CHAPTER 3

PRESENTATION OF DATA AND ANALYSIS

3.1 INTRODUCTION

It was mentioned in the previous chapter that the aim of the study is to investigate the belief systems about HIV/AIDS among elderly Xhosa-speaking people. In this chapter, the aim is to present and analyse the data that the researcher gathered. The researcher will start by presenting the data, and secondly describing the steps that she used in her data analysis method. The trustworthiness of the data will be the last aspect to be discussed. The themes, categories and patterns that emerged from the data will also be described. Lastly the conclusions will be given.

3.2 PRESENTATION OF DATA

3.2.1 The sample

The sample of the study are Xhosa-speaking people who are over 60 years of age, including both sexes. Anthea (1992) states that “these are people who are old as they are over retirement age”. The elderly people were chosen as a sample because the researcher was interested in getting in-depth information about their beliefs on HIV/AIDS, as these influence their knowledge.

3.2.2 The characteristics of older people

Hooker (1993) mentions the following as the characteristics of elderly people.

- Elderly people seem to undergo changes in behaviour which create difficulties for themselves and for the people with whom they are living. Their ability to adjust to alterations in their way of life is diminished.
- They are old and/or unwilling to think for themselves at all and they usually ask questions.
• Bereavement, moving house or going into hospital can cause unhappiness and fear.
• Deafness or loss of sight contributes to old people becoming lonely and inward-looking.
• Many people who live alone become saddened and unable to find any joy in life.
• Disabilities such as arthritis or heart disease make getting about more difficult, and physical or mental isolation sometimes results.
• Listlessness, lack of initiative, fear of the future and anxiety about minute details of order and tidiness, combined with insomnia, characterised by waking in the small hours of the morning, may be early signs of depression.
• Sometimes symptoms of other illness present themselves, which are very real to the sufferer and are occasionally interpreted as retribution for past sins.
• Confusion is usually a temporary condition and is described as a “disordered awareness of the environment”.
• A deep sense of guilt is common in people who are depressed. They lose weight, which confirms their fears, but the cause is that they are often not eating properly.
• Fear of retribution often creates conflict as many depressed people think of dying as a release from their unhappiness.
• When depression is secondary to another disability such as a stroke there is often preoccupation with constipation and fear of wanting to go the lavatory when it is not convenient.
• Living with elderly people can be difficult when you want to help them because efforts are often fruitless.
• They will not be reassured and are convinced that nobody can possibly understand them.
• The most practical thing to do is to make them feel loved and part of the family by reassuring them and including them in general conversations.

The researcher’s sample was elderly Xhosa people, and she attempted to get them to speak about their belief systems about HIV/AIDS, but none of them told the researcher what AIDS was. For example, respondent no. 7 said that “We don’t
know what Aids is because it was not there during our times and is the disease that comes now”.

3.2.3 The goal

To explore and describe the belief systems of elderly Xhosa-speaking people about HIV/Aids.

3.2.4 The objectives

- To explore and describe the belief systems of elderly Xhosa-speaking people on HIV/Aids, through an empirical study.
- To link the beliefs of the respondents with literature.
- To reach conclusions on how these belief systems influence their knowledge of HIV/Aids.
- To make recommendations regarding belief systems.

3.3 THE STEPS THAT WERE USED BY THE RESEARCHER DURING THE DATA ANALYSIS

Tesch (1990:154-156) (as cited in De Vos, 1998) identifies the following eight steps that one can follow during qualitative data analysis. These steps were also introduced in the previous chapters. Therefore, this will include the following steps:

**Step one:** The researcher gets a sense of the whole by reading through all of the transcripts carefully. During this period, the researcher can jot down some ideas as they come to mind.

**Step two:** The researcher selects one interview, for example, the most interesting, the shortest or the one at the top of the pile, and goes through it asking “What is this about?” and thinking about the underlying meaning in the information. He/she writes thoughts that come up in the margin. (Appendix C)
**Step three:** When the researcher has completed this task for several respondents, a list is made of all the topics. Similar topics are clustered together and formed into columns that might be arranged into major topics, unique topics and leftovers.

**Step four:** The researcher takes the list and returns to the data. The topics are abbreviated as codes and the codes written next to the appropriate segments of the text. The researcher tries out this preliminary organising scheme to see whether new categories and codes emerge.

**Step five:** The researcher finds the most descriptive wording for the topics and turns them into categories. He/she endeavours to reduce the total list of categories by grouping together topics that relate to each other. Lines are drawn between the categories to show interrelationships.

**Step six:** The researcher makes a final decision on the abbreviation for each category and alphabetises the codes.

**Step seven:** The data material belonging to each category is assembled in one place and a preliminary analysis is performed.

**Step eight:** The researcher recodes the existing data if necessary and draws new patterns and conclusions.

The above-mentioned steps were reduced by the researcher of this study to the following five steps:

**Step one** – Reading carefully through all the transcripts to get a sense of the data as a whole.

**Step two** – Picking any transcript file and reading through it, jotting down ideas as they come to mind, asking oneself what the interview is about, while writing thoughts in the margin and identifying the major categories represented in the universum.
Step three – Reading through the entire transcript files again and underlining units of meaning related to the identified major categories.

Step four – Putting the units of meaning into major categories while at the same time identifying subcategories within the major categories.

Step five – Identifying relationships between major- and subcategories and formulating new patterns as conclusions are drawn.

Figure 3.1: The process followed by the researcher during data analysis

3.4 TRUSTWORTHINESS OF THE DATA

Guba (1981:215-216) in De Vos (1998) states that “researchers need alternative models appropriate to qualitative designs that ensure rigour without sacrificing the relevance of the qualitative research. In this research study, the researcher used Guba’s model (Krefting, 1991) in ensuring the trustworthiness of the data. According to Guba (Krefting, 1991) the model of trustworthiness consists of the following criteria that were mentioned in the previous chapters:

- truth value,
- applicability,
- consistency, and
neutrality.

3.4.1 Truth value

The first criterion that must be addressed in establishing trustworthiness is truth value. According to Krefting (1991:215-216) truth value is determined by assessing to what extent the findings of the study are a true reflection of the life world of the informants. The criterion for establishing “truth value” is credibility. Krefting (1991:215) proposes the various actions to achieve credibility:

- prolonged and varied field experience,
- member checking,
- peer examination,
- triangulation,
- interviewing techniques,
- establishing the authority of the researcher,
- structural coherence,
- reflexivity,
- time sampling, and
- referential adequacy.

3.4.1.1 Prolonged and varied engagement:

The researcher engaged herself in some of the ward meetings of this community, especially ward 109, where she lives. Therefore there is increased rapport and trust between them. Her staying in this community provided her with the opportunity to observe the respondents in action. In this regard, she was considered an observer participant.

3.4.1.2 Triangulation:

Tutty, Rothery and Grinnel (1996) contend that “triangulation is the process of using multiple perspectives in making comparison of data collection diverse or competing theoretical frameworks or different researchers”. These authors further
state that triangulation might involve having a colleague use your data collection rules to see if he or she makes the same decisions about meaning units, categories and themes, or it may consist of collecting multiple sources of data in addition to the researcher’s interview.

Krefting (1991:219) also emphasizes that triangulation “is the comparison of multiple perspectives by using different methods of data collection, diverse or competing theoretical frameworks and/or different researchers”. Triangulation was employed in this study by utilising different methods of data collection, which were informal conversations, audio-tapes and observations. Secondly, during the literature control, theoretical frameworks from diverse areas of knowledge were used to compare and contrast with the research findings.

3.4.1.3 Peer examination:

Krefting (1991:219) states that peer examination refers to the researcher’s discussions around the findings and the problems experienced with impartial colleagues who have experience in qualitative research.

3.4.1.4 Interviewing techniques:

The researcher was able to enhance credibility as she made extensive use of various interviewing techniques and skills during the interview, such as verbal and non-verbal probing, reframing, clarifying and summarising. Therefore, the researcher can be judged as experienced in using these skills and techniques of interview.

3.4.2 Applicability

The second method for ensuring trustworthiness is applicability. De Vos (1998:349) defines applicability as “the degree to which the findings can be applied to other context and settings”. He further states that during this period, the emphasis is on “how well the threads to external validity have been managed by the researcher”.
Transferability, dense description and consistency are the methods that describe applicability. Krefting (1991:216-220) mentions that applicability is seen to be irrelevant to qualitative research as it proposes to describe a particular experience or phenomenon and not to generalise other experiences.

Guba (1981) in Krefting (1991:216) proposed that “transferability is the criterion against which applicability of qualitative research is assessed”. Lincoln and Guba (1985) in Krefting (1991) emphasised the issue of transferability as a concern of the person who wants to transfer the findings to a different situation than that of the initial researcher. Lincoln and Guba (1985) in Krefting (1991) also mention that if the initial researcher presents sufficient descriptive data to allow comparisons, the issue of transferability has been addressed. Krefting (1991:217, 220-222) also contends that “transferability in qualitative research can be achieved by the ensuing actions: using a nominated sample, time sampling, dense descriptions of the research methodology and working contextually”. This research study adopted the third criterion of transferability, which is dense description.

Krefting (1991:220-221) was of the opinion that it is essential for comprehensive detail to be provided on the respondents as well as the research contents, setting and process, as this will enable others to determine how transferable the results were. In this regard, this research study has provided a comprehensive description of the research methodology, which was accomplished through relevant literature to facilitate clarity.

### 3.4.3 Consistency

The third criterion of Guba’s model in Krefting (1991:215-222) is known as consistency. According to Tutty, Rothery and Grinnell (1996) consistency is concerned with the extent to which the study can be replicated in a similar context or with similar informants and can lead to the same results. These authors further contend that dependability is the strategy that one can use in ensuring consistency.
The authors mentioned the actions that one can take in ensuring dependability, which include the following: the keeping of a dependable audit, providing a dense description of the research method, stepwise replication, triangulation, peer examination and code decoder procedures (Krefting, 1991:216).

In this study, the actions that were taken in ensuring dependability are peer examination of the research methodology, triangulation and a dense description of the research methodology whereby the researcher initially coded and analysed the data and then allowed two weeks to pass before recording and comparing the results.

### 3.4.4 Neutrality

This is considered to be the fourth aspect in Guba’s model (in Krefting, 1991:215-222) in ensuring trustworthiness. Lincoln and Guba (1985) in Krefting (1991:217) suggest that neutrality in qualitative research should consider the neutrality of the data rather than that of the researcher and thus they suggested conformability as the strategy to achieve neutrality, whereby the researcher must achieve the following actions: conformability audit and triangulation. In this study, neutrality was employed by following both the second and third actions of conformability in ensuring the neutrality of the study.

### 3.5 FROM THE DATA THE FOLLOWING ASPECTS ARE THE THEMES, CATEGORIES AND SUB-CATEGORIES THAT EMERGED FROM THE DATA

#### 3.5.1 Theme 1: The respondents believe that people got infected due to heterosexual relationships

The theme is supported by the following:

- People get infected through family prevention methods when injections are used.
- People get infected through diseases such as cancer.
People get infected through unprotected sexual intercourse in sleeping with HIV/AIDS-infected people.

People get infected through blood transmission when, in accidents, they come into contact with injured people who are HIV/AIDS-infected.

People get the HI Virus through other diseases such as Vuilsiek and Elehashi.

People get HIV/AIDS from sores which come outside and inside their bodies.

People get HIV/AIDS because they don't respect societal norms and values.

3.5.2 Theme 2: The respondents believe that AIDS can be treated by means of traditional healers, medical doctors, sticking with one partner and maintaining trust

The theme is supported by the following

- Let people use condoms during sexual intercourse.
- Traditional herbs such as: empiza, speit, herbs for washing and drinking.
- People can also attend HIV/AIDS treatment programmes with the assistance of doctors.
- People must put their faith in God, who brought this disease to earth.

3.5.3 Theme 3: The respondents believe that HIV/AIDS was brought by the migration of foreigners to South Africa

The theme is supported by the following

- Let government deposit all these foreigners in their own countries because they brought AIDS to our country.
- AIDS was brought by Zimbabweans and Nigerians together with Europeans.

3.5.4 Theme 4: Respondents believe that AIDS can be avoided by means of condom usage and using traditional medicine

- The data shows that the respondents articulated the belief that people can avoid getting the virus by means of practising safer sex through condom usage. The data also shows that people can ask help from traditional healers whereby they will be offered herbs such as embiza and speit for healing.
3.5.5 Theme 5: The respondents believe that youngsters are vulnerable to being infected by HIV/AIDS

- Young people are the ones who die of this disease as they fall in love with old people.

3.5.6 Theme 6: The respondents believe that besides through sexual intercourse people can also get the virus through accident injuries, football playing and needle-stick injuries

The theme is supported by the following

- People can get it during family planning, when the doctors use the same needle while giving women injections as a contraceptive method.
- Others can get it while they will be playing with injured players who are HIV/AIDS-infected and where there is blood transmission.

3.5.7 Theme 7: The respondents believe that the majority of people that they know who died of HIV/AIDS got infected through sexual intercourse

3.6 DISCUSSION OF DATA

3.6.1 Theme 1: The respondents believe that people got infected due to heterosexual relationships

The data shows that most of the people interviewed believe that people can get HIV/AIDS through sexual intercourse with HIV-positive people or by sufferers not using safe precautions. They are also of the opinion that people can get Aids by using contraceptives administered by injection, and at a time when someone is ill and is given an injection by a medical doctor.

Most respondents said that Aids starts with sores which are difficult to cure either by a medical or a traditional doctor. To cite an example, respondent no. 2 said:
“The patient starts with sores inside or outside his or her tummy.” Paying special attention to the issue of unsafe sex, the data is an indication of the fact that women are sometimes pressurised by their husbands or partners who does not want to wear condoms during sexual intercourse because of their over ruling power and the myth that “condoms diminish sexual pleasure“. Although there are people who believe in practising safe sex, there are others who are against this because of the suspicion that condoms brought HIV/Aids. The respondents were not sure that the condoms were perhaps the things that brought Aids to people. For example, respondent no. 7 said: “Why since the start of Aids are there younger people who are dying?” Moreover, respondent no. 6 said: “I hate using condoms because they diminish sexual pleasure.”

Respondents also remarked that people get Aids because of infection from other sexual transmitted diseases which end up turning into Aids. The data also indicated that Aids can be something brought by witchcraft. Through witchcraft it starts in the shape of a cauliflower and when the doctors diagnose the patient they cannot see anything except a cauliflower with many sores which will be situated in the patient’s private organs and then they call it Aids. Example, respondent no. 1 “There was this somebody with a cauliflower in her private parts”.

The data also shows that some people believe that Aids can be acquired by means of blood transmission especially when they come into contact with an HIV/Aids patient during injuries like an accident. Respondent no. 2 remarked: “except needles or blood transmission there is a period whereby you will get into contact with a seriously injured person and he or she may be injured where by there will be transmission of blood”. Here there is argumentation of different views in terms of blood transmission as the other way in which people can get Aids. Other respondents are against this idea. For example, respondent no. 7 said that “The police are always helping people who are injured. Why are they not infected?”

The majority of people interviewed are of the opinion that anyone can get the virus since younger and older people fall in love with each other. The data reveals that
there is no longer in fear and respect in life and people are no longer following their traditional norms, values and morals.

The data also indicates that people, especially from the Xhosa culture, are no longer obeying society’s rules, and this also has an impact on the standard of living conditions in terms of their health. This leads to people getting diseases like Aids. For example, respondent no. 6 said that “people are no longer paying respect to our values and our cultural rules; there is no longer circumcision schools, no more fear in violating the Xhosa cultural norms and rules. It was also mentioned in the data that when people are infected by the virus there is a gradual change in their personal lives such as change in eating whereby the patient doesn’t have appetite, movement physical appearance and other things.

The data also indicated that the issue of freedom that the government has championed is another factor that can have an effect on people getting HIV/Aids. Some respondents said that people get the virus because of the migration of foreigners. For example, respondent no. 9 said that “Since the end of apartheid there is a lot and lot of diseases”. People are also disturbed by the fact that doctors do not tell their relatives at an early stage that they are infected by the virus. For example, respondent no. 9 said “They keep the secret and when there are couple of weeks to die they tell you that you are infected“. Other people also raised the issue of using the same tooth brush with the HIV/Aids-infected person especially where there is blood transmission.

3.6.2 Theme 2: The respondents believe that HIV/Aids can be treated and prevented by means of traditional healers, one partner and trust and by medical doctors.

Although the majority of people prefer to prevent HIV/Aids by practising safer sex through using condoms, others are against this idea. The reason for this is that condoms are suspected of causing the disease rather than preventing it.

For example, respondent no. 7 remarked: “I just want to ask this, why the condom thing is uplifting the Aids epidemic instead of helping or preventing it”. The data
also indicated that people must have one partner and that there has to be trust between partners/husband and wife.

In terms of the issue of treatment, the data shows that the majority of people are concerned and even suggesting that HIV/AIDS people must be treated by traditional doctors like the sangoma especially those who heal people by means of using dead bones and those who heal by means of using their head (la ba bulayo). For example, respondent no. 3 said: “In my own knowledge I think the person when he or she is infected by the virus let them go to the sangoma, especially those who heal people by using their head”.

The respondents indicated that AIDS cannot be avoided because there is no trust between lovers. Some of them believe that AIDS can be treated by means of a prayer and putting your belief in God.

3.6.3 Theme 3: The respondents believe that AIDS was brought by migration of foreigners in South Africa

The data shows that there are some people who blame the government for ending apartheid as they think that AIDS might be caused by migration of foreigners such as the Nigerians and the Zimbabweans. For example, respondent no. 9 remarked: “Why since freedom do we have so many diseases like this?” (pointing on the table). Respondent no. 6 also added that it might be brought by foreigners. The developers of condoms are also blamed as it is thought that condoms might be causing AIDS. For example, respondent no. 6 said: “The condoms are not good because they are made by plastic and they are not safe at all and inside the condoms there is a flue like [sic] which combines with a person’s blood during sexual intercourse which causes a certain illness and then we say that is AIDS”.

3.6.4 Theme 4: The respondents believe that AIDS can be avoided by means of condom usage and traditional medicine

The data shows that people believe that they can get assistance or treatment by means of using traditional herbs and medical treatment. For example, respondent
no. 1 said: “Let people go to traditional healers: they will help them with traditional herbs”.

3.6.5 Theme 5: The respondents believe that youngsters are vulnerable to being infected by HIV/Aids virus

The data shows that each and everyone (whether young or old) can get the Aids virus. But young people are especially vulnerable to HIV/Aids. The other reason is that youngsters fall in love with older people (who may carry the virus) because of financial problems.

3.6.6 Theme 6: The respondents believe that apart from sexual intercourse people can also get the virus through accidents, injuries, football playing and needle stick injuries

Some of the respondents indicated that they thought people transmit HIV/Aids by means of accidents and injuries, where there is blood transmission from injured HIV-positive people (for example, when playing football).

3.6.7 Theme 7: The respondents believe that the majority of people that they know who died of Aids got infected through sexual intercourse

The data indicates that most people got infected through sexual intercourse although there are a few who got infected through mother-child transmission.

3.7 CONCLUSION

In conclusion, the data indicates that Aids manifests as sores that develop from the person's body inside and outside and people get Aids because they use contraceptives (which involve unsafe injections) and practise unsafe sexual intercourse. Other sexually transmitted diseases like exholasi and vuilsiek also play a major role in people getting the virus. People also blame the society for not following their cultural norms and values in terms of the epidemic. It was also found that poor background and financial constraints could also have an impact on
people getting the virus because younger people engage in sex with older people just to earn a living nowadays.

Respondents also mentioned that Aids can be treated by both Western medicine and traditional doctors in their team work and by also putting their trust to God who, they believe, brought the virus to earth. The respondents also believed that it would be good if the government were to deport the foreigners in this country because they are also suspected of worsening the epidemic.