practice.

Overall, the findings of the present research add evidence to further strengthen the premise underpinning current initiatives, such as links between SRHR issues and the broader socio-economic environment as outlined in the current NSP and Maputo Plan for Action. Concurrently, the findings highlight the opportunities present. For instance, several of the key strategies commonly advocate the need for community mobilisation or stakeholder engagement, but none examine this crucial element of intervention planning more closely, such as the challenges of this, what is required to enable this, or how it can be done. Community engagement is a necessary and vital component of intervention planning and implementation; it is often stated as a principle or objective, but overlooked in detail and operationalisation. This warrants much greater and specific attention in key SRHR and development agendas. The findings of this current research, and the conceptual model develop for understanding influences on community engagement in SRHR promotion in South Africa, could provide a helpful starting point for understanding and practicing community engagement, and contributing toward achievements in several key health and development strategies.

9.3 Strengths and limitations of the research

It is important to consider the research findings in relation to the strengths and limitations of the research. A number of strengths of the research have been discussed in previous chapters (such as in chapter three where the research methods were justified) but are summarised below (section 9.3.1). A number of limitations of the research also need to be considered. These are also discussed below (section 9.3.2).
9.3.1 Strengths of the research

The research design employed a constructivist approach, and an ethnographic framework, to enable a culturally appropriate and meaningful interpretation of the data. Further, participants were offered the choice of multiple participatory methods as ways of contributing. The choice of methods provided participants with an empowering and emancipatory opportunity for participation, as discussed in chapter three. Although the majority of participants chose more traditional interview or focus group discussion methods rather than some of the more participatory methods on offer (such as diaries), some did contribute through other means of their own choosing, such as poetry or the use of video documentaries to facilitate discussions (as used by focus group six). These methods demonstrate additional creative ways that participants considered would be meaningful ways of contributing to the study.

Creative methods like such arts-based methods have been found to be an empowering method of participation in other research (Thomas et al. 2011). Thomas et al. (2011) commented that “art occupations provide a starting point for participation in community and a positive experience that encourages the construction of new identities, routines and roles”, and “allows for public recognition and social inclusion” (p.429). Although Thomas et al.’s research using arts-based methods was carried out in the context of homeless adults in Australia, it demonstrates the utility of such arts-based activities as form of civic participation among marginalised and excluded groups, and so may have similar meanings for the participants in this study. That is, participants in this study who were from communities marginalised on the intersections of location, ethnicity and socio-economic status, and sometime health status (such as being HIV positive), were able to participate in this research and add their voices to this research on a sensitive topic, further supporting the emancipatory values of this research.

Another strength of the research design was the engagement of local community members as field assistants in the research, to facilitate the cross-cultural nature of the research. While there are advantages to the research of this, there are also disadvantages of doing this which may pose limitations to the research. Potential limitations are discussed further below in section 9.3.2. As far as strengths go, however, the engagement of local community members as part of the research team assisted with multiple aspects of the design and implementation of the cross-cultural research, including the development of culturally appropriate topic guides and interview questions, facilitation of introductions to communities, facilitation of
the development of trusting relationships, and interpretation and/or translation duties when required. Their role as bi-lingual language interpreters was particularly important given the researcher’s moderate, but not fluent, ability to speak and understand the local language (isiXhosa). The language differences between the researcher and community participants posed one of the most substantial potential barriers and limitation to the research as it influenced the researcher’s daily interactions with community members and conduct of the research. South Africa has eleven official languages, including English and isiXhosa. The fieldwork was carried out in predominantly isiXhosa speaking communities in the Eastern Cape. The researcher had acquired a moderate isiXhosa competency through structured study and previous experiences in the field, but was not fluent. In the communities in which the research was carried out, the researcher observed that the vast majority of community members (and thus research participants) spoke isiXhosa as their primary language, but that many also spoke some English language. The researcher observed that English was spoken more among younger people, particularly those engaged in schooling, possibly because English is taught in schools (as discussed previously in section 3.4.1). Language barriers posed some limitation during data collection when live interpretation was required. Thus, the field assistants were asked to provide interpretation and/or translation duties to enable conversations to progress.

Additionally, rather than viewing the field assistants’ roles in language interpretation as simply one of technical interpretation, in consort with the perspectives of Shklarov (2007), Squires (2009) and Berman and Tyyska (2011), they were viewed as integral members of the research team who were able to provide the researcher with more nuanced details about the community context, culture, and meanings of language, beyond a purely technical interpretation. In this way, they were viewed as field assistants as well as key informants, and so as co-producers of knowledge (Squires 2009) who facilitated the lead researcher to gain deeper cultural insight. This helped to support the ethnographic design of the research. It also helped to strengthen the participatory nature of the research, as rather than the lead researcher being viewed as the expert in this context, the field assistants who provided both language and cultural interpretation were considered to be experts in the context, and they guided the lead researcher.
9.3.2 Limitations of the research

A number of limitations were present in the design and conduct of the research. Many of the limitations related in some way to the cross-cultural and multi-site nature of the research.

Limitations of the study design

While this research sought to theorise about community engagement in SRHR promotion in South Africa, for logistic reasons the research was carried out in communities in only one of the nine provinces of South Africa (the Eastern Cape). Further, South Africa has great diversity in ethnicities, cultural groups and languages, and the communities involved in this research were very predominantly Xhosa communities. Thus, the findings must be considered in relation to the specific demographic and cultural context, and/or other similarly contexts and groups, and may not necessarily be generalisable to other communities.

As the researcher was a visitor to the research setting, this introduced some limitations to the identification and selection of partner organisations and subsequent research communities engaged in the research. The process of identification and selection of partner organisations and communities was discussed in chapter one. For instance, many small community-based organisations do not have internet webpages so could not be located through an internet search by the researcher. Additionally, organisations sometimes operate programs which are broader in scope than SRHR specifically, but which may include some aspect of SRHR (for instance, a Home-Based Care program which may include basic personal and medical aid, food and nutrition components, as well as SRHR components). Details about all components of programs were not necessarily always publicly available, so some relevant programs or projects may have been missed by the researcher. Consequently, the organisations which were identified and selected were limited to those either already known by the research, or able to be practically and logistically reached by the researcher. Nevertheless, the three initial organisations engaged provided good starting points for introductions to other organisations and communities, from which snowballing (see Lee 2000) was used to reach further communities and participants for the research.

Limitations in the field

The cross-cultural context of the research presented a number of potential barriers and limitations to the conduct of the research in the field, including the inter-related factors of the
researcher’s position as etic to the community (discussed previously in chapter one), and related factors such as the researcher’s need to rely on bi-lingual field assistants at various times throughout the research processes, including for participant recruitment and language interpretation.

While the engagement of local community-based field assistants can be viewed as a strength of the research, as discussed above, there are also inherent limitations in this practice. For instance, the engagement of field assistants from the local communities, and their characteristics (for example, gender and age), could potentially have influenced community members’ willingness to participate either positively or negatively. While a number of different field assistants were used across the different research communities, thus bringing diversity to the overall pool of field assistants, only one field assistant was available in each research community. As the findings of this very research supports other previous research (Berman and Tyyska 2011) revealing that perspectives about the influence of local community ‘insiders’ on health promotion programs or research is contextual and varies widely; in some situations, ‘likeness’ of the field assistants in terms of gender, age, ethnicity and being a member from the research setting could be facilitatory, while in other circumstances this could pose a barrier to community members’ engagement in the research. In this research, this factor was influenced by societal norms about age, gender, status, and knowledge about the normative socio-economic context. This could be possibly be addressed in future studies by offering participants the choice of various field assistants in each research setting, including both ‘insiders’ and ‘outsiders’, but this would be dependent upon resources.

It is not only the community members’ receptiveness to local field assistants which may have influenced the research, but the field assistants’ own attitudes and actions also need to be considered as a possible influence and limitation. For instance, it is important to understand the tacit relationships and assumptions which may have influenced the work of the field assistants, such as who they chose to approach or not approach about participating, and why or why not; and what assumptions the field assistants may have made about community members (Berman and Tyyska 2011). Factors to consider may include interpersonal connections or power relationships, and social norms about age, gender and social hierarchies. Such factors could have influenced field assistants’ interactions with community members, and their subsequent influence on participant recruitment; that is, the field assistants may have acted as gate-keepers to the research, and thus contributed to shaping the
research. While the lead researcher regularly de-briefed with field assistants about the research conduct (including recruitment and gaps in recruitment), the issue of field assistants’ relationships, assumptions and social structures which may have influenced recruitment could have been more explicitly and deeply explored.

As stated above in section 9.3.1, one of the prominent duties required of the field assistants was to provide cross-language interpretation and/or translation when required. The use of cross-language interpreters itself raises potential limitations (discussed in the following paragraphs), but particularly when the interpreters are from same community or culture that the research is being conducted in, due to participant concerns about anonymity and confidentiality (Mengesha et al. 2018). Such concerns are further compounded when the topic of discussion is a culturally sensitive or taboo one, such as sexual and reproductive health (Mengesha et al. 2018).

The credentials of an interpreter are crucial to ensure trustworthy interpretation and data analysis and findings (Squire 2009). In this research, field assistants who undertook interpretation were not formally trained or qualified. Instead, they were local community members identified by partner organisations as people with fluency in both isiXhosa and English languages, and for whom some training in basic research fieldwork could be capacity building. It is acknowledged that this could have produced some limitations in the research, such as inaccuracies or bias in interpretations. Inappropriate or inconsistent use of interpreters can negatively impact the trustworthiness of the findings (Squires 2009). The field assistants provided ‘real-time’ interpretation during focus groups (or other ad-hoc discussions with community members as needed) to facilitate the progress of the discussion. At the time of live interpretation, the researcher made memos to herself to closely critically examine these points in transcripts and their implications for the discussion, such as whether the meanings captured by the interpreter were accurate, and the subsequent direction of discussions. The interpretations were later checked and verified using a professional transcription and translation service (as mentioned in section 3.4). These verifications revealed that occasionally the field assistants’ interpretations were loose or generalised descriptions of what a participants had said rather than a word-for-word interpretation. However there were no substantial inaccuracies or omissions in the participants’ meanings, as conveyed by the interpreter. Literature consistently states that word-for-word interpretations are often not possible, as often a word or concept does not transpose directly from one language to another.
Rather, paramount to ensuring trustworthiness in cross-language qualitative research using interpreters is conceptual equivalence – meaning both the technical and contextual meanings are captured. Sometimes this requires the interpreter to incorporate their own subject knowledge and contextual knowledge to convey the appropriate meaning, particularly when a direct translation is not (Shklarov 2007, Squires 2009). Shklarov (2007) argues that this is an important and rich aspect of cross-language research, and that it influences the content, outcomes and ethical merit of the research. Others similarly contend that rather than seeking to control or account for the ‘effects’ of interpreters in research, in community-based and constructivist research it is important to be reflective about their contribution to shaping the research (Squires 2009, Berman and Tyyska 2011). Indeed, Squires (2009) posits that the interpreter’s role is an important function in qualitative, constructivist approaches to research, where the interpreter “…becomes a producer of the research data who shapes the analysis through their identity and experiences” (p. 5). Thus, the use of local community members as field assistants in the research as language and cultural interpreters, bringing their own knowledge and experiences of the community relevant to the research, helped to enable necessary contextual meanings to be conveyed (as discussed above in section 9.3.1 – strengths of the research).

Also noteworthy is that the use of interpreters in qualitative research can influence the data obtained from participants, and thus influence the findings of the research (Squires 2009). In this research, interpretation provided during focus groups enabled the course of discussions to flow and continue, and so influenced the subsequent course of questions and discussion. It may be the case that in some instances when the field assistants may have missed a nuanced word or detail in their interpretations, the researcher may have liked to have explored that concept in greater depth but was not able to at the time. However, this is unlikely to be a major limitation to the research findings as all key topics and questions were still raised and explored.

A further potential limitation related to data collection was the use of focus groups as a method of collect data in some situations. The group-based nature of focus group discussions could have introduced some limitations and bias in the forms of normative discourses which are implicitly adopted by the group, or the collective voice whereby responses tend to represent a collectively constructed position rather than reflecting individuals’ own views (Smithson 2000). For instance, members of a focus group may tend to agree with a dominant
voice or view rather than present their own personal, diverse or divergent perspective, and thus may contribute to a sense that a particular view or issue is more substantial, or represented differently, than actually considered so by some participants. This was sometimes evident in this research particularly in focus group one; for instance, the phrase “staying at home doesn’t help” and the idea it entailed was repeated by several members of the same organisation. Simultaneously, some members of the focus group were rather inactive and made few other comments throughout the group discussion. This repetition could indicate the potential limitation of focus groups, or alternatively, this repetition could also indicate common values among members of this group. For instance, several of the participants who made this comment went on to further elaborate on their motivations and reasons for engaging with the organisation and activities with more specificity and further examples throughout the discussion, thereby supporting and further demonstrating their statement that “staying at home doesn’t help”. The breadth of data collection across community sites, including repeated interview with some participants, was one way of facilitating a rich analysis of the topic to try to minimise any risk of this limitation. This revealed that similar sentiments were expressed by participants in other settings also, thereby indicating the sentiments from focus group one were not simply the result of the focus group influences, but reflected more widely held views.

An additional possible limitation with any qualitative research is the potential for a researcher’s own epistemologies and ontologies to influence data collection, recording, analysis and interpretation. However, several strategies to minimise this potential were employed and thoroughly discussed previously in chapter three (research design and methods), including ethnographic methods such as immersion in the field to enhance the researcher’s understanding of the context, the practice of reflexivity and use of a reflective diary for critical reflection and analysis, and the adoption of a community-based participatory approach and engagement of local field assistants to strengthen and verify culturally appropriate and meaningful understanding of the research context and practice within the field.

9.4 In conclusion

Overall, this research reveals that SRHR promotion in South Africa is complex, multi-faceted and highly contextual. This research provides important and necessary insight about community conceptualisations of community engagement, SRHR issues and SRHR
promotion in the South African context. The discussion in this chapter has highlighted several opportunities for further research to expand knowledge and practice related to community engagement in SRHR promotion. This includes research to specifically explore and develop greater understanding about experiences of, and influences on, community engagement across different social, demographic and geographic contexts in South Africa.

As this research was conducted among predominantly Xhosa communities of the Eastern Cape of South Africa, the findings are highly culturally contextual. While the research findings may have some relevance to Xhosa communities in other provinces of South Africa, or other groups who share some cultural similarities, there is a need for similar research to be undertaken in any given setting to develop a contextually meaningful and relevant understanding.

While this research did endeavour to involve a cross-section of community participants, including participants of diverse genders, ages, and experiences with SRHR promotion, the sample was dominated by young women, and those who have been engaged with SRHR promotion to some degree. Thus, future research in this area should seek so specifically reach men, and older adults, and those who have not been engaged with SRHR promotion. Other groups identified within the current NSP as priority populations ‘vulnerable’ to SRHR issues including mine workers, people with disabilities, and LGBTIQ communities; these groups could also be the focus of future research regarding engagement in SRHR promotion. Such further research is needed in order to understand the unique experiences and needs regarding community engagement and SRHR health promotion for each of these population groups.

Additionally, while this research sought to explore community engagement in SRHR promotion across a broad range of SRHR issues, participants’ discussions were overwhelmingly focused on HIV and AIDS-related experiences, despite the researcher’s conscious efforts to expand discussions. Thus, additional research is needed to further explore influences on community engagement in other SRHR issues of emerging priority or concern such as unplanned pregnancy, sexual violence and cervical cancer. In particular, factors such as community knowledges, the representations of these issues (for instance, as sensitive, taboo or associated with particular groups), and relevance needs to be understood as health promotion efforts to address them may increase given the context of the current comprehensive NSP.
In addition to opportunities for future research, several promising avenues for future SRHR promotion practice can be identified. The first of these is that program planners and practitioners working in a similar context to this research consider the findings of this research to inform their program planning. That is, practitioners should be cognisant of the findings that SRHR promotion in South Africa is influenced by the inter-related dominant representations of SRHR issues as taboo and fatal, by community perceptions of relevance, and the broader relational environment in which they are operating; therefore, SRHR promotion programs should not be developed separately from their context. In particular, as community engagement in SRHR programs was intricately tied to community values of *Ubuntu*, community members are seemingly motivated to engage with community-based SRHR promotion by a focus on the collective wellbeing and connectedness of the community. Thus, program goals, objectives and strategies should seek to reflect this. For those embarking on new areas of health promotion, or in settings dis-similar to this research context, an exploration of the meanings of, and influences on, community engagement, similar to that undertaken through this research, should form a necessary part of the situation analysis in the program planning cycle.

It is important that when working in community-based health promotion, practitioners seek to understand community members’ experiences of habitus, including the context of the fields and dominant doxa, and examine issues of subjectivities and power present among the community in order to overcome barriers to engagement posed by these factors. Community-based SRHR promotion should seek to incorporate opportunities for capacity building and the development of various forms of social capital (such as bridging capital) and other capital (such as economic or symbolic capital, depending upon key contextual relational environment factors).

Finally, it would be useful to consider how the findings of this research could be incorporated into an operational model of practicing community engagement. That is, this research sought to conceptualise a theoretical model for understanding the meanings of, and influences on, community engagement; it did not seek to develop a model for practicing community engagement (such as those developed by Popay and others – see chapter two). While one gap in theory has been addressed by bringing the concepts of community engagement and SRHR promotion together in a conceptual model, there is still scope to develop this further in such a
way that this theory is incorporated into a model for health promotion program planning and implementation.

The findings of this research could be useful for health and community development practitioners seeking to develop and implement SRHR promotion programs in certain communities in South Africa, to enhance community engagement in programs related to sensitive SRHR issues. In particular, practitioners should invest time and effort for understanding the contextual community understandings, experiences, beliefs and values that may influence engagement in programs. This would help enhance the programs which are appropriate and sensitive to the context. This is particularly timely as the current South African National Strategic Plan for HIV, TB and STIs (SANAC 2017a) is half way through the period of implementation, and consultations for the new five year strategic plan will commence in the coming years. Attention should be given within such influential strategic plans to understanding and developing community engagement in SRHR promotion interventions, and to developing contextually sensitive SRHR promotion interventions to enhance community engagement in a broad suite of important SRHR issues, in order to contribute to improvements in community SRHR issues in the future.
REFERENCES


Koen, J., Essack, Z., Slack, C., Lindegger, G. and Newman, P. (2013). ‘It looks like you just want them when things get rought’: civil society perspectives on negative trial results and


APPENDIX A – ETHICS APPROVAL

Memorandum

To: Prof Ann Taket
School of Health & Social Development

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 06 November, 2011

Subject: 2011-200
Theorising community engagement and social inclusion in sexual and reproductive health promotion in South Africa
Please quote this project number in all future communications

The application for this project was considered at the DUHREC meeting held on 26/09/2011.

Approval has been given for Ms Greer Lamaro, under the supervision of Prof Ann Taket, School of Health & Social Development, to undertake this project from 8/11/2011 to 8/11/2015.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Recruitment script: Program workers

My name is __________ and I am from Deakin University in Australia. I am part of a team undertaking a research project to understand more about community engagement and social inclusion in sexual and reproductive health (SRH) promotion programs in South Africa. We hope that this information will increase our understanding about the factors that assist community engagement in these programs, may be used to design future programs. As [current/past] SRH program worker, your perspectives on this topic would be very valuable. Your organisation [name] has allowed me to speak to you about this project today and to invite you to participate.

In the case of verbal delivery of recruitment:
If you are interested in this opportunity and would like to know more about it, or if you have any questions, I invite you to come and speak with me.

[People who express interest will be given/sent an information pack containing the Plain Language Statement and Consent Form to consider further. Alternatively, the information contained in the Plain Language Statement and Consent Form can be read to a person if they wish. Contact details of the interested person will be recorded by the researcher to enable to the researcher to follow up after allowing the person time to consider the project e.g. after several days].

In the case of recruitment via email:
If you are interested in this opportunity and would like to know more about it, I invite you to consider the information pack attached. [Information pack contains the Plain Language Statement and Consent Form]. I will contact you again in the near future to see if you have any questions about the project or if you would like to participate. You are also free to contact me before then via email or phone (details provided below) if you wish.
Recruitment script: Community members

My name is __________ and I am from Deakin University in Australia. I am part of a team undertaking a research project to understand more about community engagement and social inclusion in sexual and reproductive health (SRH) promotion programs in South Africa. We hope that this information will increase our understanding about the factors that assist community engagement in these programs, and may be used to help design future programs. Your perspectives on this topic as a person who is living in a community in which an SRH program is currently running would be very valuable. The [headman] has allowed me to speak to members of this community about this project today to invite you to participate.

If you are interested in this opportunity and would like to know more about it, or if you have any questions, I invite you to come and speak with me now.

[People who express interest will be given an information pack containing the Plain Language Statement and Consent Form to consider further. Alternatively, the information contained in the Plain Language Statement and Consent Form can be read to a person if they wish. Contact details of the interested person will be recorded by the researcher to enable to the researcher to follow up after allowing the person time to consider the project e.g. after several days].
Recruitment script: Community leaders

My name is __________ and I am from Deakin University in Australia. I am part of a team undertaking a research project to understand more about community engagement and social inclusion in sexual and reproductive health (SRH) promotion programs that operate in South Africa. Your community, [name], is currently receiving an SRH promotion program [name program/organisation] of which you may be aware. Having the community engaged in a program is highly important for the success and long term health effects of the program. We hope that this information may increase our understanding about the factors that assist community engagement in these programs, and will be used to help design future programs.

If you are interested in this opportunity and would like to know more about it, or if you have any questions, I invite you to come and speak with me now.

[People who express interest will be given an information pack containing the Plain Language Statement and Consent Form to consider further. Alternatively, the information contained in the Plain Language Statement and Consent Form can be read to a person if they wish. Contact details of the interested person will be recorded by the researcher to enable the researcher to follow up after allowing the person time to consider the project e.g. after several days].
PLAIN LANGUAGE STATEMENT – Current Program Workers

TO: [Contact]

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<td>Principal Researchers:</td>
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<td>Associate Researcher:</td>
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PARTICIPATING IN THE STUDY

You are invited to participate in a research project that aims to investigate and understand more about community engagement in sexual and reproductive health (SRH) promotion programs in South Africa. It is important to understand how we can best engage community members in SRH promotion programs to enhance the effectiveness of the programs.

We are inviting current and past program staff to be active participants in this study. You are not obliged to participate; any participation is entirely voluntary.

WHAT IS THIS STUDY ABOUT?

This research aims to explore the perspectives and experiences of program workers and community members regarding engagement in SRH promotion programs in the community. The research will be helpful for the development of SRH promotion programs in the future.

WHO ARE THE RESEARCHERS?

The principal researchers who are supervising this project are Professor Ann Taket and Dr. Lisa Hanna, from the School of Health and Social Development, Faculty of Health, Deakin University, Australia. The associate researcher is Greer Lamaro who is currently undertaking her PhD in the School of Health and Social Development, Deakin University, Australia. This research project is being undertaken as part of the requirements for her PhD.

WHAT WILL PARTICIPATION INVOLVE?
• Reading, understanding and signing this ‘Plain Language Statement and Consent Form’ if you choose to be involved with the research.
• You have the opportunity to ask any questions at any time by contacting members of the research team.
• You will be asked for your views about community engagement in the SRH program that you are involved in. You can choose if you would like to provide this information by participating in at least one individual interview and/or group discussion with other program workers, and/or recording the information in a diary over the course of a year.
• Interviews and group discussion will be conducted by the Associate Researcher and may last up to 2 hours long. They will be audio or video recorded. You will be asked to discuss:
  o your views about whether there are particular groups that do/don’t engage in the SRH promotion program?
  o factors you see as facilitators or barriers to community members engaging in the program
  o any interventions or activities that you are aware of elsewhere or that you think would be good to implement to encourage and support community engagement in SRH programs in your community?
• The recording of the interview will be written into a text document (transcript). If you wish, you can view and comment on the transcript once it is available, and you will also be provided with a verbal summary.
• Diaries may be recorded in written form, audio/digital form, or video format. Voice recorders or video recorders will be provided for your use, and training on how to use the device(s) will also be provided if you wish to record electronic diaries.

Participation in this study is voluntary. **If you do not wish to take part you are not obliged to. If you choose not to participate, your relationship with the researchers and your organization will NOT be affected.** You are free to decline to answer any particular question and are free to withdraw participation at any time during the research by advising the researchers (contact details below). After your interview or submission of diary, if you change your mind about participation, you can withdraw the information that you have provided up until the point it is processed by the research team (four weeks after interview or submission of diary) and then it will not be used in the research and will be destroyed. After this point it will not be possible to remove your information from the study. However, all information that you have provided will be anonymised to protect your confidentiality.

**WHY HAVE I BEEN ASKED TO PARTICIPATE?**
Current program workers have been invited to be involved in this research based on your role in delivering SRH promotion programs in the community. Given your experience in this field, your input to this project would be of enormous value.
WHAT ARE THE RISKS AND BENEFITS ASSOCIATED WITH THIS STUDY?

It is not anticipated that there will be any risks to participants as a result of participating in this study as you are already participating in SRH promotion program running in your community.

You may experience some benefits from participating in this study, including:

- the opportunity to have your say about your perspectives and experiences about community engagement in SRH promotion programs
- developing a greater understanding of ways to engage different community members in your program activities
- having the opportunity to develop skills in program evaluation and research using new methods such as diaries, voice recordings and video-recordings.

Some of the benefits to the wider community which are expected to emerge from this project include an increased knowledge and understanding of the factors that influence community engagement in SRH promotion programs, including factors that facilitate engagement as well as barriers to engagement.

WILL MY PARTICIPATION BE CONFIDENTIAL?

Your participation in this research will remain confidential throughout the research process. Your participation will not be disclosed to any other organization or individual approached to participate in the study. Although the recorded diaries, interviews and group discussions may be recognizable in the recording, they will be used afterwards in a way that protects your privacy and confidentiality by changing any names and other identifying information. Nobody other than members of the research team will be able to view or listen to the recordings, and they will be stored securely. Written reports and publications arising from the project will ensure that no person or organization is identifiable.

HOW WILL THE STUDY'S FINDINGS BE USED?

A summary of the study's findings will be given to participants and communities in a verbal report at a community meeting. Summary reports will be written for key stakeholders such as organizations who deliver SRH promotion programs, and the findings will also be written for publication in the academic literature.

HOW IS THIS STUDY FUNDED?

The research has not received funding from any private, government or non-government organization. It is being funded and conducted independently by members of the research team.

WHO CAN I CONTACT FOR MORE INFORMATION?

If you require any further information on the study or your participation, please contact members of the research team:
Ann Taket - Principal Researcher

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Fax: +61 3 9244 6261
Email: ann.taket@deakin.edu.au

Greer Lamaro – Associate Researcher

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Fax: +61 3 5227 8356
Email: greer.lamaro@deakin.edu.au

COMPLAINTS

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway,
Burwood Victoria 3125, Telephone: +61 3 9251 7129, Facsimile: +61 3 9244 6581, research-ethics@deakin.edu.au

Please quote project number 2011-200.
PLAIN LANGUAGE STATEMENT—Past Program Workers

TO: [Contact]

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PARTICIPATING IN THE STUDY

You are invited to participate in a research project that aims to investigate and understand more about community engagement in sexual and reproductive health (SRH) promotion programs in South Africa. It is important to understand how we can best engage community members in SRH promotion programs to enhance the effectiveness of the programs.

We are inviting current and past program staff to be active participants in this study. You are not obliged to participate; any participation is entirely voluntary.

WHAT IS THIS STUDY ABOUT?

This research aims to explore the perspectives and experiences of program workers and community members regarding engagement in SRH promotion programs in the community. The research will be helpful for the development of SRH promotion programs in the future.

WHO ARE THE RESEARCHERS?

The principal researchers who are supervising this project are Professor Ann Taket and Dr. Lisa Hanna, from the School of Health and Social Development, Faculty of Health, Deakin University, Australia. The associate researcher is Greer Lamaro who is currently undertaking her PhD in the School of Health and Social Development, Deakin University, Australia. This research project is being undertaken as part of the requirements for her PhD.
WHAT WILL PARTICIPATION INVOLVE?

- Reading, understanding and signing this ‘Plain Language Statement and Consent Form’ if you choose to be involved with the research.
- You have the opportunity to ask any questions at any time by contacting members of the research team.
- You will be asked for your views about community engagement in the SRH program that you were involved in. You can choose if you would like to provide this information by participating in at least one individual interview and/or group discussion with other former program workers.
- Interviews and group discussion will be conducted by the Associate Researcher and may last up to 2 hours long. They will be audio or video recorded. You will be asked to discuss:
  o your views about whether there are particular groups of people in the community that do/don’t engage in SRH promotion programs?
  o factors do you see as facilitators or barriers to community members engaging in SRH promotion initiatives?
  o What you think is needed or could be done to encourage and support community engagement in SRH programs in communities in future?
- The recording of the interview will be written into a text document (transcript). If you wish, you can view and comment on the transcript once it is available, and you will also be provided with a verbal summary.

Participation in this study is voluntary. **If you do not wish to take part you are not obliged to. If you choose not to participate, your relationship with the researchers and the organization that you worked for will NOT be affected.** You are free to decline to answer any particular question and are free to withdraw participation at any time during the research by advising the researchers (contact details below). After your interview or group discussion, if you change your mind about participation, you can withdraw the information that you have provided up until the point it is processed by the research team (four weeks after the interview or group discussion) and then it will not be used in the research and will be destroyed. After this point it will not be possible to remove your information from the study. However, all information that you have provided will be anonymised to protect your confidentiality.

WHY HAVE I BEEN ASKED TO PARTICIPATE?

Former program workers have been invited to be involved in this research based on your role in delivering SRH promotion programs in the community. Given your experience in this field, your input to this project would be of enormous value.
WHAT ARE THE RISKS AND BENEFITS ASSOCIATED WITH THIS STUDY?

It is not anticipated that there will be any risks to participants as a result of participating in this study. You may experience some benefits from participating in this study, including the opportunity to have your say about your perspectives and experiences regarding community engagement in SRH promotion programs, and the opportunity to contribute information that may be useful for future program development.

Some of the benefits to the wider community which are expected to emerge from this project include an increased knowledge and understanding of the factors that influence community engagement in SRH promotion programs, including factors that facilitate engagement as well as barriers to engagement.

WILL MY PARTICIPATION BE CONFIDENTIAL?

Your participation in this research will remain confidential throughout the research process. Your participation will not be disclosed to any other organization or individual approached to participate in the study. Although recordings of the interviews and group discussions may be recognizable in the recording, they will be used afterwards in a way that protects your privacy and confidentiality by changing any names or identifying information. Nobody other than members of the research team will be able to view or listen to the recordings, and they will be stored securely. Reports and publications arising from the project will ensure that no person or organization is identifiable.

HOW WILL THE STUDY’S FINDINGS BE USED?

A summary of the study’s findings will be given to participants and communities in a verbal report at a community meeting. Summary reports will be written for key stakeholders such as organizations who deliver SRH promotion programs, and the findings will also be written for publication in the academic literature.

HOW IS THIS STUDY FUNDED?

The research has not received funding from any private, government or non-government organization. It is being funded and conducted independently by members of the research team.

WHO CAN I CONTACT FOR MORE INFORMATION?

If you require any further information on the study or your participation, please contact members of the research team:

Ann Taket - Principal Researcher

School of Health and Social Development
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Deakin University
221 Burwood highway
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Tel: +61 3 9
Fax: +61 3 9
Email: ann.taket@deakin.edu.au

Greer Lamaro – Associate Researcher

In South Africa:

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In Australia:

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Fax: +61 3 5227 8356
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COMPLAINTS
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: +61 3 9251 7129, Facsimile: +61 3 9244 6581 research-ethics@deakin.edu.au

Please quote project number 2011-200.
PLAIN LANGUAGE STATEMENT – Community Members

TO: [Contact]

Date:

Full Project Title: Theorising community engagement and social inclusion in sexual and reproductive health promotion in South Africa

Principal Researchers: Prof. Ann Taket, Dr. Lisa Hanna

Associate Researcher: Ms. Greer Lamaro

PARTICIPATING IN THE STUDY

You are invited to participate in a research project that aims to investigate and understand more about community engagement in sexual and reproductive health (SRH) promotion programs in South Africa. It is important to understand how we can best engage community members in SRH promotion programs to enhance the effectiveness of the programs.

We are inviting people who live in communities which currently have an SRH promotion program operating to participate. Your participation is entirely voluntary.

WHAT IS THIS STUDY ABOUT?

This research aims to explore the perspectives and experiences of program workers and community members regarding engagement in SRH promotion programs in the community. The research will be helpful for the development of SRH promotion programs in the future.

WHO ARE THE RESEARCHERS?

The principal researchers who are supervising this project are Professor Ann Taket and Dr. Lisa Hanna, from the School of Health and Social Development, Faculty of Health, Deakin University, Australia. The associate researcher is Greer Lamaro who is currently undertaking her PhD in the School of Health and Social Development, Deakin University, Australia. This research project is being undertaken as part of the requirements for her PhD.
WHAT WILL PARTICIPATION INVOLVE?

- Reading, understanding and signing this ‘Plain Language Statement and Consent Form’ if you choose to be involved with the research.
- You have the opportunity to ask any questions at any time by contacting members of the research team.
- You will be asked for your views about community engagement in the SRH program that you are involved in. You can choose if you would like to provide this information by participating in at least one individual interview and/or group discussion with other members of the community, and/or recording the information regularly in a diary throughout the year.
- Interviews and group discussion will be conducted by the Associate Researcher and may last up to 2 hours long. They will be audio or video recorded. You will be asked to discuss:
  - Your perspectives about SRH promotion programs operating in the community.
  - Your reasons for engaging with the SRH promotion program operating in the community.
  - Factors that have encouraged and helped or hindered you in engaging with the SRH promotion program.
  - Your views about anything else that could be done to support yourself and others in the community to engage with SRH promotion programs in the future.

- The recording of the interview will be written into a text document (transcript). If you wish, you can view and comment on the transcript once it is available, and you will also be provided with a verbal summary.
- Diaries may be recorded in written form, audio/digital form, or video format. Voice recorders or video recorders will be provided for your use, and training on how to use the device(s) will also be provided if you wish to record electronic diaries.

Participation in this study is voluntary. If you do not wish to take part you are not obliged to. If you choose not to participate, your relationship with the researchers and the organization providing the [XXX] program will NOT be affected. You are free to decline to answer any particular question and are free to withdraw participation at any time during the research by advising the researchers (contact details below). After your interview or submission of your diary, if you change your mind about participation, you can withdraw the information that you have provided up until the point it is processed by the research team (four weeks after the interview or submission of the diary) and then it will not be used in the research and will be destroyed. After this point it will not
be possible to remove your information from the study. However, all information that you have provided will be anonymised to protect your confidentiality.

WHY HAVE I BEEN ASKED TO PARTICIPATE?
Community members have been invited to be involved given that you are currently living in a community that is the recipient of an SRH promotion program. Your perspectives on this topic are central to understanding the issue and your input to this project would be of enormous value.

WHAT ARE THE RISKS AND BENEFITS ASSOCIATED WITH THIS STUDY?
It is not anticipated that there will be any risks to you as a result of participating in this study.

You may experience some benefits from participating in this study, including having the opportunity to have your say about your perspectives and experiences about engaging with the SRH promotion program running in your community, and the opportunity to contribute information that may be useful for future program development.

Some of the benefits to the wider community which are expected to emerge from this project include an increased knowledge and understanding of the factors that influence community engagement in SRH promotion programs, including factors that facilitate engagement as well as barriers to engagement.

WILL MY PARTICIPATION BE CONFIDENTIAL?
Your participation in this research will remain confidential throughout the research process. Your participation will not be disclosed to any other organization or individual approached to participate in the study. Your name or information about you will not be recorded in any way that identifies you. Although the, interviews, group discussions and diary records may be recognizable in the recording, they will be used afterwards in a way that protects your privacy and confidentiality by changing any names or other identifying factors to protect your privacy and confidentiality. Nobody other than members of the research team will be able to view or listen to the recordings, and they will be stored securely. Reports and publications arising from the project will ensure that no person or organization is identifiable.

HOW WILL THE STUDY’S FINDINGS BE USED?
A summary of the study’s findings will be given to participants and communities in a verbal report at a community meeting. Summary reports will be written for key stakeholders such as organizations who deliver SRH promotion programs, and the findings will also be written for publication in the academic literature.
HOW IS THIS STUDY FUNDED?
The research has not received funding from any private, government or non-government organization. It is being funded and conducted independently by members of the research team.

WHO CAN I CONTACT FOR MORE INFORMATION?
If you require any further information on the study or your participation, please contact members of the research team:

**Ann Taket** - Principal Researcher
School of Health and Social Development
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221 Burwood highway
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Email: [ann.taket@deakin.edu.au](mailto:ann.taket@deakin.edu.au)

**Greer Lamaro** – Associate Researcher

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Please quote project number 2011-200.
CONSENT FORM

TO: [Contact]

Date:

Full Project Title: Theorising community engagement and social inclusion in sexual and reproductive health promotion in South Africa

Reference Number:

I have read, or have had read to me, and understand the attached Plain Language Statement.

I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant’s Name (printed) …………………………………………………………………

Signature ……………………………………………………… Date ………………………

Please return this form to:
Greer Lamaro
Associate Researcher

South Africa:
Box 1925
East London
5201
SOUTH AFRICA
Fax: +27 43 743 7684
Email: greer.lamaro@deakin.edu.au

Australia:
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Locked Bag 20000
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Victoria 3220
AUSTRALIA
Fax: +61 3 5227 8356
Email: greer.lamaro@deakin.edu.au
REVOCATION OF CONSENT FORM

TO: [Contact]

Revocation of Consent Form

(To be used for participants who wish to withdraw from the project)

Date:

Full Project Title: Theorising community engagement and social inclusion in sexual and reproductive health promotion in South Africa.

Reference Number:

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University.

Participant’s Name (printed) ……………………………………………………

Signature …………………………………………………………………………

Date …………………

Please return this form to:
Greer Lamaro
Associate Researcher

South Africa:
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