THE CULTURAL CONTEXT OF HIV/AIDS IN SOUTH AFRICA

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SUMMARY

The HIV/AIDS epidemic in South Africa continues to grow at a rapid rate, and it is estimated that a total of 4.2 million people are infected with the virus. HIV/AIDS has been described as the biggest threat to the continents development, with severe economic, social and human impact. In South Africa, young people are considered a particularly vulnerable group, especially young women between the ages of 15 to 29 years, due to various predisposing biological, psychosocial and economical factors. Despite the numerous efforts that have been made at education and prevention, people's behaviour has been slow to change, and the disease continues to spread at an alarming rate. It has been reported that between 1998 -1999, there was a 65% increase in the prevalence of HIV in 14-24 year olds. It has further been estimated that 50% of our population could die of AIDS in the next 5 years.

This study was undertaken to research the cultural context of HIV/AIDS in South Africa, as the gap between knowledge about HIV/AIDS and behaviour change, with particular focus on our young African females. The study was based on present literature, research and media, which provided for an exploration of the cultural context of HIV/AIDS and how it applies to behaviour change. The respondents of the study were female pupils in Grade 11 at two African high schools, namely Northview and Soweto.

An exploratory study was conducted, in which 234 pupils responded to the questionnaire sent out by the researcher. The primary limitation being the scope of the study, as it was limited to only two schools and one particular grade. However, due to the population size, the sample can be representative of the broader population of urban black female adolescents.

The results showed that the respondents have knowledge about HIV/AIDS, however, numerous cultural contextual factors have impinged and shaped their risk-reduction behavior. The results therefore support the hypothesis that the cultural context is a key to understanding the gap between knowledge and behaviour change.

HIV/AIDS prevention, education and recommendations were discussed according to results from the study.

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CHAPTER 1

BACKGROUND TO THE STUDY

1.1 INTRODUCTION

AIDS is not only a medical disease: it is indeed also a social disease that sheds significant light on the characteristics of the society in which we live. The struggle of the medical community to provide an answer to the HIV/AIDS issue has placed an emphasis on the social sciences to address the crisis facing South Africa. Success in combating the disease evades us, and the list of unanswered questions regarding socio-behavioural dynamics continues to grow, with increasing recognition of the inherent complexity of the epidemic. The importance of understanding the complex dynamics of the epidemic is often overlooked, according to van Niekerk (1991), to the detriment of the formulation of appropriate preventative programmes. The need for this understanding is the core of what this researcher hopes to research, with particular attention to the cultural context around AIDS in South Africa.

It has come to the researcher's attention that there appears to be a gap between knowledge about AIDS and behaviour change. Despite the numerous attempts at prevention and education, it is now fair to claim that, as a threatening disaster with enormous consequences, AIDS is currently Africa's most serious problem.

In light of this, the researcher would like to explore various contextual issues underpinning AIDS in our society, such as: cultural beliefs and myths surrounding AIDS, general awareness about the disease, attitudes around HIV/ AIDS and risk-behaviour, access to resources and information, and the behaviours related to our particular cultural context that render individuals vulnerable to contracting the virus. By exploring these issues, the researcher hopes to gain a better understanding of the potential for these to have bearing on behavioural change. This research is therefore designed to understand some of the cultural dynamics underlying HIV/AIDS, and to appreciate the context in which this disease is on the increase, with reference to the literature in this study. HIV/AIDS does not exist in a vacuum, and therefore we need to understand its context if we are to be successful in intervention efforts.

According to Perkel and Strubel (1989) AIDS is a disease of attitudes and behaviours. Because we cannot control, cure or treat AIDS it is of utmost importance that the disease is prevented from spreading. In this context Kelly et al. (1989) indicated that the provision of information only will not result in the kind of behaviour change that is necessary to prevent the transmission of HIV/AIDS. In this regard, Kelly et al. (1989) asserts that a change need not occur only on the informational level, but also on the attitudinal and behavioural levels.

Over the past decade there has been little systematic behavioural research related to HIV/AIDS in South Africa, particularly at the broader national level. Therefore it seems vital to develop strategic approaches to prevention that recognise the broader

context of health behaviours. In a study conducted by the Department of Health (2000), it was noted that advanced epidemics such as AIDS in South Africa can no longer be seen to be affecting only clearly defined at risk groups where risk could be attached to particular sexual relationships and risk behaviours- for example, the epidemic amongst the homosexual community, or groups such as truckers, sex workers and injecting drug users. In this regard, it seems vital that research in the field of HIV/AIDS is inseparable from cultural, social and psychological issues.

Hence this research will focus on the cultural context of HIV/AIDS in our society, with particular reference to various factors that render our young population more susceptible to infection. By exploring the cultural context of HIV/AIDS, the researcher hopes to shed new light on our understanding of the gap between knowledge and behaviour change, thereby creating a new perspective for prevention and treatment that focuses on the context that informs an individual's behaviour.

1.2 MOTIVATION FOR THE STUDY

HIV/AIDS is a disease with deadly consequences. It is one that disproportionately impacts on South African children, adolescents and adults and, therefore it is of great concern for our country. The statistics on HIV/AIDS indicate that the disease is not only currently killing large numbers of our population, but that it will take an increasing toll on our young and our productive adult years in the future. In a recent article published in The Saturday Star (July 14, 2001), Seroke, author of the article

and chairperson of The Commission of Gender Equality, makes reference to reports from the Health Department which state that the highest HIV/AIDS rates are among women aged between 15 and 29. The statistics provided in the article indicate that during the period May 1994 to April 1995 there was an 80% increase in the number of HIV-positive cases, of which a large proportion were schoolchildren. This is a horrifying prospect, and it has captured our concerns, our commitment and our resources. AIDS has reached epidemic status in our country, and more and more people are risk to contracting this killer disease. There have been numerous preventative programmes developed to try and combat the spread of AIDS, however, they seem to be proving ineffective, as people's behaviour has been slow to change despite the amount of information prevailing on the issue.

There are many challenges associated with the development of more effective health promotion and prevention programmes, as well as service intervention programmes, associated with HIV/AIDS in South Africa. This study hopes to begin to meet the challenge by exploring the cultural context surrounding AIDS within our present day society, which may prove to be the key to understanding AIDS related behaviour i.e. the gap between knowledge and behaviour change. This study will therefore serve to contextualise AIDS within a cultural context, so that those working in the field will be better able to understand the complex dynamics that underpin this phenomenon. Thus, this researcher believes that we must begin to meet the challenge through more thoughtful attention to cultural beliefs and myths, people's awareness and attitudes, and the culturally informed behaviours within our present day context, that

make individuals vulnerable to infection. This comes about through increased cultural knowledge, attention to context, and the development of more effective programmes and skills. We cannot therefore develop more effective strategies for prevention and intervention until we understand the important role that the cultural context plays in South Africa.

Based on the knowledge that will be found in this study, new programmes can be developed that will accommodate and take into account the cultural context in which knowledge about HIV/AIDS and behaviours are formed. As we already know, AIDS is a social, medical and cultural issue. If we have a better understanding of the context in which our youths find themselves, then all those working in the field will be able to deal more appropriately and effectively with preventing further spread of the disease. This study can help create a more culturally competent understanding of the complex dynamics surrounding the disease within our society, with particular relevance to our younger population. In support of this, Seroke (2001) asserts that the reality of HIV/AIDS and oppressive cultural concerns speak of a physical battle for survival waged by the young and vulnerable in our society. Thus a study of this nature can help to protect our young from the factors within our social context that render them vulnerable and at risk to this devastating disease.

1.3 GOALS AND OBJECTIVES OF THE STUDY

In light of the above introduction, the following research question can be formulated: By exploring the cultural context of HIV/AIDS, can we find the key to understanding the gap between knowledge and behaviour change. For the purpose of this study, 2 groups of respondents were chosen from different contexts, so that they can be studied on two levels; as one relatively homogenous group in terms of age, gender, and race; and as two separate groups as they apply to their different contexts namely, Soweto and Northview. The aim of this study is not comparative, rather it is to explore the cultural context of HIV/AIDS in which the respondents live, so as to gain a richer understanding of the gap between knowledge and behavior change. Intervention has recently been focused on the youths in our society through various sources imparting information about HIV/AIDS, however, with the alarming growth in the number of infected or at risk youths, it would seem that people's behaviours have been slow to change.

Thus, this study aims to explore various factors that render our youths vulnerable to HIV infection. These include: background factors, levels of AIDS awareness and knowledge about HIV/AIDS, cultural beliefs and myths, attitudes towards HIV/AIDS and risk behaviours, access to resources and information, and lastly sexual behaviours informed by the cultural context in which our youths find themselves, so as to enhance our understanding of what is needed to bring about behaviour change thereby reducing the risk and vulnerability.

This study will therefore explore the cultural context underpinning HIV/AIDS in our society, so as to determine whether these various factors play a role in prevention, treatment and transmission of the virus. Furthermore the study will seek to explore the gap between knowledge and behaviour, by focusing on a group of urban black South African females between the ages of 14 and 20. This group was chosen for the purpose of this study as it has been identified as the main at risk group for contracting the virus.

In order to achieve this goal, the following objectives have been set:

1.3.1 To review relevant literature concerning HIV/AIDS in the South African context.

1.3.2 To use the literature study to formulate a questionnaire, which will be distributed to various school-going African female adolescents, so as to ascertain:

- awareness and understanding HIV/AIDS;
- attitudes towards the disease;
- perceptions around behaviours that put them at risk;
- the cultural myths and beliefs around HIV/AIDS within the South African context;
- access to resources and information; and

- what they perceive as being the way forward.

Thus, a quantitative approach will used, so as to capture data that can be analysed statistically and numerically.

1.3.3 To outline the related findings of the study.

1.3.4 To provide recommendations based on the findings from this study.

The research goal in this study is applied, as this study will help to generate solutions to problems and applications in practice. There is a dearth of information around HIV/AIDS in South Africa at present, however, there appears to be a need for information that can be applied to prevailing attempts at prevention, treatment and intervention in the area of HIV/AIDS.

The research objective that will lead to the aforementioned goal is exploratory. It is exploratory in the sense that the researcher wants to find out more about the cultural context, which shapes the individual, and how this could relate to behavioural change.

1.4 OVERVIEW OF RESEARCH METHODOLOGY

According to Mark (1996) research is a systematic method of enquiry. Drew (in Mark, 1996) states that research involves a quest for knowledge, one that is

conducted in a rational way using scientific methodology. Its purpose is to discover answers to questions and to accumulate dependable knowledge.

As mentioned the study will be quantitative in its approach. The researcher will make use of questionnaires so as to capture relevant data for the purpose of this study. The questionnaire will include: open questions, which will require of the participants to provide their opinions; closed questions, with an option to respond "yes" or "no", "true" or "false"; and statements on which the respondents were required to provide their opinions using a 4-point scale ranging from 'strongly agree' to 'strongly disagree'. According to De Vos (1998), the basic objective of such a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue, which in this case is the Cultural Context of HIV/AIDS in South Africa.

The research will make use of the following sample, by using the following individuals as the unit of analysis: black female adolescent's in Grade 11, from two High Schools, namely; one in Soweto and one in Northview, Gauteng.

The researcher has focused on this age group as it has been identified as one of the main groups at risk for contracting HIV/AIDS.

The data will be captured by means of a questionnaire, which will then be entered into a database and analysed statistically. Standard descriptive and inferential statistics will be employed to discover the trends within the group.

1.5 LIMITATIONS TO THIS STUDY

1.5.1 This research used a sample group of African adolescents, and as a result, many of the concepts under discussion may have lost their meaning, or been misunderstood by the respondents who had to answer in English, which was not their first language.

1.5.2 The questionnaires were distributed by the respective class teachers during the lesson and were collected by them after completion. This could have allowed for teacher involvement, interpretation or assistance. The researcher tried to control for this, by providing teachers with instructions on how to conduct the data collection, with their respective classes.

1.5.3 For the purpose of this study, a sample size of 234 respondents was used. This group consisted of grade 11 female pupils from the above-mentioned schools. This sample was appropriate within the scope of this study, however, due to the small sample its generalisability was limited.

1.5.4 Lastly, AIDS is not a disease that is openly spoken about due to the negatives perceptions associated with it, and the shame, guilt and blame that often accompanies the disease. More importantly, some believe that the disease does not even exist. These issues have the potential to make any study on AIDS difficult in terms of accessing peoples beliefs and opinions around HIV/AIDS. However, such issues if encountered, could prove to add more value to the study, which aims to explore the cultural context of HIV/AIDS in South Africa.

1.6 DEFINITION OF CONCEPTS

1.6.1 HIV

HIV is the abbreviation for Human Immune Deficiency Virus, which is believed to be causing AIDS. According to Riekstins (1995, p. 2) the CDC classification system for defining HIV-infection includes three separate groups. The criterion in group 1 do not always emerge in all individuals who contract the virus, as only certain individuals develop acute, glandular fever type symptoms soon after exposure to the virus and before antibodies are detected. Stage 2 involves the asymptomatic phase of HIV infection, with the serum testing positive for the HIV antibody. The asymptomatic or latent phase is followed by the experiencing of symptoms that are not persistent or continuous in their nature. Thus at stage 3 there are no indicators of opportunistic or secondary infections.

1.6.2 AIDS

AIDS refers to the Acquired Immune Deficiency Syndrome. According to Messinis (1995, p. 16) the Center for Disease Control stipulates that an individual may be positively diagnosed for AIDS when the patient has a reliably diagnosed disease that points to an underlying deficiency in the immune system which is not due to immunosuppressive drugs of any other immunosuppressive disease, and has been tested positively for the HIV antibody.

1.6.3 Vulnerability

According to Hubert and Delor (2000, in Walker & Gilbert, 2001, p. 11), the HIV/AIDS epidemic has been linked to the term 'vulnerability'. These authors offer a tripartite explanation of vulnerability consisting of entitlement, empowerment and political economy. In applying these concepts, they argue that all human beings are biologically susceptible to infection by different diseases such as HIV/AIDS, however, certain social and economic factors place some individuals and groups in situations of increased vulnerability. This study will focus on a particular group who are more vulnerable to the HIV/AIDS epidemic, namely, young female adolescents.

1.6.4 Culture

In any discussion of HIV/AIDS and behaviour, the centrality of culture cannot be ignored, according to Nduati and Kiai (1997), as culture is a significant factor in communication and behaviour.

Culture has been defined in different ways:

> Culture is a system of shared beliefs, values and customary behaviours and artifacts that the members of a society use to cope with one another and with their world and that are transmitted from generation to generation through learning (Bates & Plog, p. 466, in Mlungwana, 2001, p. 5).

Certain aspects of culture are pertinent in any deliberation on HIV/AIDS and behaviour. The basic consideration for the purpose of this study is that: "Culture constitutes the very matrix within which people formulate their ideas, within which they carry out their activities". (Borofsky, in Dissanayake et al., p. 22, cited in Nduati and Kiai, 1997, p. 52)

1.6.5 Cultural competence

Cultural competence provides systems, agencies and practitioners with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called Eurocentric. The word 'culture' is used and defined as "the integrated pattern of human behaviour that includes thoughts, communication styles, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or

social group". The word 'competence' is defined as "the capacity to function in a particular way"…. the skills and abilities to perform a set of tasks successfully (Cross et al., 1989). Thus, cultural competence can be defined as a set of congruent behaviours, attitudes, practices and policies that enable people or groups to work effectively in cross-cultural situations.

1.6.6 Behaviour

According to Fishbein (2000) the definition of behaviour includes at least four elements: the action (e.g. the using), the target (e.g. the condom), the context (cultural practices), and the time period in which the behaviour is observed.

The concept of 'behavioural change' is often thought of as the primary focus of HIV prevention work. However, for the purpose of this study, it is vital to view behaviour in the broader context of health behaviours.

According to Walker and Gilbert (2001), behaviour is to a great extent shaped by the environment and the social context in which people live. Therefore, these authors believe that freedom of choice with respect to life styles may be restricted by environment, which in turn will have bearing on a person's behaviour.

1.6.7 Adolescence

Adolescence is defined by WHO as the age between 15-24 years. Centers for Disease Control (CDC) define it as 13-19 years, while the American Academy of Pediatrics and Society for Adolescent Medicine define it as 13-31 years (Kunins 1993, in Nduati & Kiai, 1997, p. 7). The concern for adolescents is firstly, the 5-15 years age group is relatively free of HIV/AIDS and secondly, it is extrapolated from epidemiological data that two out of every three HIV infected individuals acquired infection during adolescence, according to WHO (Nduati & Kiai, 1997). Thus, the adolescents and youth have been identified as high-risk groups who need to be targeted specifically, so that they remain free from HIV infection.

1.7 OUTLINE OF THIS STUDY

The study is outlined in chapters as follows:

Chapter 1: Introduction

This includes, as already outlined, introductory background, motivation for the study, potential value of the study, goals of the study, overview of research methodology, limitations of the study and definition of concepts.

Chapter 2: Literature Review

The researcher consulted relevant available literature on HIV/AIDS. Due to the current nature of HIV/AIDS, the researcher focused her review on present literature and media. This enabled the researcher to become aware of and familiarise herself with a number of concepts and issues involved in HIV/AIDS with particular attention to the Cultural Context of HIV/AIDS as it applies to behaviour change and prevention.

Chapter 3: Research methodology and design

This chapter includes and explanation of the research design, population, sampling, measuring instrument and data analysis used in the study.

Chapter 4: Research results

Analysis of questionnaires completed by the respondents from Northview and Soweto are outlined in this chapter.

Chapter 5: Discussion, conclusions and recommendations

This includes, a discussion of the findings as laid out in Chapter 4 and an evaluation of the study with the aim of implementing the recommendations, as they apply in the field, in the broader context of HIV/AIDS and for future researchers.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

> Imagine a disease that is spread through sex, that has no symptoms, and may take a decade to show itself: a disease which initially seemed to 'prefer' marginalised and oppressed people, homosexuals and blacks, before moving into the whole population. Think of a virus which attacks the very cells that should order its destruction, which multiply, mutate and destroy, until many years later the host will die a cruel and wasting death (Crewe, 1992, p. 2).

The scenario outlined above seems hard to believe, and even more difficult to accept is that the origin and treatment of HIV/AIDS is still unknown despite medical advancement. It is therefore not surprising that the resulting phenomenon is clouded by conspiracy, prejudice, fear or disbelief, and that the reaction to the disease is discrimination, blame, and lack of ownership of it's existence.

Despite a decade of knowledge and intervention in an attempt to learn more about the virus, care for those infected by the virus, and educate and inform the public about the devastating effects of the virus, many lives are still being lost. In South Africa and elsewhere many still believe that AIDS does not really exist or that it only affects certain groups of people - gays and blacks. The most fundamental facts about HIV/AIDS remain misunderstood. This, according to many sources, is because the entire subject is shaped by a cultural agenda that is as medically misinformed as it is socially misleading and politically motivated. Why this disease

has captured the attention of academics, politicians, business organisations, social scientists, and the general public at large is related to its potential for massive social and economic disturbance. As a result, this disease has come to be described as, a 'killer disease', a 'slow plague', and in African culture, 'isidliso' or 'black poison'. The syndrome has now become the most studied disease in history and has spawned a host of journals, books, newsletters and conferences devoted to its study and monitoring.

However, despite the dearth of knowledge around this disease, the epidemic continues to spiral out of control and on an individual level, little has changed in terms of behaviour to ensure its prevention and spread.

It is crucial to approach AIDS as a disease of society, of political economy and culture - both of which can change - rather than simply a virus spread by individuals (Schoepf, 1991, in Webb 1997, p. 39).

2.1.1 Statistics

This paper engages some aspects of the HIV/AIDS epidemic and the complexities associated with it. Since the beginning of the AIDS epidemic 50 million individuals have been infected with HIV and over 16 million have died (UNAIDS, 1999). In 1999 AIDS deaths, internationally, reached a record 2.6 million with a further 5.6 million adults and children becoming infected (UNAIDS, 1999 in Walker & Gilbert,

2001). In 1990, one per cent of pregnant women attending antenatal services in the public sector in South Africa were HIV positive. Walker and Gilbert (2001) further note that by the end of 1999 this figure had risen to 22.4 per cent (Department of Health; Abdool Karim, 2000). Furthermore, it is estimated that over 15000 South African's are infected with HIV daily. Recent figures provided by The South African Health Review (2000), indicate that one in eight adults (15-49 years of age) is infected with HIV in South Africa. It is estimated that there are some 18 million South Africans under the age of 20 years, accounting for approximately 44% of the total population. In South Africa, young people are considered a particularly vulnerable group, especially young women, who according Jackson, Kerkhoven, Lindsey, Mutangadura and Nhara (1999), are disproportionately affected by HIV/AIDS: up to eight times more adolescent girls than boys are living with the disease. This paper hopes to explore the factors that are at play in rendering our young females vulnerable to this disease. Indeed, according to Collins and Stadler (2001), older youth have been described as 'the lost generation' in view of the fact that so many were involved in the struggle against apartheid and few had opportunities for education, skills development and appropriate socialisation.

Today, our post-apartheid government is faced with the incredible task of supporting the development of youth from formally disadvantaged communities - who have had little education, and been brought up in a climate of, violence, broken families, poverty, and oppression (Collins & Stadler, 2001).

2.1.2 HIV/AIDS in South Africa

From the data presented above, it is evident that the pattern of HIV/AIDS in developing countries, particularly South Africa, is unique. The features of this pattern are as follows; the epidemic is primarily a heterosexual one, the rates of infection of the general population are very high, and the percentage of HIV positive women is greater than men (Walker & Gilbert, 2001). An additional unique feature is the young age of onset of infection for women. This therefore demonstrates a need to focus our attention on young women and the factors underpinning their predicament.

Within this context of historical disadvantage and rapid social transformation, it is evident that a new adversity faces the nation. HIV/AIDS has already infected more than four million people and our former president Nelson Mandela described the pandemic as the new 'enemy' against which South Africa must struggle (Collins & Stadler, 2001). Once again, young people, and especially young women appear to be amongst the most vulnerable sectors of this population. The reasons for their vulnerability will be explored in this study with reference to culture and the cultural context in which the young women of today find themselves.

Marcus (2001) in her article 'Kissing the Cobra', describes HIV/AIDS as being socially as toxic as the cobra's venom for three reasons. Marcus (2001) asserts that HIV/AIDS is a generalised epidemic affecting millions of people. It strikes the very

act that is essential to survival and integral to human life, sex. And it strikes at those who are at the debut of this life long engagement - the adolescents and young adults for whom sex and sexuality is integral to their self-assertion as independent individuals and adult members of society.

More than 40% of South Africans are under 15 years of age. These young South Africans are at great risk of HIV infection. At the current rate of infection more than 50% of South Africans under 15 years today could die if AIDS related causes in the next five years. Moreover, many sexually active teens are making unsafe choices and hold attitudes that put them at risk for HIV infection (Hlongwa, 2001).

2.1.3 Behaviour change

Historically, HIV prevention programmes sought to alter sexual behaviour by providing information concerning disease management, health risks and condom distribution. However, these interventions are renowned for their persistently high failure rates, as it has been acknowledged, that information on its own plays a limited role in HIV management: AIDS knowledge does not directly translate into behaviour change (Hoosen & Collins, 2001) The provision of information will not lead to behaviour change, as behaviour is said to be rooted within culture and social history, and is conceptualised within social relations, according to Richter and Griesel (1998). As opposed to the biomedical and traditional psychological view points which have typically tended to be individualistic in their focus, current

approaches are moving towards more multi-dimensional perspectives, which considers the individual, social, and cultural spheres simultaneously in order to gain some meaningful understanding of sexual behaviour and achieve change.

There has been growing awareness that interpersonal ties, and social, political, cultural and economic factors play influential roles in HIV transmission and prevention (Hoosen & Collins, 2001). This realisation has lead to a shift to investigate social and cultural factors that promote or hinder behaviour change in specific social settings (MacPhail & Campbell, 1999), where the aim is to not only to provide information, promote individual behavioural change and the treatment of STDs, but also to encourage the development of social and cultural environments that enable behaviour change to take place, by taking into account broader dynamics which shape and constrain certain behaviours.

This is important because it shows that the specific content and approach of any intervention regarding HIV/AIDS needs to be tailored to the specific culture in which it is being implemented, and that we cannot simply import unmodified methods from developed countries (Campbell & Hayes, 1998).

It is in light of the above that this study draws attention to two important factors about HIV/AIDS in South Africa. Firstly, that one cannot focus attention on knowledge as being the key to behaviour change, as the one fails to acknowledge both the culture in which people live and the context in which the behaviour needs to

occur. For example, we can educate our youth about condom use, however, if the context does not allow access to such prevention methods, then how can we expect behaviour to change? Secondly, we can focus our efforts on encouraging the youth to use condoms, however, if ones culture is founded on male domination and long established patrilineal lines, where men are usually in charge and make important decisions for their family and community. How then can we expect young woman to speak out about insisting that their partners wear condoms, this, according to African culture would constitute a sin for which one would be hit or scalded. Traditional cultural practices, which inform gender role expectations, may be disconcordant with particular behaviours, and this could reduce woman's power to determine to determine their position (Strebel, 1992). This therefore raises many questions around trying to understand the gap between knowledge and behaviour, as it alludes to the need to explore the context and the culture in which behaviour change is meant to occur.

This research is designed to understand some of the social dynamics which underlie the context of HIV/AIDS, and to appreciate how this context should be engaged in the interest of promoting behavioural repertoires which are sustainable within the framework of everyday community realities. HIV risk exposure does not happen in a vacuum, and we need to understand its context if we are to be successful in intervention efforts (Kelly & Parker, 2000). In light of this, Lawson (1999), asserts that it will be impossible to introduce the fundamental changes required to master this pandemic so long as the interrelationships between HIV/AIDS, medical factors,

cultural and social values and human rights are not fully understood (1999, p. 1). This is supported by UNAIDS (2001), which states that individuals do not live in a vacuum, therefore, do not make decisions in a vacuum. As a result, after years of focusing on personal choices around lifestyles, by the early 1990s, AIDS prevention programs were giving renewed attention to the social and economic context of peoples daily lives – the context that shapes behaviour.

2.2 REVIEW OF SOCIAL RESEARCH

In developing an understanding of HIV/AIDS in South Africa, an extensive review of existing social research was conducted.

It is necessary for the purpose of this study to look critically at research previously done in the field of HIV/AIDS and behaviour change, as despite there being a dearth of information and research on the topic, little has changed in terms of the spread of the virus, behaviour change and intervention.

Based on a paper presented at the AIDS in Context conference held at Wits University in April 2001, Kelly and Parker (2001), assert that sustainability of behaviour change is contingent upon factors largely not within the scope of individual decision making. The knowledge, attitudes and practices of individuals, rather than the affordances of their environments, have been the primary concern of most social researchers, whilst the contextual determinants of behaviour have been

given scant attention. It has therefore been argued that research priorities need to move from a focus on individuals to a focus on the environment within which people live. Furthermore, it has been said that in a mature epidemic such as AIDS in South Africa, there is a need to move beyond awareness raising and to focus on providing information and resources that orient individuals, families, communities and social formations to appropriate forms of action (Kelly & Parker, 2001, p. 1). In support of this, Collins (2001) argues that in recent years, cognitive behavioural models of behaviour change have been criticised for a disproportionate emphasis on the individual, as well as failure to address social context. Furthermore, he believes that even those models that have made some reference to social environment such as the theory of reasoned action) have given little attention to social dynamics and relations that may limit an individual's autonomy to change or maintain certain behaviours. It is in light of this, that this study will attempt to explore contextual and cultural factors around HIV/AIDS with reference to Black females, so as to begin to understand the gap between that exists between knowledge and behaviour change.

In reviewing the social research on HIV/AIDS in South Africa a number of emphases and deficiencies in existing social and behavioural research were identified by Kelly and Parker (2001):

- Much of the work produced has been descriptive in nature, and has therefore not been designed to develop theoretical frameworks for understanding, or tools for intervention. According to these authors, the research has lead to

intervention derived from international frameworks, rather than from a local framework.

- There have been no significant South African attempts to establish common criteria for monitoring socio-behavioural responses to the epidemic, and therefore researchers have used diverse indicators such as describing condom use.

- There has been little research on social mobilisation, integration of services, service delivery and other crucial issues which impact on prevention and care efforts.

- The largest category of studies focuses on knowledge, attitudes, perceptions and behaviours of discrete and accessible groups such as school or university goers, sex-workers, truckers, and perceived high risk groups amongst others. Most of the research is framed in terms of individual choice, that largely assume that an enabling context or environment exists, as well as emphasising sexual behaviour over the many other behaviours and practices that are crucial to understanding HIV/AIDS.

It is this point that the present study will explore so as to enhance our understanding of HIV/AIDS by focusing on the socio-cultural context, thereby shifting away from highlighting individual choice, and rather looking at the cultural context in which

that choice is made. However, due to the constraints around this study, a discrete group will be used, namely young black females as they have been identified as the main at risk group within our society.

Even when behaviour change is explored from a cultural or social framework, there has been a tend toward treating the individual as the level of analysis, rather than the environment.

Lastly, much of the research that does exist is scattered in evaluation reports, subject specific journals, and theses, and according to these authors there have been few attempts to comparatively analyse the findings and take stock of what we know. For example, the creation of a website (Kelly and Parker, 2001. 'From people to places: prioritising contextual research for social mobilisation against HIV/AIDS').

Having examined some of the shortcomings of social research in the academic arena, the author will now provide a theoretical account of the context of AIDS in South Africa, so as to provide a framework in which to explore and understand the gaps between knowledge and behaviour change as they apply to young African females in our society. This study is based on the premise that behaviour is to a great extent shaped by the environment and the social context - thus, freedom of choice at an individual level may be restricted by the environment and the cultural context in which people find themselves.

2.3 AIDS IN CONTEXT

2.3.1 AIDS in first world versus AIDS in third world

It is important, that a distinction be made between AIDS in the First World and AIDS in the Third World - that there is a difference in the prevalence and spread of the virus and in the reactions and strategies to combat the disease. According to van Niekerk (1991), this needs to be looked at from a social point of view, as the distinction is one of social conditions, and it is this that generates the difference in AIDS-related beliefs and behaviour.

In the researcher's view, we cannot begin to conceptualise and understand AIDS in Africa without taking into consideration the sociocultural context of the beliefs and practices within which the disease is spreading. However, very few studies have taken into account the basic sociocultural factors in the comparative analysis of HIV-prevalence in Third World countries as compared to first world countries. In a third world country like South Africa, it would be dangerous to regard HIV/AIDS in the same way as in a modern first world country. In our South African society, we are a population of many cultures, we are a society still battling with the remains of apartheid, and most importantly our entire heterosexual population are at risk of being infected. This is different from First World countries, where the risk groups until now have been identified as mainly homosexuals and intravenous drug-users.

Whether the HIV/AIDS epidemic be regarded as Third World, African, or heterosexual, the very large population group in South Africa now at high risk has particular social characteristics and circumstances that do indeed make the HIV/AIDS epidemic a public enemy and the greatest threat to the public health of our society. It is the population outlined below and the unique contextual circumstances in which we find ourselves that are directly relevant to both the spread of AIDS and the strategies to combat the disease; they are the components that structure the real problem and overwhelming challenge of AIDS in South Africa.

The characteristics and circumstances of this population group can be sketched as follows (Van Niekerk, 1991):

2.3.1.1 Characteristics of the population at risk

- The people are predominantly black and demographically young: they have a low standard of education, occupational status and income levels; they live in poverty in urban or semi-urban townships, but have not been settled or established there for generations.

- They are highly and increasingly politicised; their daily lives have become disorganised, exposure to extreme disruption, crime and loss of life; they

have low-quality public services.

- Their normative structures have broken down to a large extent: there is little security in their personal lives or in communal living.

- It is under these conditions that an understanding and awareness of AIDS, on an individual and public level be established, in order to intervene in an effective way in helping to combat the spread of the disease.

2.3.1.2 Factors influencing the spread of HIV/AIDS

Walker and Gilbert (2001) outline a number of factors that have influenced the pattern and severity of the HIV/AIDS epidemic in South Africa. According to the report by Abt Associates South Africa (2000) these include:

- Established epidemics of other sexually transmitted diseases.
- Disrupted family and communal life, due in part to apartheid, migrant labour patterns and high levels of poverty in the region.
- Good transport infrastructure and high mobility, allowing for rapid movement of the virus into new communities.
- Resistance to the use of condoms based on social and cultural norms.
- The low status of women in society and within relationships.

- Social norms that accept or encourage high numbers of sexual partners, especially among men.
- Parallel norms that frown on open discussion of sexual matters including sex education for children and teenagers.

From the information presented above, it is evident that the pattern of HIV/AIDS in developing countries, particularly South Africa, is unique. The features are as follows, the epidemic is primarily a heterosexual one, the rates of infection in the general public are very high, and the percentage of HIV positive women is higher than men (refer to chapter 1). An additional unique feature is the young age of onset of infection for women. This demonstrates the need to focus our attention on young women and the factors underpinning their vulnerability.

Walker and Gilbert (2001), break this down further by positioning the above mentioned factors on a continuum from the 'macro' material-social environment such as the governments response to HIV/AIDS, living conditions, cultural-behavioural aspects related to life style and health behaviour, including knowledge, values and attitudes to 'micro' psycho-social/individual factors such as susceptibility, resistance, and coping resources.

An important feature of the context of AIDS in South Africa is the politicised and controversial response of our present government. The spread of HIV/AIDS has, according to Webb (1997), been mostly unhindered in South Africa, and it is

reasonable to propose that governmental intervention in the region has had very little impact on the course of the epidemic. The response of governments, in particular, have come under close scrutiny, and in relation to south Africa the verdict of academic analysts has been one of criticism (Zwi & Bachmeyer, 1990). In understanding epidemics, the role of key organisations in influencing people's behaviour is vital, and as a result one can then make sense of the crises we are facing on the macro and micro levels. Of all the countries in the Southern African region, the response of South Africa to the aids epidemic has been one of the most characterised by denial, ministerial wrangling, and the misallocation of resources thereby creating a debate fuelled by media hysteria, and shaded by political colourings (Webb, 1997). Despite South Africa having the fastest growing AIDS epidemics in the world, and more HIV positive people than in any other country, the governments response has been slow, stumbling and at times counter-productive (Skordis & Nattrass, 2001). What messages are then being communicated to our youth when adults in power and the ruling government deny that a state of crisis exists? The answer to this is rather clear when analysing data around AIDS in our country to find that many people do not see themselves as vulnerable, that many people are still seeing AIDS as a source of witchcraft or 'Idliso', and that traditional healers are prescribing muti that can 'cure' the killer disease. Why should people own the crisis, when our own government are not owning the problem, and example of this is provided by Ashforth (2001), who writes about the most notorious example of the hypocrisy surrounding the death of ANC Presidential spokesperson Parks Mkahlana in November 2000, who 'apparently' died from a long illness, despite

rumor that he in fact died from AIDS. What is all of this telling our youth of today?

We need to turn our heads to the situation in Uganda only to understand the role that our Government should play in combating the spread of the disease. Uganda's government was the first government on the continent to recognise the danger of HIV to national development, by taking active steps with the help of other groups in society to fight its spread they were able to bring down the HIV prevalence rate among 13-19 year old girls, increase the use of condoms, and promote later sexual onset (UNAIDS, 2000). This point highlights the notion that in order to tackle the fight against HIV/AIDS we need to focus on both the context and the culture which will lead to behaviour change- as ultimately, the success of efforts is determined by the dedication and efforts of the change agents who need to be constantly motivated, supervised and supported by the political leadership (UNAIDS, 2001).

With reference to the above, it is now well illustrated that at the behavioural level, personal choice is not always he main reason that a person becomes HIV-positive. Human behaviour is shaped by interpersonal, cultural, social and economic factors. Tackling HIV/AIDS therefore needs an approach that recognises all of these factors. According to Parker, Dalrymple and Durden (1998), there is thus a need to understand both individual behaviour as well as the complex social factors that lead to HIV infection and a need to develop strategies that are holistic and integrated.

The concept of 'behaviour change' is often thought of as the primary focus of HIV

prevention work and there are reasons for us to think critically about this. In particular, this study cautions against the assumption that individuals are largely empowered, both contextually and ideationally, to make proactive choices about their behaviours. There is much research that demonstrates that socio-economic and cultural factors considerably influence risk of HIV infection, and in the case of resource poor environments can, according to Kelly (2000), can dramatically limit personal empowerment and the ability to make safer choices.

In revisiting the concept of vulnerability, we must acknowledge again, that individuals do not live and make decisions in a vacuum. At a preventative level, the literature shows that programmes are now giving renewed attention to the social and economic context of people's daily lives - the context that shapes behaviour.

Many factors and forces have been identified that are said to restrict people's autonomy leaving them particularly vulnerable to HIV infection and needless suffering. In sum, these include: lower status of women, abuse of power by older, wealthier individuals - and in the case of young women this has resulted in the 'sugar daddy' phenomenon, scarcity of HIV counselling, testing and condoms, poverty or trafficking that leads to prostitution, domestic violence and rape, labour migration which splits up families, economic dependence of women and the use of sex for goods in return, lack of parental care, cultural taboos around sex, and inadequate access to health services - this list is a long one and varies from place to place and from group to group. Recognition of the factors that fuel the HIV

epidemic can prompt the development of new understandings and programmes for reducing vulnerability - in the civil, political, economic, social and cultural arenas - that could work in synergy with the more traditional prevention approaches aimed at diminishing risk-taking behaviour.

In elaborating on the above, the study will now take a more in depth look at the vulnerability of women in South Africa, with particular reference to those factors associated to context and culture that influence behaviour thereby hindering individual choice and informing a perspective on AIDS that takes into account the environmental factors in behaviour change. In this sense, the study of contexts, of place, is arguably more primary and important than is the study of people's behaviour (Kelly & Parker, 2001).

2.4 YOUNG WOMEN AT RISK - HIV/AIDS

On a global scale, the AIDS epidemic has been identified as an issue that impacts upon gender relations, so much so, that it has been referred to as a 'gendered epidemic' (Patton, 1994, in Hoosen & Collins, 2001). Studies indicate that women are economically, psychologically, and socially dependent on men and this influences the way in which AIDS affects women. It has been argued, that central to understanding women's vulnerability to HIV infection is their economic disempowerment, hence, the epidemic has also been described as the 'feminisation of poverty' (Hoosen and Collins, 2001, p. 3) as poverty places women at greater risk

as they need to exchange sex to meet the basic needs of their family members and themselves. Increasing unemployment and the need to provide for households further exacerbates women's vulnerability, according to Ankrah and Long (in Hoosen and Collins, 2001).

In support of this, Mlungwana (2001) provides the following reasons in explaining women's vulnerability to HIV infection:

> Women are biologically vulnerable: As a receptive partner, women have a larger mucosal surface exposed during sexual intercourse, moreover, semen has a far higher concentration of HIV than vaginal fluid.
>
> Women are epidemiological vulnerable: women tend to marry or have sex with older men who may have more sexual partners and hence are more likely to be infected.
>
> Women are socially vulnerable to HIV: men are expected to be assertive and women passive in their sexual relationships, whenever these social norms predominate, the result is sexual subordination and this creates a highly unfavorable atmosphere for AIDS prevention (United Nations, 1995, p. 20).

The latter two points are crucial in understanding the vulnerability of women to HIV/AIDS in South Africa, and will be further elaborated on for the purpose of this study.

2.4.1 Adolescence as an at-risk-group

Despite women in general being most vulnerable to HIV/AIDS, female adolescents in our society have been identified as most at risk to contracting the HIV virus. Adolescence has been defined by the World Health Organisation (WHO) as the age between 15-24 years (cited in Nduati and Kiai, 1997).

According to WHO (1992), adolescence is a period of profound physical and psychological change, during which young people learn to assume control of their own lives and make mature decisions in the light of the consequences for themselves and others. However, rapid changes in society - urbanisation, industrialisation, the spread of non-traditional values through mass media, transformation of values, the decline of the influence and support of the extended family - have given many adolescents a wider range of behaviour from which to choose, some of which may be harmful - particularly sexual behaviour. Thus, the WHO feel that young people need to be made aware of the potential consequences of such behaviour and to be helped to develop the skills and resources to help them.

Adolescent sexuality is associated with many adverse outcomes that include pregnancy, disrupted education, low-income, sexually transmitted diseases, health and developmental risks, and now HIV/AIDS (Nduati & Kiai, 1997).

According to developmental theory, adolescents are raised in a nurturing unit, which is usually the family or clan. These units set the spiritual, emotional and physical identity of the youth. The family therefore plays a vital role in setting the limits for behaviour. However, in South Africa, observation, experience and literature reflect a lack of information, and barriers in communication, because of the socially determined taboos, which serve to limit the parent's ability to counsel the adolescent (Nduati & Kiai, 1997). A second barrier is the observation that parents have a bigger impact on the younger adolescent while the older adolescents are influenced more by their friends or peers (Grant, in Nduati & Kiai, 1997).

Determinants of risk behaviour in adolescence therefore include developmental characteristics, biological and physio logical uniqueness, individual attribute and the influence of the environment (Grant, in Nduati & Kiai, 1997). The latter determinant will be explored further throughout this chapter, in an attempt to understand how the cultural context shapes or hinders behaviour change.

2.4.1.1 Adolescence in the African context

For the purpose of this study it is important to further expand on adolescence as it applies in our South African context. In the diverse African cultures, the passage from childhood to adult was marked with a variety of rites and specific customs (WHO, 1992). According to Nduati and Kiai (1997), customs serve as the important building blocks of each culture, as customary laws define the transition from

childhood to adulthood, and prescribe behaviours and roles that individuals should take. The African cultures taught that community was more important than the individual, and social integration takes precedence over individual interest. In contrast, western education and culture emphasises the individual, and teaches that personal goals take precedence over communal goals. Nduati and Kiai (1997), state that the process of traditional education imitation and observation of parents and community members in their various roles. With the current transformation and modernisation processes, parental employment away from the home and urbanisation has resulted in a dramatic decline in the exposure to cultural learning (Balmer, in Nduati & Kiai, 1997). In fact, some authors argue that the adolescent phenomena as experienced in South Africa today, is a creation of the westernisation and modernisation of the African Cultures, resulting in a vacuum which lacks clearly defined roles and values that adolescents can emulate (Webb, 1997 and Manuel, et al., 1998). Thus, the adolescent is left to find his/her own set of values and moral codes.

In addition, the adolescent in Africa has been exposed to political change, and now the spread of HIV/AIDS, families have been decimated and young people are called upon to be the heads of households. At the same time, due to the economic crisis and experience of poverty, adolescents have been affected in spheres such as education and meeting of their basic needs. The above-mentioned factors have resulted in a lack of common responsibility on social issues, for instance, the lack of clear

definition of who will undertake sex education and HIV/AIDS education for our youth.

The prevailing political, cultural, economic and social turmoil in South Africa have resulted in the emergence of the disempowered and demoralised adult society, that is complacent or helpless when faced with handling the issue of adolescent development, or with the HIV/AIDS epidemic (Nduati & Kiai, 1997).

Thus, in order to be able to develop programmes that address change in behaviour in our youth, it is important to have an understanding of the youth culture surrounding sexuality, their sources of information and the factors that influence them. This study presents a synthesis of literature and data so as to explore the cultural context of HIV/AIDS in South Africa, in our understanding of the gap between knowledge and behaviour change among our youth.

2.4.2 Contextual and cultural determinants of HIV/AIDS related behaviour

As illustrated above, young women in particular are especially vulnerable to HIV infection for a number of reasons. In attempting to understand the gap between knowledge and behaviour change, it is imperative to explore the contextual and cultural determinants of behaviour, so that one can better understand the spread of the HIV virus, and to begin conceptualising prevention from a different perspective - one that shifts focus from the individual in isolation to the context and cultures that

influence decisions and behaviour change.

2.4.2.1 Socio-economic factors

Poverty has been singled out as the main culprit responsible for the spread of AIDS in Africa (Mbeki, 2001). Within the framework of poverty, it seems that women are particularly affected resulting in higher rates of infection at an earlier age.

Unemployment rates are higher for women than for men, in all racial categories. In 1995, 47% of economically active African women and 29% of African men were unemployed, and on average, women earn between 72% and 85% of what men with similar education earn and continue to predominate in low skilled and low paid occupations (Walker & Gilbert, 2001). In addition, women are often **less educated** and less qualified and therefore have more difficulty in finding regular employment. This marginal position of women in the South African economy is in part because of their limited access to education. This is corroborated by recent figures from Statistics South Africa which show that "in one year, more than 17 000 babies were born to mothers 16 and younger. Of that number, 4000 babies were born to mothers under 14" (The Star Newspaper, March 4, 2000).

These figures indicate that young women are the poorest, most economically marginalised and least educated sector of the South African population thus placing them at the bottom of the health pile in this country, and rendering them particularly

vulnerable to HIV/AIDS, in terms of their race, gender and class position (Susser & Stein, 2000; Ndiaye, 2000 in Walker & Gilbert, 2001).

It can reasonably be argued, that men or women with a certain level of education, have greater access to information on HIV, its modes of transmission, and methods of prevention. However, data on the relation between HIV and educational level are still insufficient, but it appears that when young girls become sexually active, their education level does not necessarily lead to a standard of living that would allow them to adopt less risky behaviour, such as the systemic use of condoms, fidelity or abstinence, in a context where the behaviour of the partners has a powerful influence on the transmission of the disease (Lawson, 1999). In an attempt to draw correlations between sexual behaviour and education, UNAIDS (2000) analysed the results of studies conducted among 15-19 year olds in African countries. They found that as the level of education increases, some kinds of risky behaviour increase in frequency while other kinds decrease. Better educated girls tend to start having sex later, were far more likely to protect themselves by using condoms and had less casual sex. According to UNAIDS (2000), one thing is clear: education and information are fundamental human rights. When children and young people are denied the basic information, education and skills to deal with HIV - whether because of religious values, social mores or cultural preferences - they are much less empowered to reduce their own risk of infection.

Increasing unemployment and the need to provide for households further exacerbates women's vulnerability (Quirk & De Carlo, 1998). Most often the male

partner brings assets such as money, status and security to the relationship, and the female partner is usually dependent on these resources. As a result of the women's struggle to provide for their families, women are more likely to depend on a regular partner, have multiple partners for financial survival, and may be less able to insist on safe sea for fear of jeopardising the relationship (Strebel & Lindegger, 1998). If one considers the role of parents in terms of learning theories, then one can imagine what sort of message is being given to young women in terms of behaviour and roles.

Thus it appears that there is a strong link between low income, high unemployment, poor education and rates of HIV infection.

In all these dimensions, women emerge as the worst off (Walker & Gilbert, 2001).

2.4.2.2 Socio-cultural position of women

As previously mentioned, women are socially, economically and psychologically dependent on men, and this influences the way in which AIDS affects women (Hoosen & Collins, 2001). Compounding their biological vulnerability, women often have a **lower status in society** at large and in sexual relationships in particular - this having important implications on the spread of HIV. This gender vulnerability, according to UNAIDS (2000), is particularly acute for young girls.

Prior to explaining women's vulnerability in terms of sexual behaviour, it is necessary to provide a brief description of women's inferior position in society at large, with particular reference to traditional African perspectives.

Macheke and Campbell (1998), and Makhaba (1994) point out that the majority of traditional African societies are established along **patrilineal lines**, where men are usually in charge and make important decisions for their family and community. Traditional cultural practices, which inform gender-role expectations, may be disconcordant with condom use, and this could reduce women's power to determine their position. Furthermore, some Africans still believe in **polygamy**, and this has also proven to speed up the transmission of HIV. Lawson (1999) further states, that HIV is brought in by a polygamous man who works in the city but returns home to see his family. Women are thus more often victims than the active perpetrators of the infection. It is also common in many societies for older men to marry younger girls, and this again poses a risk for spreading HIV, as the men have previously been in other relationships. Related to this, is the social control of women in many communities, particularly over their sexual behaviour, as women and girls are regarded as child-bearers, whose duty is to perpetuate the lineage of the husband's family (Lawson, 1999). This control is said to not only exist between husband and wife, but also by a brother over his sister.

This coincides with the levirate system in many African communities, whereby, a woman forms part of her husband's property, and her reproductive potential belongs to his family (Lawson, 1999).

According to Lachenicht (1993), using condoms and other contraceptives functions in opposition to the African emphasis on fertility. In South Africa, childbearing in some societies is associated with positive social status and indications of worth. These views therefore can hinder any attempt at prevention the spread of HIV, and furthermore, act to increase young women's vulnerability in terms of their AIDS related behaviour.

This area of vulnerability was further explained in the paper, 'Shifting discourse- Teenage masculinity and the challenge for behavioural change (April, 2001, Author Unknown)'. This paper explored teenage gender relationships and sexuality in the context of the HIV/AIDS epidemic, with particular focus on masculinity and its relation to risk-taking behaviour. Related to this argument, the following points reinforce women's position in society, from a males perspective: boys see themselves as powerful, in control of relationships and sexual encounters and as holding the right to seek satisfaction for their own needs and any negotiation around these views is regarded as a threat to masculinity; a man is only a real man if he has several partners; there is no such a thing as 'no' from a girl; lastly, brothers and uncles are used as reference points and this further perpetuates the dominant discourse in society which leaves young women in a vulnerable position in society.

According to this article, effective behaviour change will occur if we are to challenge the dominant discourse of masculinity which is a barrier to much needed social change amongst the youth of South Africa. [Author unknown]

The general low status of women in society, renders then particularly vulnerable and denies them any real choice, in other words, this highlights the point that there are forces beyond the control of individual women which influence their capacity to alter or change individual behaviours - their own or their sexual partners. As Doyle (2000) suggests, gender differences are especially significant for women, since they usually involve discrimination and inequality, and nowhere is this more evident than in regard to the issue of HIV/AIDS in South Africa.

2.4.2.3 Sexual-cultural behaviours

The socio-cultural position of women in society has severe implications for the sexual behaviour of our young females, and it is the interplay of biological, cultural and economic factors that make young girls particularly vulnerable to the sexual transmission of HIV.

According to Ntlabati, Kelly and Mankayi (2001), it is important to understand patterns of **early sexual activity** in trying to understand HIV/AIDS in South Africa, as we need to recognise the high levels of early adolescent sexual activity within our present day context. Intervention strategies for youth have largely aimed at condom

use, and according to these authors, there is a need to reconceptualise high HIV risk adolescent sexuality as an environmental, social and cultural problem rather than as a problem located within the individual. Parker (1995) emphasises this by stating, "emphasis has been placed largely on individual determinants of sexual behaviour and behaviour change, and the diverse, cultural, economic, and political factors potentially influencing or even shaping sexual experience have more often than not been ignored" (1995, p. 261).

In describing the sexual context of behaviour among the African youths in our society, a number of important factors can be shown, which serve to highlight the abovementioned argument of behaviour change. Given women's limited power in society, women who refuse sex or insist on the use of condoms may be coerced into sexual activity, and given the imbalance of power relations between males and females, such coercion is often seen as acceptable behaviour. In such situations, the successful negotiation of safe sex is significantly low, and high levels of violence may be directed to women who suggest condom use or initiate discussion around HIV/AIDS (Hoosen & Collins, 2001). Another factor is that women may believe that their partners dislike condoms, and the attitudes of male partners toward condom use influences the likelihood of women introducing condoms into sexual relationships (St. Lawrence, 1998 in Hoosen & Collins, 2001). Women may also view condoms negatively in that they are unromantic, and sex is socially constructed as an expression of romantic love, and thus condom use is often also regarded as a sign of mistrust between partners (Strebel & Lindegger, 1998). Women may also be

constrained by fears of anger, violence and abandonment, as well as economic resources, if attempts to introduce condoms are made. As a result, women prefer to avoid condom use in order to maintain relationships. Thus, prevention strategies focusing solely on negotiating condom use may not be very effective, since it assumes equity of power between males and females thereby ignoring the cultural context the women find themselves in (Heise, 1995, in Hoosen & Collins, 2001 and Skinner, 2001).

In terms of our young females, girls are often more likely to be coerced into sex by older, wealthier men, where the power over them may be physical strength, social pressure to acquiesce to elders, and sometimes it is a combination of factors as may be the case with older 'sugar daddies' who offer school girls gifts or money for school fees in return for sex. In the era of AIDS, the consequences for young girls may be disastrous (UNAIDS, 2001). This raises the important issue of the need for money, linked to poverty. Webb (1997) terms this sociosexual phenomenon as **'transactional sex'**, implying some sort of exchange in return for sexual favors- money, food, drinks, favors, clothing - which is not classed as prostitution, more a socially sanctioned way of money distribution through the youth which is accepted as a fact of life once becoming sexually active. Webb (1997) quotes a young female from Soweto who stated, "parents don't have the means to maintain us, so we resort to guys who can provide us with clothing and food" (1997, p.130). Related to this, is the issue of **age-mixing**, which is another crucial factor, pushing up HIV rates in young women. If the girls sole sex partners were boys of their own age, they would

run little risk of becoming infected. However, UNAIDS (2000) reports that girls are having sex with older men who tend to be more heavily infected than younger males. While there are many cultural and economic reasons for this kind of cross-generational sex, the fear of HIV seems to be prompting some men to seek out partners they believe are less likely to be infected - younger girls.

A further important factor related to sexual behaviour and HIV/AIDS is **violence** directed against girls and women (UNAIDS, 2001). The relationship between violence and HIV is often indirect: the fear of violence makes it more difficult for females to refuse unsafe sex. In the case of sexual violence, the relationship can be very direct, like rape and coercion through violence which is extremely common in our society today. Sexual abuse in childhood is on the increase in South Africa, and this has many long-term consequences, apart from the immediate risk of HIV and other sexually transmitted diseases (UNAIDS, 2000). For example, UNAIDS (2000) makes reference to evidence that suggests that sexual abuse of young girls may lead them to taking sexual risks in adolescence, perhaps due to the fact that abused children have lowered self-esteem and find it harder to assert themselves in sexual negotiation in later life.

Teenage pregnancy is also an important feature of this discussion. Webb (1997) explains how with rapid urbanisation teenage pregnancy is becoming more socially acceptable, and less liable to cause stigmatisation. Therefore, one can see how early

sexual onset is increasing, as the social values and norms are becoming more accepting of teenage pregnancies (Glaser, 2001).

2.4.2.4 Breakdown in traditional structures

Lack of parental care has been highlighted as an important factor in HIV/AIDS, and with regards to teenage pregnancy. There are various explanations for this, but the one that seems particularly pertinent in the case of our African youths, is that African families have been experiencing breakdowns in their normal structures, due to urbanisation, change in family structures, and new array of pressures of traditional versus modern lifestyles (Webb, 1997). The parents interviewed by Webb (1997) in his study on African youths, saw themselves as being negligent in three ways: first, they did not see themselves as playing the role of educators for their children in terms of sexual behaviour; secondly, they reported that they were uncaring if their children's welfare due to domestic concern; and third, they did not see themselves as setting good examples for their children in terms of their own sexual behaviour.

This account raises important cultural issues, namely: that sex is often seen to be a cultural taboo and not discussed openly, therefore much regarding sexual behaviour is acquired through peers and personal experience. In support of this, Mbetse (2001), reports that children mostly take the cue from their peers about when it is appropriate to begin sexual experimentation, so that when others start 'doing it' it becomes normatively acceptable and decisions around sex will become mediated by

this, even when there is no strong individual desire. This has raised important issues with regards to peer education in AIDS prevention, in that values and risk judgments are made in relation to the attitudes and behaviours of peers, especially in the formative years of teenage and adolescence. In support of this, Friedman (1993) draws our attention to a commonly held myth in many African contexts, in which young people are viewed, as being sexually promiscuous by nature and that providing them with information about sex, will make them more sexually active. Thus, South Africa now has to deal with the consequences of its silence around sexuality and HIV/AIDS, and more so, we are also facing the consequences of shifting values and the failure to provide bridges to assist young people to cope within a modern context (Mlungwana, 2001). Social values especially those of African cultures, have been going through transformation, and according to Mlungwana (2001), this has had a negative impact on the lives of African youths, because the structures that served vital roles of nurturing the social and psychological growth of teenagers were abandoned, in favor of western ways of doing things. Delius and Glaser (2001), further describe the transformation in values that is occurring within the African Culture. These authors state that in the past, African communities were relatively open in their recognition and discussion of sexual issues. The power of adolescent sexual activity was recognised and techniques such as limited intercourse, and controls such as virginity testing existed to help minimise the socially destructive dimensions of sexual issues. However, in the 20th century, these forms of sexual socialisation have crumbled, leading to an increase in teenage pregnancy, sexual coercion, and violence (Delius & Glaser,

2001). As a result, peer groups now urge for greater levels of sexual experimentation and helped to entrench models of masculinity that celebrated the conquest and control of young women (Delius & Glaser, 2001).

Thus, according to Mlungwana (2001), we need to recognise the social circumstances of the African youths, and further acknowledge that concepts such as independence, assertiveness and personal choice are enshrined in a western lifestyle, and form the core of the person. Whereas the identity of the African person, is intertwined within that of the group and is found within concepts such as interconnectedness, and collectivism.

In conclusion to this point, the author makes reference to the recent *Yizo Yizo* controversy which, if anything, has highlighted the profound breakdown in communication between youth and their parents. According to Glaser (2001), few parents seem willing or able to confront awkward issues around sexuality, and as a result, more than ever before, it seems youths are being left to negotiate their sexuality on their own.

2.4.2.5 Cultural practices and behaviours

In both developed and less developed countries, adherence to a set of cultural behaviours and practices help explain the reasons why some people are more at risk for contracting HIV/AIDS. Anthropologists refer to the traditional practices in Africa as sociocultural practices, and identification of these practices can help to

explain a number of problems specific to women which may promote behaviour conducive to the spread of HIV/AIDS.

The transmission of HIV through traditional practices such as circumcision, the sexual mutilation of women, ritual sacrifices and various skin perforations performed by traditional healers during ritual ceremonies for the protection of the women and perhaps even her unborn child, should be studied closely asserts Lawson (1999), as such practices are tending to be seriously challenged by the very development of the epidemic.

The practice of dry sex has also become deeply concerning in terms of the HIV epidemic, as it has become common practice among women to insert herbs or powders to tighten their vaginas so as to enhance male sexual satisfaction (Halperin, 2001). Such behaviours increase the likelihood of becoming infected by the HIV virus, and therefore, we need to take all the abovementioned practices into account if we are to understand risk-reducing behaviour changes.

In view of the above contextual and cultural description of the environment of individual behaviour change, it is in this author's view, that the understanding of HIV/AIDS in South Africa cannot be understood without taking into consideration the sociocultural context of the beliefs and practices within which the disease is spreading. Furthermore, we can no longer adopt the previously held simplistic focus on changing individual behaviour patterns based on the early framing of HIV/AIDS

as an individual health issue. From what we have seen above, it is evident that people's behaviours are to a great extent shaped by the environment and social context in which they live, and the present South African context is not proving conducive to behaviour change. Thus, in order to understand the relative failure in the prevention of HIV/AIDS transmission, we need to critically analyse the behaviour theories which have tended to focus on the individual making the decisions, and to rather explore the possibility that it is the cultural context in which the decisions are being made that leads to the perpetuation of the epidemic in South Africa.

For the purpose of this study, the author will now provide a brief critique of the behaviour theories underpinning present studies and preventative programmes in the field of HIV/AIDS in South Africa.

2.5 CRITIQUE OF BEHAVIOUR THEORIES

Traditionally, AIDS interventions have operated on the assumption that conveying knowledge and information about HIV/AIDS will lead to behaviour change. People were therefore assumed to move through a continuum beginning with knowledge, moving to attitude change and ultimately to behaviour change. However, with regards to the AIDS epidemic, providing people with knowledge about HIV/AIDS and its transmission alone, has shown to have little impact on attitudes and behaviour (Usdin, et al., 2001). The concept of 'behaviour change' is still often

thought of as the primary focus of HIV prevention efforts, and the following two models have been commonly used in trying to understand behaviour change:

- Theory of Reasoned Action, which argues that behaviour change, is ultimately the result of changes in beliefs (Fishbein, 1975, in Mlungwana, 2001). According to this model, a belief underlies and determines a person's attitude. This theory has been developed into the well-known 'knowledge, attitudes and practice' approach to achieving behaviour change. This model assumes that human behaviour is the result of objective, logical thought processes, and the decision to take action concerning health issues is determined by the person's readiness to take action because of the perceived benefits of the action weighed against the perceived cost and barriers (Salazar, 1991).

- Theory of self-efficacy, which is based on the premise that the expectation of personal mastery and success determines whether or not the individual will engage in a particular behaviour (Bandura, 1982). According to this theory, the types of expectancy exert a powerful influence on behaviour. For example, outcome expectancy is the belief that certain behaviours will lead to certain outcomes, and self-efficacy is the belief that one can successfully execute the behaviour required to achieve the outcome (Mlungwana, 2001).

Seidel (1996, in Mlungwana, 2001), criticises these models for being rationalist, and for assuming that individuals are in a position to make choices in their own best interests. For example, in light of the information a woman is given, and her beliefs or attitudes, she will choose a healthy behaviour. This model therefore does not take into account the social circumstances in which she lives. Personal choice as discussed is not always a simple matter, as human behaviour is shaped by interpersonal, cultural, social and economic factors. Thus, this woman may have to choose between securing a life for herself that her family cannot provide, and having sex with a man who may be HIV infected. This example highlights the fact that there are many societal and cultural factors that influence choice. Social norms and susceptibility to these norms are key processes through which the social environment impacts on individual behaviour. Thus, according to Usdin et al. (2001), shifting social norms is a particularly important factor in behaviour change, especially amongst young people who are vulnerable to HIV/AIDS.

UNAIDS (2000) have called for a new framework for HIV/AIDS that moves away from focus on the individual, to a focus on contexts that influence behaviours such as: socioeconomic status, government policy, culture, and gender. This new way of thinking heralds a shift away from a focus on individual behaviour change alone, towards a more social and interpersonal approach, which conceptualises individuals within a web of social norms and cultural values, and aims to facilitate an environment that supports and sustains behaviour change (Usdin et al., 2001).

2.6 THE WAY FORWARD

The research shows that youths are responding to the challenge of prevention, although many obstacles confront them in the form of poor environmental provision, manipulative relationships born of poverty and gender, and a number of other factors as outlined above, that, according to Kelly and Parker (2001), are not easily remedied by education alone. Thus, these authors assert, that we need to be more probing in our understanding of these issues and to do this; we need to understand how all of these factors interact in context, to produce the outcomes we wish to change.

The notion of behaviour change is readily internalised by program developers, strategists, sectoral leaders, politicians, governments, social scientists and the like. However, genuine understanding of the limitations of behaviour change theories and interventions within poorly resourced contexts are uncommon. This, according to Kelly and Parker (2001), has had the unfortunate consequence of perpetuating inappropriate and costly interventions, with little regard for the necessary supporting activities at a social level. "This has had the further effect of placing us behind the epidemic, rather than in front of it" (Kelly & Parker, 2001, p. 1).

The complexity of both the social, cultural context of the epidemic and the responses, which it has generated, underlines the need for prevention programs to be developed in our society. Furthermore, Jemmott et al. (1999) conclude that the

statistics highlight the pressing need to develop effective behavioural interventions to dissuade adolescents from engaging in HIV-risk associated sexual behaviour, by using cultural sensitive intervention strategies that take the context into account.

Various solutions have been proposed in terms of this challenge. These include: educating the youth from a culturally relevant perspective and not from a western import, educating young girls in particular from within their frame of reference, government policy to protect the youth, working around male discourse, empowering women in society and developing their assertiveness, working with adults and parents in opening up communication channels and providing the bridge for African adolescents so that the shift from traditional to modern society be made safer and easier.

In addition to these solutions, the findings from Sentinel Site Monitoring and Evaluation Project - Stage two report, "Contextual mediators of youth response to HIV/AIDS" (2000), suggest the following: firstly, behaviour change models which try to encourage safer practices, need to be complimented by initiatives aimed at creating contexts of change, and communities of practice which are conducive to desired behavioural outcomes. Secondly, appropriate resources need to be deployed or promoted, as behaviours are contingent on the availability of resources for action. Given that individual behaviours always depend upon practical and material conditions, behaviour change models need to be supported and sustained by changes at a structural level where such conditions are determined. Thirdly, the solution to

the need to develop more active and sustainable responses to the epidemic lies in the creation of contexts for change. Lastly, this project suggests that the society as a whole needs to be mobilised to a much greater degree to develop responses to HIV/AIDS. Apart from the context specific issues and mobilisation, there is a need to mobilise a supportive national context, whereby, intervention takes place at both micro and macro levels.

Webb (1997) provides a valuable contextualisation, of the link between context and the individual, through the process of empowerment. The term 'empowerment' is frequently used in Social work efforts within our South African context, and it would therefore seem greatly fitting in any attempts at facing the HIV/AIDS challenge. According to Webb (1997), two themes emerge in HIV/AIDS prevention and intervention: that of behavioural empowerment, and structural empowerment. For example, behaviour empowerment will allow girls and women to have more control over decision making, thereby rendering then less vulnerable to infection. Structural empowerment is the improvement of the various structures that render women vulnerable, such as socio-economic position of women, the family, discourse and more. However, the importance here is that the two need to occur simultaneously, in order to create behaviour change.

One of the recommendations of the most comprehensive HIV/AIDS study in South Africa, was that, "finding ways to protect young girls must be given the highest possible priority" (Gilgen et al., in Walker & Gilbert, 2001, p. 22). This study hopes

to begin to meet this challenge as it focuses primarily on this particular group, with the aim of exploring the contextual factors that make young girls vulnerable to infection and risk behaviours.

The basic premise underlying these potential solutions is the need to consider context and culture in terms of understanding the gap between knowledge and behaviour change.

2.7 CONCLUSION

In conclusion it can be safely said that given the above illustrations, studies of behaviour can never explain the complexities of response to HIV/AIDS. In this sense, the study of contexts, of place, is arguably more primary and important than the study of people's behaviour.

In summary, this research has argued that the concept of 'behaviour change', which is often thought of as the primary focus of HIV prevention work, must be critically reviewed. This study further points out that we should be cautious in assuming that individuals are empowered to make choices about their behaviour, including sexual practices. There is much research that demonstrates that socio-economic and cultural factors considerably influence risk of HIV infection, and, in the case of resource poor environments, can dramatically limit personal empowerment and the ability to make safer sexual choices. These factors as laid out in this chapter, include: poverty,

urbanisation, unemployment, inferior social positions of women, shifting values, modernisation, male discourse, adolescent sexual behaviours, break down in traditional structures, amongst others. By considering these factors as they manifest in context, strong priority is given to place rather than behaviour as a unit of analysis. In this sense, Kelly and Parker (2001) state that behaviour be seen as an outcome or symptom. In addition, this study undertook a review of existing literature in the field, and provided suggestions for the way forward. In light of the above, the results of this study can provide further recommendations, and cast further light on our understanding of the gap between knowledge and behaviour change.

> Every young person that is reached by an HIV/AIDS prevention message and who successfully adopts safe patterns of behaviour is a saved life. Our children and our youths are the most important resource that our nations have and we owe it to them to create an environment in which they can learn skills that will help them negotiate life successfully in this era of HIV/AIDS (Nduati & Kiai, 1997, p. 222).

CHAPTER 3

RESEARCH METHODOLOGY AND DESIGN

3.1 INTRODUCTION

In this chapter, the researcher will present the methodology and the procedures followed in this study. According to Mark (1996), methodology should entail decisions about population, sample, research design, data collection methods and data analysis procedures. The methodology that will be followed in this chapter will focus on the above mentioned aspects. In light of the following statement made by Macintyre (2001), " by focusing on people, and their biographies and perceptions, we become more aware the role of agency, power and culture in shaping how people use or fail to use local opportunity structure", the methodologies used in this study are applicable to understanding culture and behaviour change with reference to the AIDS epidemic in our society.

3.2 RESEARCH DESIGN

A research design is defined by Thyer in De Vos (1998, p. 77) as a -

> blueprint or detailed plan for how a research study is to be conducted - operationalising variables so that they can be measured, selecting a sample of interest to the study; collecting data to be used as a basis for testing hypotheses, and analysing the results.

Thus, the research design refers to all of the decisions made about how a research study is to be conducted.

Rubin and Babbie (1993, p. 330) further points out that research design can be classified according to their purpose. The research design used in this study is classified by De Vos (1998) as exploratory, as it seeks to describe a particular phenomenon thoroughly, the purpose being to develop ideas and theoretical generalisations.

Rubin and Babbie (1993, p. 30) explain that there are two research approaches: quantitative methods and qualitative methods. Quantitative methods emphasise the production of precise and generalisationable statistical findings. When we want to verify whether a cause produces an effect, we are likely to use quantitative research methods. When we are wanting to emphasise depths of understanding, the attempts to tap the deeper meanings of human experience and that tends to generate theoretically richer observations which are not easily reduced to numbers, we generally use qualitative methods.

For the purpose of this research project, the researcher has chosen to employ a predominantly quantitative approach. The quantitative approach will produce numerical and factual data that will provide for a statistical and numerical analysis of the phenomenon of HIV/AIDS, which is being explored in this study.

3.3 POPULATION

Mark (1996) defines population as the collection of all individuals, families, groups, organisations, communities and events that we are interested in finding out more about. This study is aimed at exploring the cultural context of HIV/AIDS in South Africa, as the potential gap between knowledge and behaviour change, with particular reference to black females between the ages of 15 to 19 years, as this group has been identified as being most at risk to HIV/AIDS for reasons outlined in chapter two of this study. Thus, for the purpose of this study, the population will consist of 234 female pupils in Grade 11 at two African high schools, namely, Northview and Soweto.

3.4 SAMPLING

According to Arkava and Lane (1983), a sample is the element of the population considered for actual inclusion in the study. In other words, we study the sample in order to understand the population from which it comes. This research will therefore study a sample of black females in Grade 11 whose ages are between 15-19 years. This sample will be representative of the broader population of urban black female adolescents- a group that has been described as being most at risk to HIV infection, for reasons outlined in chapter two of this study. It is important to note, that due to the scope of this research study, it may not be possible to use a sample that will be

generalisable to the whole population, and therefore, the accuracy of the findings are subject to the scope of this study.

Sampling also focuses on concepts such as homogeneity and heterogeneity. On the outset, one would assume that youths are a heterogeneous group, however, in a study by Hlongwa (2001), she reported that there are more similarities in youth lifestyle than there are differences. This author was able to arrive at such a finding based on research in which she compared the lifestyles of urban and rural youth, therefore covering diverse areas and groups. In light of this, the present author hopes that her sample will be appropriate in terms of homogeneity and representativeness.

For the purpose of this study, non-probability sampling was used. According to Grinnell (1988, p. 133), this sampling procedure is suitable to studies where the interest is to obtain as much unique data on a research question as possible.

The type of non-probability sample procedure used is purposive or judgmental sampling as this allows the researcher to select the sample on the basis of his/her own knowledge of the population, its elements and the nature of the research aims. De Vos (1998) highlights, that this type of sample is based entirely on the judgment of the researcher, in that such a sample is composed of elements which contain the most characteristic, representative, or typical attributes of the population. The typical respondents required for this sample are black female high school students. The researcher therefore chose Grade 11 female pupils from two schools in different

contexts, i.e. Gauteng and Soweto. The researcher chose these schools specifically, based on her judgement of this group being most characteristic of the population of modern youths in our society. Based on the research question of this study, which seeks to determine whether context shapes behavior change, this particular sample was chosen. The sample will provide for an analysis on two levels; firstly, as one group, and secondly, as two separate groups, from two different physical contexts. The researcher hopes that such analyses will provide for a richer exploration of the cultural context of HIV/AIDS, and whether exploring the different contexts can add value to our understanding of behavior change.

3.5 DATA COLLECTION METHOD

It was decided that a suitable data collection instrument for this study was group-administered questionnaires. In this case respondents in a group complete a questionnaire on their own. According to De Vos (1998) each respondent should preferably receive the same stimulus and complete his/her own questionnaire without discussion with the other members of the group. For the purpose of this study, the questionnaires were distributed by the respective class teacher and were completed within class time, with the teacher present. The teachers were provided with instructions from the researcher on how to conduct the data collection method, so as to ensure consistency between the schools and the classes and to avoid teacher bias.

The definition of a questionnaire according to the New Dictionary of Social Work cited in De Vos (1998, p. 152) is "a set of questions on a form which is completed by the respondent in respect of a research project". The basic purpose of using this method is to obtain facts and opinions of the respondents about HIV/ AIDS. The questionnaire included both open ended and closed ended questions, and was guided by the available literature on the subject (Chapter 2).

According to De Vos (1998) it is essential that newly constructed questionnaires be pilot-tested before being used in the main investigation. This ensures that errors can be rectified, and the necessary modifications can be made before presenting the questionnaire to the full sample. For the purpose of this study, the questionnaire was pilot-tested, and in this manner the researcher obtained a general impression of the feasibility of the questionnaire and the data that was obtained.

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3.6 DATA ANALYSIS

De Vos (1998) describes analysis as a reasoning strategy with the objective of taking a complex whole and resolving it into its parts. Using the research methodology and design described in this Chapter, it was possible to conduct the research, which rendered the results following in Chapter 4. By means of statistical analysis, the contextual variables and factors relevant to the understanding of the AIDS phenomenon were isolated, interpreted and reported. The SPPC data analysis programme was used to analyse the data. Univariate, bivariate, linear and correlation

analysis was used to describe the data. The researcher then presented the data (Chapter 4) in an organised manner that permitted conclusion drawing and created the basis for thinking about its meaning in terms of the research question.

3.7 CONCLUSION

The focus of this chapter was the research procedures followed in this study, these included: decisions about population, sample, research design, data collection methods and data analysis procedures.

The implementation of the above methods led the researcher to obtain data which will be presented and analysed in the next chapter of this study.

CHAPTER 4

RESEARCH RESULTS

4. INTRODUCTION

This chapter will show the research findings on the cultural context of HIV/AIDS in South Africa as the potential gap between and behaviour change, and how these findings related to the objectives of the study and the theory discussed in chapters 2 and 3.

A questionnaire was administered to grade 11 females in two predominantly African high schools, namely one in Northview, and one in Soweto. The total number of respondents being 234, of which 116 were from Northview and 118 from Soweto.

The questionnaire consisted of six sections (see Appendix A).

1. Background information.
2. AIDS awareness. Access to sources of information and resources.
3. Perceptions around behaviour.
4. Myths and beliefs.
5. The way forward.

For the purpose of this study, the questions will be analyzed, as they apply to the group of respondents as a whole, and where significant differences are evident

between the Northview respondents and the Soweto respondents they will be reported, so as to link to the hypothesis of this study.

4.1 FINDINGS OF QUESTIONNAIRES

4.1.1.a Section 1: Background information

Table 4.1: Respondents involved in the study

School	Group	
	Frequency	%
Northview	116	49.6
Soweto	118	50.4
TOTAL	234	100

4.1.1.b Section 1: Age of Respondents

Table 4.2: Frequency distribution of respondents' age

Age					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	13.0	2	.9	1.2	1.2
	14.0	4	1.7	2.4	3.7
	15.0	5	2.1	3.0	6.7
	16.0	41	17.5	25.0	31.7
	17.0	42	17.9	25.6	57.3
	18.0	35	15.0	21.3	78.7
	19.0	24	10.3	14.6	93.3
	20.0	9	3.8	5.5	98.8
	21.0	2	.9	1.2	100.0
	Total	164	70.1	100.0	
Missing	System	70	29.9		
Total		234	100.0		

From Table 4.2, the youngest respondent was 13 years old, and the oldest respondent was 21 years old. The average age of respondents was 17 years old. As can be seen from above, 57% of the respondents were 17 years and below, and 78% of the respondents were 18 years and above.

It is important to note the missing rate of 70, as this table therefore reflects only 164 of the 234 respondents who answered the questionnaire. The reason for this is unclear.

4.1.1.c Section 1: Home language

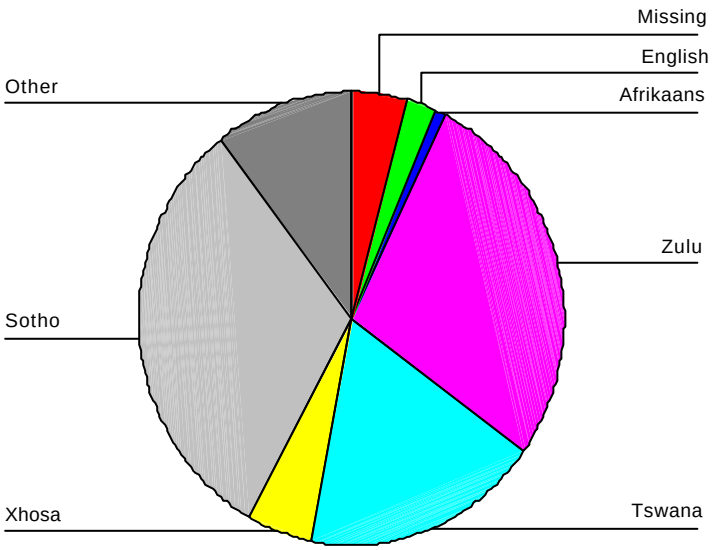


Figure 4.1: Pie chart describing home language

From Figure 4.1, it can be seen that the most common home languages used are Sotho (32.6%) and Zulu (29.0%).

4.1.1.d Section 1: Family members living at home

Table 4.3: Frequency distribution of family members living at home

Family Members	Yes		No		Total	
	Count	%	Count	%	Count	%
Mother	154	65.8	80	34.2	234	100
Father	100	42.7	134	57.3	234	100
Brother(s)	118	50.4	116	49.6	234	100
Sister(s)	118	50.4	116	49.6	234	100
Grandparent(s)	67	28.6	167	71.4	234	100
Other	28	12.0	206	88.0	234	100

As can be seen from the above Table 4.3, there is a high number of mothers living at home, followed by brother(s)/sister(s) and then fathers.

However, the following tables will represent a cross tabulation between the Northview respondents and the Soweto respondents, in which significant differences were found.

Table 4.4: Cross tabulation of mothers living in the home

			Group		
			Northview	**Soweto**	**Total**
Mother	**Yes**	Count	92	62	154
		% Mother living at home	59.7%	40.3%	100.0%
	No	Count	24	56	80
		% Mother living at home	30.0%	70.0%	100.0%
Total		Count	116	118	234

Table 4.5: Chi-square tests of mothers living in the home

	Value	**Df**	**Asymp. Sig. (2-sided)**	**Exact Sig. (2-sided)**	**Exact Sig. (1-sided)**
Pearson chi-square	18.628[2]	1	.000		
Continuity Correction[1]	17.458	1	.000		
Likelihood Ratio	19.030	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	18.549	1	.000		
N of Valid Cases	234				

From Table 4.4, it can be seen that the majority (59.7%) of respondents who answered 'yes' were from Northview, and the majority (70%) of respondents who answered 'no' were from Soweto. Thus more of the respondents from Northview have their mothers living at home. From Table 4.5, a significant difference is evident between the two groups, as the p = 0.000.

Table 4.6: Cross tabulation of fathers living in the home

			Group		
			Northview	**Soweto**	**Total**
Father	**Yes**	Count % Father living at home	61 61.0%	39 39.0%	100 100.0%
	No	Count % Father living at home	55 41.0%	79 59.0%	134 100.0%
Total		Count	116	118	234

Table 4.7: Chi-square tests of fathers living in the home

	Value	**Df**	**Asymp. Sig. (2-sided)**	**Exact Sig. (2-sided)**	**Exact Sig. (1-sided)**
Pearson chi-square	9.122[2]	1	.003		
Continuity Correction[1]	8.341	1	.004		
Likelihood Ratio	9.185	1	.002		
Fisher's Exact Test				.004	.002
Linear-by-Linear Association	9.083	1	.003		
N of Valid Cases	234				

From Table 4.6, it can be seen the majority (61%) of the respondents who answered 'yes' were from Northview, and the majority (59%) of the respondents who answered 'no' were from Soweto. Thus, more often respondents from Northview have their fathers living at home, in addition to their mothers, as shown in Table 4.4. This is confirmed in Table 4.7 which indicates a p value of 0.002, showing a significant difference between the two groups.

Table 4.8: Cross tabulation of grandparent(s) living in the home

			Group		
			Northview	**Soweto**	**Total**
Grandparents	**Yes**	Count	15	52	67
		% Grandparent(s)	22.4%	77.6%	100.0%
	No	Count	101	66	167
		% Grandparent(s)	60.5%	39.5%	100.0%
Total		Count	116	118	234

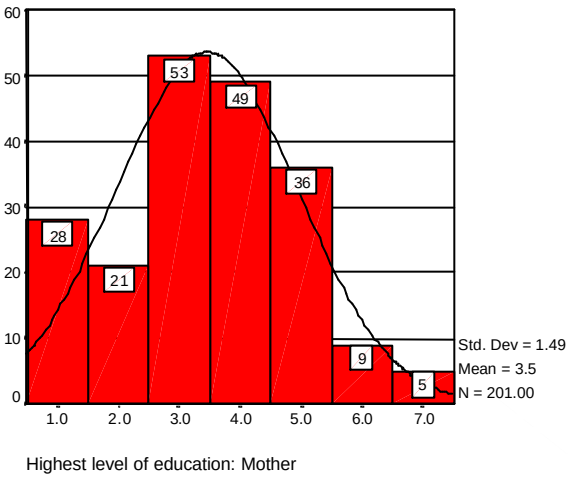
Table 4.9: Chi-square tests of grandparent(s) living in the home

	Value	**Df**	**Asymp. Sig. (2-sided)**	**Exact Sig. (2-sided)**	**Exact Sig. (1-sided)**
Pearson chi-square	27.753[2]	1	.000		
Continuity Correction[1]	26.250	1	.000		
Likelihood Ratio	28.997	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	27.634	1	.000		
N of Valid Cases	234				

From Table 4.8, it can be seen that the majority (77.61%) of the respondents who answered 'yes' were from Soweto, and the majority (60.5%) of the respondents who answered 'no' were from Northview. It is therefore evident that more respondents from Soweto have their grandparent(s) living at home. This is confirmed in Table 4.9 which indicates a p value of 0.000 showing a significant difference between the two groups.

As can be concluded from Tables 4.4, 4.8 and 4.9, the respondents in Soweto do not live with their parents, but perhaps live with their grandparent(s) compared to the Northview group in which the majority reported living with both/either mother or father. It is important to note, that the answers for the variable 'other' included mainly - uncle, aunt or cousin.

4.1.1.e Section 1: Highest level of education for parents



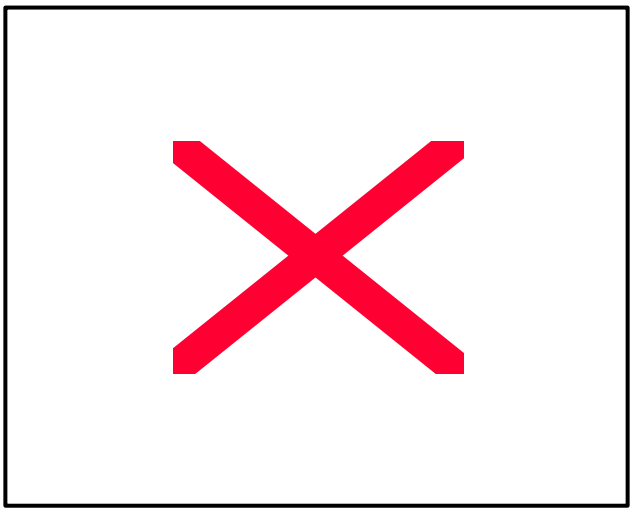


Figure 4.2: Highest level of education - Mother

Figure 4.3: Highest level of education - Father

Key	
1	No formal school education
2	Some primary school education
3	Some secondary school education
4	Matric
5	Post matric certificate/diplomas
6	University degree
7	Post graduate degree

The above figures show that amongst the group of respondents, the highest levels of education achieved by their mothers is some secondary education and matric, with 24.3% having lower levels than secondary education. In terms of their fathers' levels of education, they range between some primary school education and post matric certificates/diplomas, with very few achieving university or post graduate levels.

4.1.1.f Section 1: Involvement in AIDS related programmes in the past year

Table 4.10: Frequency distribution for AIDS education programmes and sex education programmes

	AIDS educational programmes		Sex education programmes	
	Count	**%**	**Count**	**%**
Yes	170	86.3	133	74.3
No	27	13.7	46	25.7
Total	197	100.0	179	100.0

The above table shows that within the entire group of respondents, 86.3% have been involved in AIDS Education Programmes, and 74.3% have been involved in Sex Education programmes. However, the tables below reflect a significant difference between the two groups with regards to such programmes.

Table 4.11: Cross tabulation of Soweto and Northview with regards to AIDS education

			Group		
			Northview	**Soweto**	**Total**
AIDS educational programmes	**Yes**	Count % AIDS educational programmes	104 61.2%	66 38.8%	170 100.0%
	No	Count % AIDS educational programmes	9 33.3%	18 66.7%	27 100.0%
Total		Count % AIDS educational programmes	113 57.4%	84 42.6%	197 100.0%

Table 4.12: Chi-square tests for AIDS education

	Value	**Df**	**Asymp. Sig. (2-sided)**	**Exact Sig. (2-sided)**	**Exact Sig. (1-sided)**
Pearson Chi-square	7.385[2]	1	.007		
Continuity Correction[1]	6.291	1	.012		
Likelihood Ratio	7.340	1	.007		
Fisher's Exact Test				.011	.006
Linear-by-Linear Association	7.348	1	.007		
N of Valid Cases	197				

From Table 4.11, 61.2% of the respondents who reported an involvement in AIDS Education Programmes were from Northview, and 66.7% of the respondents who reported non-involvement were from Soweto. A significant difference (p = 0.006) on the Fisher's Exact Test indicates that in comparison to the Northview group, the Soweto respondents have not had much involvement in such programmes in the past year.

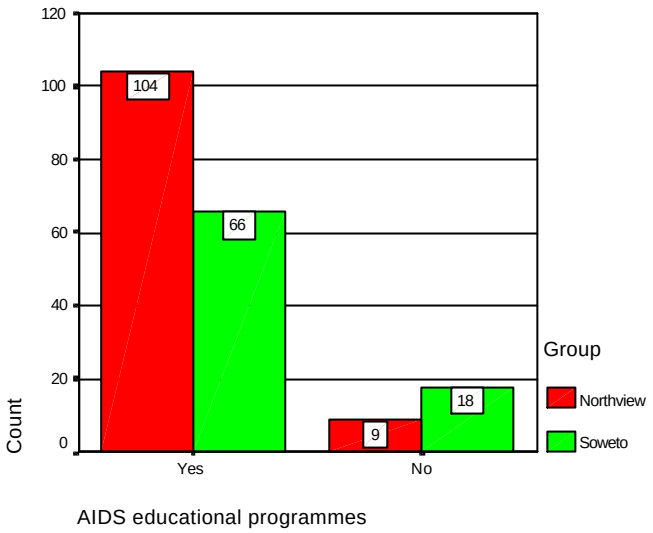


Figure 4.4: Sex education programmes

From the above graph, it can be concluded that both Northview and Soweto respondents have had sex education programmes, to confirm this, the p value from a chi-squared test (0.507) indicated no significant difference.

Tables 4.11, 4.12 and Figure 4.4 indicate that the Northview respondents have had more AIDS education than the Soweto respondents. However, both groups indicate more involvement in sex education than no-involvement in the past year.

4.1.2 Section 2: AIDS awareness

This section contained 15 statements. The respondents were required to indicate whether they believed each statement was either TRUE or FALSE, so as to ascertain their awareness and understanding of HIV/AIDS.

Table 4.13: AIDS awareness

	True		False	
	Count	**%**	**Count**	**%**
AIDS is a curable disease	34	15.3%	188	84.7%
AIDS can be contracted by anyone	192	87.7%	27	12.3%
Only older people can contract AIDS	22	9.9%	200	90.1%
Boys are more likely to get AIDS than girls	31	14.0%	190	86.0%
AIDS can be transmitted through kissing	23	10.5%	197	89.5%
Even if you have only one partner you can get AIDS	171	78.4%	47	21.6%
A person can only get AIDS by sleeping with many partners	99	45.8%	117	54.2%
A mother can pass AIDS on to her baby through breast feeding	182	83.5%	36	16.5%
Using condoms is a safe way of protecting oneself from becoming infected	209	94.1%	13	5.9%
Condoms are readily available	212	95.1%	11	4.9%
A young girl's chances of contracting AIDS are extremely high	178	81.7%	40	18.3%
HIV/AIDS education is important in combatting the disease	202	94.4%	12	5.6%
Learning the simple facts about HIV/AIDS is enough to stop the problem	140	65.1%	75	34.9%
I am not at risk to contracting HIV/AIDS	48	22.4%	166	77.6%
Only prostitutes contract AIDS	16	7.4%	199	92.6%

From Table 4.13, we can see that the overall responses indicate a sound awareness and understanding of the facts about HIV/AIDS, with the majority of respondents choosing either TRUE or FALSE accurately. This therefore indicates their awareness that AIDS is incurable (84.7%), that they are at risk of contracting the disease (77.6%), the modes of transmission, that learning the simple facts is insufficient (65.1%), and 94.4% believe that HIV/AIDS education is important in combatting the disease.

The results make it possible to conclude, that the respondents have a high level of AIDS awareness, thereby reflecting the variable 'knowledge' being tested in this study, which seeks to explore the gap between knowledge and behaviour change.

4.1.3 Section 3: Access to sources of information and resources

This section contained two questions:

The first question required the respondents to indicate from 'whom' or 'what' they had received most of their information about HIV/AIDS, answering either 'yes' or 'no'.

The sections questions contained twelve statements which required the respondents to indicate whether the statements were either TRUE or FALSE.

Table 4.14: Source of information

Source of information about HIV/AIDS	Yes		No		Total	
	Count	%	Count	%	Count	%
School programme	207	95.4	10	4.6	217	100
Parents	140	66.7	70	33.3	210	100
Brother(s)/sister(s)	105	54.4	88	45.6	193	100
Friends	181	87.9	25	12.1	206	100
Television	212	98.1	4	1.9	216	100
Family doctor	115	59.6	78	40.4	193	100
Radio	203	95.8	9	4.2	212	100
Articles in newspapers/magazines	203	96.2	8	3.8	211	100
Computer/internet	40	23.1	133	76.9	173	100
Teachers	192	89.3	23	10.7	215	100

From Table 4.14, we can see that the respondents received most of their information about HIV/AIDS from the following sources:

- Television (98.1%)
- Newspaper/magazines (96.2%)

- Radio (95.8%)
- School programmes (95.4%)
- Teachers (89.3%)
- Friends (87.9%)

The results from Table 4.14 also indicate that the majority (76.9%) of respondents did not get their information from computers, this could indicate a lack of access to such resources. One-third (33.3%) of the respondents reported that their parents are not a major source of information.

Only 54.4% of the respondents reported their brother(s)/sister(s) as being a source of information, and 59.6% reported their family doctor as a source of information.

The results from Table 4.15 indicate that the Soweto respondents receive more information than do the Northview respondents from the following sources: parents (77.5%); brother(s)/sister(s) (72.51%); friends (94.1%); family doctor (71.4%); and teachers (93.5%). The given percentages are according to percentages within the group.

These results therefore reflect that friends, teachers, and the family doctor are main sources of information for all respondents. It is important to note, that family doctor might include the sangoma, witchdoctor, and this may have implications on the

myths surrounding HIV/AIDS, which have been discussed further on in this chapter (see section 5).

Table 4.15: Cross tabulation between Northview and Soweto regarding sources of information

			Northview	Soweto	Total	p-val
Parents	**Yes**	Count	61	79	140	
		% within group	56.48	77.45	66.67	
	No	Count	47	23	70	0.001
		% within group	43.52	22.55	33.33	
	Total	Count	108	102	210	
		% within group	100	100	100	
Brother(s)/ sister(s)	**Yes**	Count	39	66	105	
		% within group	38.24	72.53	54.40	
	No	Count	63	25	88	0.000
		% within group	61.76	27.47	45.60	
	Total	Count	102	91	193	
		% within group	100	100	100	
Friends	**Yes**	Count	86	95	181	
		% within group	81.90	94.06	87.86	
	No	Count	19	6	25	0.006
		% within group	18.10	5.94	12.14	
	Total	Count	105	101	206	
		% within group	100	100	100	
Family Doctor	**Yes**	Count	50	65	115	
		% within group	49.02	71.43	59.69	
	No	Count	52	26	78	0.001
		% within group	50.98	28.57	40.41	
	Total	Count	102	91	193	
		% within group	100	100	100	
Teachers	**Yes**	Count	92	100	192	
		% within group	85.19	93.46	89.30	
	No	Count	16	7	23	0.040
		% within group	14.81	6.54	10.70	
	Total	Count	108	107	215	
		% within group	100	100	100	

Table 4.16: Access to information and resources

	True		False		Total	
	Count	%	Count	%	Count	%
My parents talk to me about HIV/AIDS	144	66.7	72	33.3	216	100
I discuss HIV/AIDS with my friends	214	95.1	11	4.9	225	100
I feel uncomfortable talking to my parents about HIV/AIDS	108	49.5	110	50.5	218	100
I have been exposed to advertising and campaigns on HIV AIDS	115	53.7	99	46.3	214	100
As a result of the above, I have made different choices regarding my behaviour in order to avoid getting HIV/AIDS	201	92.2	17	7.8	218	100
Adults do not like to talk to children about HIV/AIDS or sex	189	84.8	34	15.2	223	100
I know some people with HIV/AIDS	160	71.7	63	28.3	223	100
People in my community believe that people with AIDS should move away	51	23.2	169	76.8	220.	100
I have never seen anyone with AIDS	75	34.1	145	65.9	220	100
People with AIDS look like ordinary people	182	82.0	40	18.0	222	100
I am not scared of HIV/AIDS	28	12.7	192	87.3	220	100
I know people who have died from AIDS	165	74.7	56	25.3	221	100

From Table 4.16, we can see that the majority of the respondents (95.1%) discuss HIV/AIDS with their friends. This result is supported by the information in Tables 4.14 and 4.15.

Of the respondents, 92.2% reported that they have made different choices regarding their behaviour in order to avoid getting HIV/AIDS. The majority (84.8%) of the respondents reported that adults do not like talking to children about HIV/AIDS.

The majority of respondents now people with AIDS, and know people who have died from AIDS. The majority (87.3%) of the respondents are scared of HIV/AIDS and this is supported by the results in Table 4.13.

In addition, the respondents appear to have a positive perception regarding people with HIV/AIDS, in that 76.8% disagree with moving the sufferers away from their communities.

4.1.4 Section 4: Perceptions around behaviours

This section contained questions and statements which assessed the respondents' behaviours, and their perceptions around the behaviours that put them at risk of contracting HIV/AIDS.

Table 4.17: Age of first experience of intercourse

	At what age did you have sexual intercourse with a man/boy for the first time?	
Age	**Count**	**%**
9-10 years	3	1.4
11-12 years	1	.5
12-14 years	3	1.4
14-16 years	18	8.1
16-18 years	85	38.3
Not applicable	112	50.5
Total	222	100.0

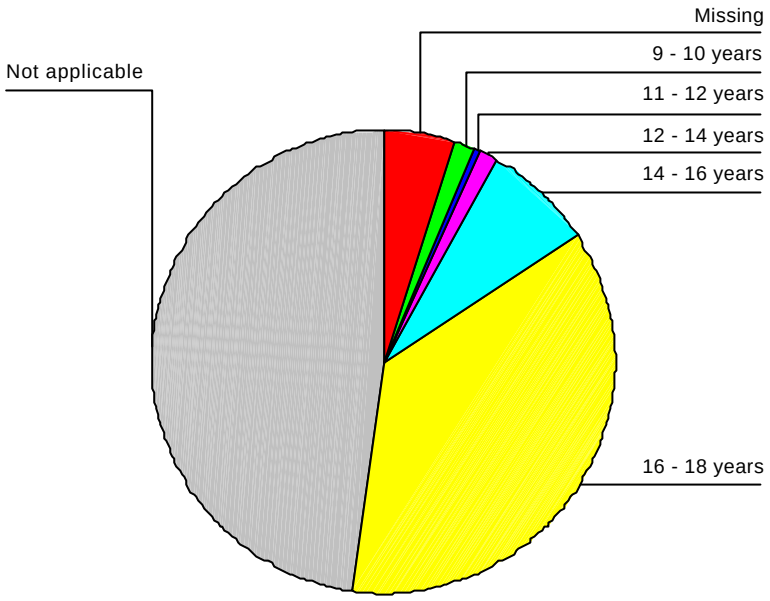


Figure 4.5: Age at first experience of intercourse

From Table 4.17 and Figure 4.5, it can be concluded that half (50.5%) of the respondents have not had sexual intercourse. This is not supported in the literature which claims that today's youth are beginning with earlier sexual onset, with youngest age being about 9 to 10 years.

The large percentage of not applicable results can indicate an unwillingness on the part of the respondents to answer the question due to the social taboo around sex.

However, of those who answered the question, 38.8% of the respondents had sexual intercourse for the first time between 16 to 18 years of age, with the youngest age being 9 years at first experience of sex.

From Table 4.18 it can be concluded that the majority of respondents do not believe that men have all the control over sexual decision making. However, 80% of the respondents reported that men do not like to use condoms.

Furthermore, 85.4% (187) respondents feel that they can insist that their boyfriend use a condom, however, nearly half of the respondents (49.8%) feel as though they have no control over some situations.

The results from this table also indicate a high level of teenage pregnancy, transactional sex, a preference for older sexual partners/boyfriends, and sex without condoms. However, most of the respondents (69.7%) agree that abstinence is the best way of avoiding contracting AIDS. This result is therefore contradictory to their reported sexual behaviours.

Table 4.18: Perceptions around behaviour

		Strongly agree	Agree	Disagree	Strongly disagree	Total
It is OK to have sex with many different men/boys	Count	4.00	2.00	56.00	159.00	221.00
	%	1.81	0.90	25.34	71.95	100.00
A man has the right to insist on having sex without a condom	Count	9.00	1.00	63.00	146.00	219.00
	%	4.11	0.46	28.77	66.67	100.00
The man is the one who decides on using a condom	Count	7.00	34.00	58.00	124.00	223.00
	%	3.14	15.25	26.01	55.61	100.00
If my boyfriend decides not to wear a condom, then there is nothing I can do	Count	6.00	34.00	40.00	138.00	218.00
	%	2.75	15.60	18.35	63.30	100.00
If I really love my boyfriend, then I don't have to worry about getting infected with HIV/AIDS	Count	3.00	30.00	48.00	142.00	223.00
	%	1.35	13.45	21.52	63.68	100.00
I may insist that my boyfriend use a condom	Count	111.00	76.00	13.00	19.00	219.00
	%	50.68	34.70	5.94	8.68	100.00
Teenage pregnancy is common in my community	Count	78.00	115.00	19.00	9.00	221.00
	%	35.29	52.04	8.60	4.07	100.00
Many girls at my school are having sex with men for money or gifts	Count	45.00	98.00	63.00	14.00	220.00
	%	20.45	44.55	28.64	6.36	100.00
Most of the girls my age are having sex with men older than themselves	Count	83.00	116.00	15.00	9.00	223.00
	%	37.22	52.02	6.73	4.04	100.00
I prefer to have a boyfriend older than me	Count	28.00	109.00	49.00	35.00	221.00
	%	12.67	49.32	22.17	15.84	100.00
Sometimes I feel very alone and scared because I can't talk to my family about sex	Count	51.00	83.00	58.00	30.00	222.00
	%	22.97	37.39	26.13	13.51	100.00
In my community, the men are the ones who make the decisions	Count	9.00	66.00	44.00	102.00	221.00
	%	4.07	29.86	19.91	46.15	100.00
I feel as though I have no control over some situations	Count	21.00	89.00	70.00	41.00	221.00
	%	9.50	40.27	31.67	18.55	100.00
When I meet a man/boy, it is not important to know about his previous sexual partners or experience	Count	12.00	16.00	82.00	114.00	224.00
	%	5.36	7.14	36.61	50.89	100.00
The risk of becoming infected with HIV/ AIDS decreases during a relationship	Count	23.00	54.00	66.00	78.00	221.00
	%	10.41	24.43	29.86	35.29	100.00
The best way to avoid getting AIDS, is to not have any sexual relations	Count	92.00	62.00	47.00	20.00	221.00
	%	41.63	28.05	21.27	9.05	100.00
I hear about HIV/AIDS all the time, but it can't happen to me, so I don't need to protect myself	Count	6.00	15.00	51.00	148.00	220.00
	%	2.73	6.82	23.18	67.27	100.00
It is difficult for girls to speak about using condoms	Count	23.00	73.00	61.00	64.00	221.00
	%	10.41	33.03	27.60	28.96	100.00
Most girls have sex without using condoms	Count	49.00	127.00	26.00	18.00	220.00
	%	22.27	57.73	11.82	8.18	100.00
Men don't like to use condoms	Count	77.00	112.00	10.00	17.00	216.00
	%	35.65	51.85	4.63	7.87	100.00
I believe that the young people of today don't know enough about HIV/AIDS	Count	58.00	86.00	45.00	33.00	222.00
	%	26.13	38.74	20.27	14.87	100.00

It is interesting to note, that despite reporting the knowledge and awareness about HIV/AIDS (see section 3), the results from this section indicate at risk behaviours and vulnerability areas that place these respondents at risk to contracting HIV/AIDS.

4.1.5 Section 5: Myths and beliefs

This section contained 13 statements regarding various myths and beliefs surrounding HIV/AIDS. A 4-point scale was used. The respondents were required to state whether they 'Strongly Agreed', 'Agreed', 'Disagreed', or 'Strongly Disagreed' with each statement.

Table 4.19: Myths and beliefs

		Strongly agree	Agree	Disagree	Strongly disagree	Total
Sex with a virgin can cure AIDS	Count	3.00	2.00	29.00	187.00	221.00
	%	1.36	0.90	13.12	84.62	100.00
AIDS does not exist	Count	5.00	5.00	33.00	179.00	222.00
	%	2.25	2.25	14.86	80.63	100.00
Traditional healers can cure AIDS	Count	1.00	26.00	69.00	125.00	221.00
	%	0.45	11.76	31.22	56.56	100.00
AIDS is part of witchcraft	Count	6.00	28.00	45.00	140.00	219.00
	%	2.74	12.79	20.55	63.93	100.00
There is a lot of silence around HIV/AIDS	Count	45.00	40.00	73.00	58.00	216.00
	%	20.83	18.52	33.80	26.85	100.00
AIDS is a punishment put on a person by another person	Count	17.00	34.00	84.00	82.00	217.00
	%	7.83	15.67	38.71	37.79	100.00
AIDS is a curse from the ancestors	Count	3.00	24.00	61.00	129.00	217.00
	%	1.38	11.06	28.11	59.45	100.00
AIDS has been designed to control the population	Count	8.00	19.00	82.00	111.00	220.00
	%	3.64	8.64	37.27	50.45	100.00
AIDS is caused by the lubricants on condoms	Count	2.00	11.00	97.00	109.00	219.00
	%	0.91	5.02	44.29	49.77	100.00
AIDS is sometimes called “Siyesu” meaning disease as poison	Count	16.00	47.00	81.00	70.00	214.00
	%	7.48	21.96	37.85	32.71	100.00
A person with AIDS has been poisoned	Count	5.00	16.00	92.00	103.00	216.00
	%	2.31	7.41	42.59	47.69	100.00
AIDS only occurs in areas other than where I live	Count	3.00	4.00	74.00	138.00	219.00
	%	1.37	1.83	33.79	63.01	100.00
If a married woman gets AIDS, it is because she has been having sex with other men during her marriage	Count	20.00	29.00	84.00	89.00	222.00
	%	9.01	13.06	37.84	40.09	100.00

From Table 4.19, it can be concluded that the majority of respondents disagreed with the prevailing myths and beliefs surrounding HIV/AIDS. However, in each statement there were a few respondents who did agree. This, therefore, indicates that some people do ascribe meaning to these myths.

4.1.6 Section 6: The way forward

This section consisted of five questions.

Question one involved five open-ended questions designed to explore the respondents' opinions and suggestions about HIV/AIDS education programmes. These questions will be analysed qualitatively in this chapter.

Question two contained a 4-point scale, in which the respondents were required to indicate whether they 'Strongly Agreed', 'Agreed', 'Disagreed', or 'Strongly Disagreed' with the statements concerning what they felt needed to change in their communities.

Question three contained a 4-point scale, in which respondents were required to indicate whether they 'Strongly Agreed', 'Agreed', 'Disagreed', or 'Strongly Disagreed' with the statements concerning what they felt needed to change in their families to face the challenge of HIV/AIDS.

Question four required the respondents to indicate three of the given options that they thought should be targetted in terms of AIDS education and awareness.

Question five required the respondents to indicate the importance of such a study, based on an open-ended question to be analysed qualitatively.

4.1.6.a Question 1

1. If applicable, what types of AIDS education programmes have you had?

This question was analysed qualitatively, and the respondents' answers indicated that they had received AIDS education programmes from the following sources:

- AIDS educators at school, by means of theatre, drama and puppet work.
- HIV positive people talking to them at school.
- Television programmes such as Felecia on e, Take 5, Soul City and Love Life.
- Pamphlets and books containing information.
- School guidance classes.
- School teachers.
- Workshops held in clinics.

It is important to note that the majority of pupils from Soweto, as mentioned in section 4.1.1.f, have had only limited exposure to AIDS education programmes. These results can reflect that perhaps the respondents in Soweto do not have access

to resources such as radios, televisions or preventative programmes, and hence, their context limits their ability to make safe choices.

1a. What do you feel was helpful about them?

From the data obtained, the respondents felt that learning about the facts, i.e. modes of transmission, symptoms and lack of cure, was helpful in terms of prevention. The one respondent wrote that she was able to ask the questions that she was previously sacred to ask. This links to another respondent who felt that it was beneficial to be told about HIV/AIDS in public, not privately. Most of the respondents commented on the benefit of seeing someone with AIDS, being shown the reality of the disease, which they reported as being 'scary', as prior to this, many did not know much about HIV/AIDS. The respondents also reported that they admired the courage that the speakers showed in addressing their school. A further advantageous element was that the respondents were able to understand the myths about AIDS, and be educated about the truths.

Many of the respondents also reported that abstinence is the safest way to protect themselves, and that “sex is not worth it”.

1b. What would you say was not helpful?

The majority of respondents answered this question by stating "nothing". In other words, they knew very little before, and whatever they had learned from these programmes/sources was helpful.

Other comments included:

> "They do the play about HIV/AIDS but don't hand out condoms. In the location, its hard to go to the clinic and ask for condoms as the nurses shout at you".
>
> "Parents will not talk about it, they even change the channel on the radio or TV".
>
> "More of the parents need to learn about HIV/AIDS. Education starts at home".

A common comment seen was that the pupils do not take it seriously, it is all a big joke, and this makes the pupils angry - "They don't show us how to use the condom".

What can be concluded from the above, is that the programmes were perceived by the respondents as beneficial, however, their contexts do not support the programmes, thereby enhancing the gap between their knowledge/awareness and behaviour change.

1c. How do you think we should be dealing with the problem?

The results obtained from this question indicate that many of the respondents think that there should be more media campaigns, more education, enhanced openness and communication about the disease, and greater access to condoms. The one respondent wrote, “Supply the condoms, especially to the girls, as the boys are irresponsible and don’t carry with them”.

Again, more parental education was expressed, “More parents should help, instead of criticising the plays and programmes on TV”.

An interesting point was that in many of the respondents’ answers, they made reference to the rural areas, and as one respondent called it, “the dark areas”. They felt that more attention needs to be given to the rural areas, as they do not have access to such school programmes, newspapers, radio or television, and they therefore do not know enough about HIV/AIDS. One respondent wrote: “flood posters in the rural areas, like the government do at the time of elections”.

1d. Do you think that AIDS education (i.e. learning about the facts) is enough to stop the problem?

From the data obtained in Table 4.10 AIDS Awareness, and from Question 1a, it is evident that the majority of the respondents believe that AIDS education is

important. However, this question was purposeful in accessing their opinions about whether or not AIDS education alone can assist in combatting the problem.

Many of the respondents answered 'no' to this question for the following reasons:

- Too many pupils do not take the education seriously.
- AIDS education is only helpful if the entire society is educated.
- Seeing people with HIV/AIDS is more beneficial than just learning about the facts.
- In the rural areas, there is less education and a high illiteracy rate, and therefore more creative programmes are needed.

This question can therefore be concluded by saying that AIDS education has proven beneficial on a knowledge level, for those who have had access to the various educational means. However, as can be seen from the data, the socio-cultural context in which the respondents live, does not support their attempts at risk-reducing behaviour. Furthermore, the results also indicate a dire lack of resources in the rural areas, which will have implications on both a knowledge and behavioural level.

4.1.6.b What in your communities needs to change in order to stop HIV/AIDS from spreading?

Table 4.20: Changes in the community

		Strongly agree	Agree	Disagree	Strongly disagree	Total
Greater access to services	**Count**	72.00	114.00	18.00	9.00	213.00
	%	33.80	53.52	8.45	4.23	100.00
Greater access to condoms	**Count**	97.00	102.00	9.00	10.00	218.00
	%	44.50	46.79	4.13	4.59	100.00
Increased use of condoms	**Count**	101.00	105.00	7.00	10.00	223.00
	%	45.29	47.09	3.14	4.48	100.00
More AIDS education	**Count**	128.00	79.00	6.00	8.00	221.00
	%	57.92	35.75	2.71	3.62	100.00
More open communication	**Count**	134.00	78.00	7.00	5.00	224.00
	%	59.82	34.82	3.13	2.23	100.00
Not having many partners	**Count**	127.00	81.00	8.00	5.00	221.00
	%	57.47	36.65	3.62	2.26	100.00
Increase of women's power	**Count**	88.00	100.00	23.00	9.00	220.00
	%	40.00	45.45	10.45	4.09	100.00
Less emphasis on AIDS	**Count**	30.00	49.00	80.00	48.00	207.00
	%	14.49	23.67	38.65	23.19	100.00
Men need to change	**Count**	109.00	91.00	12.00	8.00	220.00
	%	49.55	41.36	5.45	3.64	100.00
The government should be doing more to protect the people	**Count**	96.00	84.00	29.00	12.00	221.00
	%	43.44	38.01	13.12	5.43	100.00

From Table 4.20, the results indicate that the majority of respondents either 'agree' or 'strongly agree' that all the aforementioned areas of change need to occur. It can further be concluded that 'Increase of women's power' (95.5%), 'Men need to change' (94.9%), 'More open communication' (94.6%), 'Not having many partners' (94.2%), and 'More AIDS education' scored top of the list.

4.1.6.c. What in your families needs to change in order to face the challenge of HIV/AIDS?

Table 4.21: Changes in the family

		Strongly agree	Agree	Disagree	Strongly disagree	Total
More openness with parents about issues such as AIDS/sex	**Count**	157.00	54.00	4.00	5.00	220.00
	%	71.36	24.55	1.82	2.27	100.00
Parents should talk to us more about AIDS	**Count**	155.00	56.00	4.00	5.00	220.00
	%	70.45	25.45	1.82	2.27	100.00
Parents/adults should learn more about AIDS	**Count**	147.00	62.00	4.00	3.00	216.00
	%	68.06	28.70	1.85	1.39	100.00
Parents should realise that the youth today are confronted with many challenges that are different from when they were young	**Count**	147.00	55.00	7.00	8.00	217.00
	%	67.74	25.35	3.23	3.69	100.00

From Table 4.21, it can be concluded that the majority of pupils (96.8% and 96%) agree that parents should talk to them more about HIV/AIDS and that parents/adults should learn more about HIV/AIDS.

In other words, all respondents felt that their parents should be more involved in educating them about HIV/AIDS, i.e. more open to talking and discussing such issues.

4.1.6.d Who do you think should be targeted in terms of AIDS education and awareness?

Table 4.22: Targets of AIDS education and awareness

	Young girls	Young boys	Adults	Prostitutes	Homosexuals	Drug users	Other
Who do you think should be targeted in terms of AIDS Education and Awareness?	169	152	94	57	14	47	15

From Table 4.22, it can be concluded that the targets for AIDS awareness and education programmes should be young girls (169 respondents marked this), young boys (152 respondents marked this), and adults (all respondents marked this).

It is important to note, that many of the respondents did not indicate any specific variables, rather they wrote on the 'other' variable that all targets are important.

4.1.6.e Do you think a study of this nature is important, and why?

Table 4.23: Importance of the study

		Yes	No	Total
Do you think a study of this nature is important	**Count**	180	7	187
	%	96.3	3.7	100

As can be concluded from this table, the majority (96.3%) of respondents reported that a study of this nature is important. The 'why' component of this section was interpreted, and the data collected indicates the following reasons given for the importance of such a study.

The majority of respondents believe that this study is of importance because it can create further understanding about the HIV/AIDS epidemic, so that the necessary steps can be taken to help prevent more youths from becoming infected. In addition, according to the respondents, this study can assist in finding out what the youth think and know about HIV/AIDS, and this information can be used to combat the spread of this killer disease.

Many respondents stated that this study and others can perhaps help to find a cure for HIV/AIDS, "as it is killing many teenagers in my community", as written by a respondent.

"There are many reasons for the existence of this disease - the old people think it is witchcraft, ancestors, and the act of White people, this needs to change". This was a statement written by one of the respondents, and it indicates that the youth of today are aware of the facts, yet the elders still have their beliefs rooted in the myths. This was confirmed in Table 4.16, where the results indicated that the majority of the respondents did not agree with the myths, however, they find themselves within a

culture of myth vs. fact, and this too will have a bearing on their ability to discuss HIV/AIDS with their elders.

This is reflected in Table 4.14 which highlights the parents as being low on the list in terms of sources of information regarding HIV/AIDS. This theme has been prevalent throughout this chapter, and links closely to theory in Chapter 2.

A profound statement appeared in the questionnaires, "People know enough, they must now practice what they know".

As we have noted in this chapter, there are many reasons for the delayed action, despite having the knowledge.

In conclusion to this question, the following statement provided by a respondent - further highlights the importance of such a study:

> "I feel it is important because you are focusing on the youth with this questionnaire, and I now realise just how serious and important it is, for me, being young".

4.1.7 Section 7: Factor analysis

This section contains a factor analysis between subject factors. In order to test the reliability of the variables within this study, the following was done:

Principal factor analysis with Varimax Rotation for the first analysis and a Direct Oblimin Rotation for the second analysis. For every section, one dimension was extracted.

Table 4.24: Reliability analysis

		Cronbach Alpha	%
Dimension 1	Perceptions around behaviour	0.7897	78.87
Dimension 2	Myths	0.8046	80.46
Dimension 3	Change in communities	0.8609	86.09
Dimension 4	Change in families	0.8771	87.71

Table 4.24 indicates that a reliability analysis was done per dimension in which the Cronbach Alpha was determined. The alpha must be between 0 and 1. A Crombach Alpha of 0.7 and higher shows a reliable dimension. In conclusion, we can therefore see that these dimensions are reliable.

The dimensions (1 to 4) were extracted from the related sections in the questionnaire. In order to create these dimensions, the following statements were grouped together (see Table 4.25).

Table 4.25 indicates the components of dimension, so that the various analyses could be carried out.

Table 4.25: Overview of the dimensions

Perception around behaviour
If my boyfriend decides not to wear a condom, then there is nothing I can do
If I really love my boyfriend, then I don't have to worry about getting infected with HIV/AIDS
The man is the one who decided on using a condom
The risk of becoming infected with HIV/AIDS decreases during a relationship
In my community, the men are the ones who make the decisions
I feel as though I have no control over some situations
I hear about HIV/AIDS all the time, but it can't happen to me, so I don't need to protect myself
If I had to ask my boyfriend to wear a condom, he would feel angry and insulted
When I meet a man/boy, it is not important to know about his previous sexual partners or experiences
It is difficult for girls to speak about using condoms
Teenage pregnancy is common in my community
Most of the girls my age are having sex with men older than themselves
I may insist that my boyfriend use a condom
The best way to avoid getting AIDS, is not to have any sexual relations
A man has to right to insist on having sex without a condom
It is OK to have sex with many different men/boys
Myths
AIDS is a curse from the ancestors
AIDS is part of witchcraft
Traditional healers can cure AIDS
AIDS is caused by the lubricants on condoms
A person with AIDS has been poisoned
AIDS has been designed to control the population
There is a lot of silence around HIV/AIDS
Change in communities
More open communication
More AIDS education
Greater access to condoms
Increased use of condoms
Greater access to services Not having many partners
Men need to change
The government should be doing more to protect the people
Increase of women's power
Change in families
Parents should talk to us more about AIDS
More openness with parents about issues such as AIDS/sex
Parents/adults should learn more about AIDS
Parents should realise that the youth today are confronted with many challenges that are different from when they were young

Table 4.26: Multivariate Analysis of Variance

Descriptive Statistics	Group	Mean	Std Deviation	N	F-value	p-value
Dimension 1	Northview	55.64	4.01	94		
	Soweto	48.45	6.78	71	72.358	0.000
	Total	52.55	6.44	165		
Dimension 2	Northview	24.93	2.51	94		
	Soweto	21.89	4.04	71	35.269	0.000
	Total	23.62	3.58	165		
Dimension 3	Northview	8.72	2.93	94		
	Soweto	10.41	3.50	71	11.305	0.001
	Total	9.45	3.29	165		
Dimension 4	Northview	5.00	1.67	94		
	Soweto	5.80	2.63	71	5.717	0.018
	Total	5.35	2.17	165		

Hotelling's Trace	473
F-value	18.904
p-value	0.000

If the p-value is smaller than 0.05, then there is a significance of 95%, if the p-value is <0.01, the significance level is at 99%. From Table 4.26, we can see that a significant difference exists between the two groups on the above mentioned dimensions:

Dimension 1, Perceptions around behaviour – it can be seen on this dimension that there is a significant difference, as p = 0.000, between the Northview respondents and the Soweto respondents. The Northview respondents reflected higher scores, and the Soweto respondents reflected lower scores. This indicates that Soweto 'agreed' more with the statements regarding behaviour.

Dimension 2, Myths – it can be seen on this dimension that there is a significant difference, as p = 0.000, where the Soweto respondents agreed more on the statements about myths than the Northview respondents.

Dimension 3, Changes in the community – it can be seen on this dimension that there is a significant difference, as p = 0.001, between the Northview respondents and the Soweto respondents. The results indicate that the Northview respondents achieved a lower score, thereby agreeing more with the statements on changes in the community.

Dimension 4, Changes in the family – it can be seen on this dimension that there is a significant difference on the 95% level (p = 0.018), with the Northview respondents achieving a lower score by 'agreements', this therefore indicates more of an openness to change compared to the Soweto respondents.

From the results in Table 4.26, it can be concluded that there are significant differences between the Northview respondents and the Soweto respondents with regard to the above four dimensions. These results can further indicate the differences in the contexts in which the respondents live.

Thus, we can conclude that the two groups of respondents are not the same, thereby confirming that the socio-cultural context, in which people live, can be a key to understanding the gap between knowledge about HIV/AIDS, and behaviour change.

This is further supported by the literature in Chapter 2, which highlights various contextual factors that influence decision making, and that shape behavior change. This will further be discussed in Chapter 5, which focuses on discussion, conclusions and recommendations.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Aids report paints grim picture for South Africa's youth
(Headline in The Star, 17 October 2001)

HIV hits women (15-35) the worst
(Headline in The Citizen, 31 October 2001)

In South Africa, an estimated 4.2 million people are infected with HIV. Young women are particularly vulnerable, due to physiological and social factors. Most HIV prevention programmes attempt to persuade people to change their sexual behaviour - and in the case of women, that of their partners too. They assume that men and women can be given knowledge which will lead them to make rational decisions to practice safer sex and then to implement those decisions. However, they often fail to recognise the difficulties facing those women who attempt to do this.

The focus of this study was to explore the cultural context of HIV/AIDS in South Africa as the potential gap between knowledge and behaviour change. With reference to the above headlines, this study was aimed at exploring the cultural context of HIV/AIDS that renders our young females vulnerable to infection.

Questionnaires were distributed to 234 respondents, all of whom were black female adolescents in grade 11 at two schools, namely, Northview and Soweto.

The questionnaires were designed in accordance with the following objectives of this study, as laid out in Chapter 1:

1. To establish the background information of the respondents.

2. To determine the sample group's level of awareness and understanding regarding HIV/AIDS.

3. To determine the sample group's access to information and resources regarding HIV/AIDS.

4. To explore the respondents' perceptions around the behaviours that put them at risk to contracting HIV/AIDS.

5. To determine the meanings ascribed by the respondents to the myths surrounding HIV/AIDS within the South African context.

6. To establish what the respondents perceive as the way forward.

The data captured in the questionnaires has been presented in Chapter 4.

A discussion of the results will now be provided.

5.2 DATA OBTAINED

The results of this study indicate that the respondents have an awareness and understanding regarding HIV/AIDS. Despite this, the literature and HIV/AIDS statistics indicate that young females are most at risk of contracting HIV/AIDS.

This study therefore explored the gap between knowledge about HIV/AIDS and behaviour change, and the results obtained support the hypothesis that attention to the cultural context of HIV/AIDS as experienced by our at risk group, can enhance our understanding of this gap. Furthermore, the findings of this study as laid out in Chapter 4, validate and support the literature in Chapter 2, which describes various contextual factors that render our female youth vulnerable to HIV/AIDS.

This takes us back to the literature where Hoosen and Collins (2001) state that AIDS knowledge does not directly translate into behaviour change. This realisation has led to a shift to investigate social and cultural factors that promote or hinder behaviour change in specific settings. Where the aim, according to MacPhail and Campbell (1999), is not only to provide information, and to promote individual behavioural change, but to also encourage the development of social and cultural environments that enable behaviour change to take place, by taking into account broader contextual dynamics which shape and constrain certain behaviours.

Related to this, the main findings of this study can be summarised as follows:

5.2.1 Breakdown of traditional structure

From the data presented in Chapter 4, the results indicate that many of the respondents do not necessarily live with their parents (see Tables 4.3 - 4.9), and it is this breakdown in the family structure, that Walker and Gilbert (2001) identify as one of the main factors influencing the spread of HIV/AIDS. According to the literature, this feature of disrupted family and communal life are due in part to apartheid, migrant labour, poverty, change in family structures, and a new array of pressures of traditional versus modern lifestyles (Webb, 1997).

This can be further translated into the potential for a breakdown in communication between parents and children around HIV/AIDS and sex, which was reflected in the respondents' answers on Sources of information (see Tables 4.14 – 4.16) and their answers regarding Changes in the family (see Table 4.21).

The literature also makes reference to the transformation and shifting of traditional, social values inherent in African culture, which have created gaps for the youth between traditional and modern lifestyles. Some of the respondents reported that they live with their grandparents. This, therefore, indicates some of the difficulties faced by the youth in bridging the gap between their traditional values such as silence around sex, belief in myths around HIV/AIDS, and lack of open communication; with their changing needs and present challenges they now face, such as: HIV/AIDS, sexuality, teenage pregnancy, age mixing with regards to sexual

partners, independence and free choice, and lack of open communication with parents.

5.2.2 Sources of information and access to resources

The majority of respondents participating in this study did have access to most of the HIV/AIDS information services mentioned in the questionnaire. However, the data in Chapter 4 also indicated that there was a difference between Northview and Soweto in terms of access to some of the sources of information (see Tables 4.13 – 4.15). Furthermore, the results from the open-ended questions indicated a perceived need for more information and media in the rural areas, as these areas seem to be lacking in technological sources, media sources, and educational interventions regarding HIV/ AIDS.

According to van Niekerk (1991), HIV/AIDS education can take place through various sources. It is thus of utmost importance, for preventative purposes to determine who the current information sources are who the youth rely upon for their own HIV/AIDS education.

From the study, the following information sources were identified as playing a role in HIV/AIDS education: television, newspapers/magazines, radio, school/teachers, friends, parents and the family doctor.

5.2.2.a Parents/peers

However, on further analysis of access to information and resources, it became apparent that the majority of respondents discuss HIV/AIDS with their friends. The majority of respondents also reported that they felt uncomfortable talking to their parents about HIV/AIDS, and their parents do not like to talk to them about HIV/AIDS or sex. This is supported in the literature, which states that sex is often seen to be a cultural taboo and not discussed openly, therefore, according to Mbetse (2001), much regarding sexual behaviour is acquired through peers and personal experience.

The literature also talks of the belief held by parents in the African culture that children are by nature promiscuous, and that providing them with information about sex, will make them more sexually active (Friedman, 1993). This can therefore explain the respondents' experiences of the criticism their parents express regarding HIV/AIDS and sex education. Related to this, Glaser (2001) states that few parents seem willing or able to confront awkward issues around sexuality, and as a result, youths are being left to negotiate their sexuality on their own, or with their friends, as has been shown.

This issue highlights the attempts of this study to explore the context of HIV/AIDS that either shapes or constrains individual behaviour. It can therefore be deduced that

the role of parents in HIV/education needs to be highlighted, so as to bridge the gap between knowledge and behaviour change. This was supported by many of the respondents who indicated that there should be more openness with parents, parents should talk to them more about HIV/AIDS, and that parents/adults should learn more about HIV/AIDS (see Chapter 4, 4.21 and 4.22).

5.2.2.b Media

The results further indicate the value of mass media in HIV/AIDS education and prevention. The respondents reported having made different choices regarding their behaviour so as to avoid becoming infected with HIV/AIDS (see Tables 4.14 – 4.16). However, the power of mass media is dependent on the area in which people live. What we have seen in the literature, is that many South African youths have a low standard of education, occupational status, and income levels; they live in poverty; their daily lives are disorganised and highly politicised; they have low quality public services and resource; and their normative structures have broken down to a large extent (van Niekerk, 1991).

It is therefore within this context that one needs to consider its role in the gap between knowledge and behaviour change.

5.2.2.c School

The role of the school in HIV education has come under the spotlight since the start of the HIV/AIDS epidemic. The respondents from Northview and from Soweto have been involved in school programmes regarding HIV/AIDS. The majority of these respondents reported the value of such programmes in educating them about the facts of HIV/AIDS, however, the respondents felt that the various mentioned factors within their contexts did not support the programmes, thereby enhancing the gap between their knowledge abut HIV/AIDS and behavio ur change (See Chapter 4, section 6).

5.2.3 Perceptions around sexual behaviour

The literature states that we need to recognise the high levels of early adolescent sexual activity within our present day context. The data obtained in this study regarding age at first sexual intercourse reflected that half of the respondents had not yet had sex, wit the majority of those who are sexually active being between 16 to 18 years of age. With reference to the literature, these results do not seem accurate, therefore one needs to question the reliability of these results. The author is of the opinion that perhaps the respondents did not answer truthfully, or perhaps the HIV/AIDS message of abstinence is being heard.

The results from the study indicate that the majority of respondents perceive themselves as having some degree of control over sexual negotiation, i.e. condom use. This is not supported in the literature which states that unequal power relations between genders is a major factor in women's vulnerability to HIV/AIDS, as they are unable to negotiate safe sex with their partners. The literature further states that the dominant discourse of masculinity needs to be challenged in order to bring about social change. The literature makes reference to an article titled "Shifting discourse - teenage masculinity and the challenge for behavioural change" (April 2001; author unknown). Stated in this article was the perception of males, who see themselves as powerful and in control of relationships and any forms of negotiation. Thus, the results of the study may indicate the respondents' perceptions of their own power, but in reality, the men do no perceive women as having any power, and this can therefore lead to power struggles which women, being physically and socially lower than men, will ultimately lose. This is supported further on in the study where the majority of the respondents felt that men/young boys should be the targets for HIV/ AIDS education.

The results from the study also indicate high levels of teenage pregnancy, transactional sex, a preference for older partners, and sex without condoms. These factors support the literature which describes the sexual-cultural behaviours of our youth. Parker (1995) emphasised this by stating that,

> Emphasis has been placed largely on individual determinant of sexual behaviour and behaviour change, and the diverse cultural, economic, and political factors

> potentially influencing or even shaping sexual experience have more often than not been ignored (1995, p. 261).

Lastly, it is apparent from the data obtained that the majority of respondents disagree with having many partners, and agree that abstinence is the safest way to protect oneself. The respondents do see themselves as vulnerable and at risk to HIV/AIDS, and have mentioned throughout the study that they are scared of this disease, and do not know enough about it.

5.2.4 Myths around HIV/AIDS

The results of this study indicate that the majority of respondents do not believe in the prevailing myths surrounding HIV/AIDS. However, this could be a significant reflection of the gap between traditional values and modern values, and more importantly, the gap between the youth of today and their parents or elders, as discussed previously.

5.2.5 The way forward

Most of the respondents either 'agreed' or 'strongly agreed' that changes need to occur on both the micro- and macro-level, so as to face the challenge of HIV/AIDS in South Africa.

Tables 4.20 (Changes in the community) and 4.21 (Changes in the family) highlight the main contextual factors that need to be created in order to bridge the gap between knowledge about HIV/AIDS and behaviour change.

Furthermore, the respondents identified the groups in society that need to be targetted in terms of HIV/AIDS education, and these included: young girls, young boys, and adults. Many of the respondents in fact identified that everyone should learn more about HIV/AIDS.

This, therefore, indicates that on an individual level, the respondents are taking cognisance of the high risk of HIV/AIDS, however, in order for them to be able to make safer, more informed decisions regarding their behaviour, many changes need to occur within the context they find themselves in, starting at home and extending to the broader structures of our society.

5.3 CONCLUSIONS

It is clear that culture and social context have a significant impact on risk behaviour and at the same time tremendous potential for addressing the same issues. It has been recognised that HIV/AIDS is both a biological and cultural disease, and attempts at prevention have reflected this dual system. It is significant that HIV/AIDS prevention messages only superficially address cultural factors, but not contextual determinants of behaviour change (Nduati & Kiai, 1997). It is, therefore, significant to further explore the gap between knowledge and behaviour change, by

taking into account, the cultural context of HIV/AIDS that can impede or support prevention, care and treatment.

This study set out to explore the cultural context of HIV/AIDS in South Africa, with particular focus on young females who have been identified as the most at risk to HIV/AIDS. In line with the definition of culture (refer to 1.6.4), various cultural factors were addressed, namely; beliefs, values, behaviors and other contextual factors that constitute the very matrix in which ideas are formulated and behaviors are carried out. It can therefore be concluded that the aim of the study was achieved and the goals outlined in Chapter 1 were met. The results obtained in the study validated and confirmed the literature, and therefore, one can conclude that by exploring the cultural context of HIV/AIDS in South Africa, we can enhance our understanding of the gap between knowledge and behavior change. In light of the results of this study, new initiatives and interventions, that take the cultural context of HIV/AIDS into account, can be developed, so that we can approach the crisis more effectively and with greater understanding.

5.4 RECOMMENDATIONS

The following are recommendations that arose from the results of this study. The recommendations apply to all levels of society, both individuals and organisations, some of which are echoed from the literature in Chapter 2.

1. HIV/AIDS education and sex education should be enforced in all schools across our country, as school programmes account for 95.4% and teachers account for 89.3%, as sources of information (see Table 4.14). These programmes should target all age groups, particularly the youth, as stated by the respondents in Table 4.22.

2. Parental involvement in HIV/AIDS issues is imperative for the success education and prevention. Parents need to be educated about such issues, so as to begin bridging the gap between children and parents. The education can be from various sources, namely: school, media and workplace.

3. Unequal gender relations have been identified as a factor in the spread of HIV/AIDS. It is therefore important to not only focus on females, but also young males so as to begin breaking the dominant male discourse and unequal gender relations that render women vulnerable to the disease (see Table 4.20).

4. From the information received from the respondents, the following methods of education and prevention can be employed: to expose our youth to the reality of HIV/AIDS, to maximize the use of mass media particularly in the rural areas, to create greater access to resources and services, and to continue

emphasizing the seriousness of HIV/AIDS so that our youth will start to comprehend the enormity of the epidemic and their vulnerability.

In light of this study and the researcher's own experience, the following recommendations can be made:

1. In order for schools to play a role in HIV/AIDS education and prevention, teachers and staff members should be trained in the area of HIV/AIDS so that they can sustain the interventions and provide ongoing support for their pupils. Through training, teachers will become more comfortable with issues around AIDS and sex, thereby avoiding the perpetuation of silence, and creating the context for open communication between the youth and the adults in our society.

2. Social workers, individuals and organizations dealing with HIV/AIDS issues, should continue advocating on behalf of our youth, that the government and those with power begin to acknowledge the issues so that our youth can be saved from the epidemic and can enjoy productive and healthy futures.

3. It is strongly recommended by the researcher that further research on HIV/AIDS and the vulnerability of our youth be conducted in South Africa. Future studies can focus on both young males and females of all ages and races, so as to broaden our understanding of the context of HIV/AIDS as it as

it applies to behaviour change. Furthermore, the issue of context can be further expanded beyond the scope of this particular study, so as to explore the numerous facets inherent in any context that shape and restrict behaviour change. Lastly, an understanding of the gap between knowledge and behaviour change is of paramount importance in preventing the spread of HIV/AIDS. The researcher therefore suggests that further studies be conducted to explore other potential factors that are creating and maintaining this gap, thereby perpetuating the spread of HIV/AIDS.

> "Since at present there is no cure, what hope is there for Africa? ….Medically hope seems yet a great way off. And so, education and prevention are our only resource at this present time" (Schwartz in Van Niekerk, 1991, p.37).

In light of the above statement and the findings of this study, the researcher hopes that our efforts at education and prevention will prove more successful, given our enhanced understanding of the cultural context of HIV/AIDS in South Africa. The identification of factors within our context that render our youth vulnerable to HIV/AIDS, is a useful and necessary exercise, but unless this exploration can provide for new ideas and awareness, the exercise remains academic. The researcher hopes that this study will be of value to those working in the field, and most importantly, to our youth, as they are the most valuable resource to our nation, and we owe it to them, to protect and support them in the face of this crisis.

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ANNEXURE A