Adolescents' Knowledge, Attitudes and Behaviour Regarding HIV/AIDS in Valhalla Park: An Exploratory Study.

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A Mini -Thesis submitted in partial fulfillment of the requirements for the degree of Masters in Development Studies in the Faculty of Arts, Institute for Social Development, University of the Western Cape

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November 2008

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KEY WORDS

Adolescent

Attitude

Behaviour

Beliefs

Denial

HIV/AIDS

Knowledge

Perceptions

Vulnerability

Valhalla Park

ABSTRACT

In South Africa there is still a substantial amount of prejudice towards people living with Aids (PLA). Initially, Aids was seen as a 'gay' disease, then a 'black' disease. People thus tended to avoid high-risk groups rather than high-risk behaviour, and denied their own vulnerability by displacing the disease to an 'other' who did not belong to 'their' group.

This study focuses on factors that influence and motivate adolescents' behavior towards HIV/AIDS at Beauvallon High School in Valhalla Park; an impoverished, peri-urban and previously coloured only community.

This research is of an exploratory nature that includes a semi-structured survey with 20 school-going adolescents (between the ages of 15 to 18 years) at Beauvallon High. The primary objective was to conduct an analysis of the knowledge, perceptions, beliefs, attitudes and behaviour of the group towards HIV/AIDS. The secondary aim of this study has been to establish, explore and examine factors that influence the group's perceptions, beliefs, attitudes, and behaviour towards HIV/AIDS. As HIV/AIDS is a social phenomenon with historical roots deeply seated in societies' knowledge, perception, attitudes and behavior, the researcher also attempted to examine the ways in which the adolescent respondents construct their own understanding of HIV/AIDS within their culture. A variety of research tools was used in order to gather the necessary data.

This included:

1. a literature review, which is the secondary document analysis;
2. a semi-structured questionnaire, in the form of a quantitative and qualitative model, was administered to a selected group of twenty (10 males and10 females) adolescent scholars.

The findings were analyzed within an interpretative research paradigm using thematic content analysis to determine the themes that emerged from the

research material, as the research seeks to understand the respondents' definitions and understanding of HIV/AIDS and how it influences and motivates their behavior. Evidence from this study's data of high-risk sexual behavior includes multiple sexual partners, sexual and relationship coercion, substance abuse, unequal power relationships, deceitful partners and penetrative sex which are perpetuated by factors such as cross-generational 'trauma and pain,' single parenthood and low parental monitoring, social construction and prescription, socio-economic circumstances, poverty and deprivation, lack of knowledge on prevention of HIV infection, biological urges, peer pressure, fear of losing a partner, own and social identity, low self-esteem, silence, denial, stigma and blaming. These reasons can however pose barriers to safe sex as it was found that the adolescents are aware of the effectiveness of condoms, but have negative attitudes towards using them.

The study finds that adolescents' knowledge, perceptions and attitudes relating to and motivating HIV/AIDS risk behavior indicate a lack of awareness on how to avoid such high risk behavior and that this may be a contributing factor that fanned South Africa's high prevalence rate of 16,2% among the youth. Lessons born out of experience have been identified to highlight best practice and potential problems that adolescents at national level are experiencing. As an outcome, the study indirectly seeks ways to increase HIV/AIDS awareness and to decrease risk behavior, particularly amongst the youth, through effectiveness and availability of a monitoring and continuous assessment process of the adolescents' HIV-risk behavior.

DECLARATION

I declare hereby that this thesis: **"Adolescents' Knowledge, Attitudes and Behaviour Regarding HIV/AIDS in Valhalla Park: An Exploratory Study",** unless specifically indicated to the contrary in the text, is my own original work and that it has not been previously submitted for any degree or examination at any other university. All the sources/authors I have used or quoted have been indicated and acknowledged as complete references.

Conrad Henry Isaacs ----------

(Signature)

Student Number: 2565801 Date: November 2008

ACKNOWLEDGEMENTS

I would like to thank the following people for different contributions they have made to the development and completion of this thesis:

1. The principal, staff and scholar participants at Beauvallon High School. I am most grateful for their generous and eager involvement, contributions, advice and hospitality.

2. Sincere recognition and praise belongs to my supervisor, Ms Ina Conradie, who, without hesitation, inspired and shaped me with diligence, to perform and deliver work to her expectations at all times. Under her supervision I grew and developed academically.

3. My wife, Geri, for our years apart, her love, resilience, dedication, inspiration and encouragement. Who provided me, with utmost patience, space to finish this thesis and continues to be the centre of my existence.

4. Roark and Amourelle, our children, for their unwavering assistance and stimulated support.

5. Ms Letitia Lekay, the ISD librarian, who assisted me in numerous ways.

6. Ms Priscilla Kippie, to whom I am indebted for her whole hearted support throughout my study period.

7. Professor Peter Le Roux, Ms Sharon Penderis and the rest of the staff at the Institute for Social Development, Fuzzy Hendricks and Barbro Engdahl. Thank you for your unselfish commitment and dedication in making this journey a memorable one.

DEDICATION

This mini- thesis is dedicated to my late parents, Arthur and Anne Isaacs, my wife and children, my supervisor, as well as to the scholar-participants, principal and staff at Beauvallon High School. Without their efforts and support this study would not have been possible.

ACRONYMS AND ABBREVIATIONS

Aids	Acquired Immune Deficiency Syndrome
AHIV C-Q	Adolescents' HIV/AIDS Challenges Questions
ARV	Antiretroviral
ASGISA	Accelerated and Shared Growth Initiative for South Africa
HIV	Human Immune-Deficiency Virus
HIVBS-AQ	HIV Blaming, Stigma and Attitude Questions
HIVK-PQ	HIV Knowledge Perceptions Questions
Ibid	Etymology: L *ibidem*: - in the same place: used in referring again to the book, page, etc. cited just before.
KABP	Knowledge, Attitude, Behaviour and Practice
MRC	Medical Research Council of South Africa
PLA's	People Living with Aids
SA	South Africa
SRBB-SEQ	Sexual Risk Behavior Beliefs and Self-Efficacy Questions
STD's	Sexually Transmitted Diseases
STI's.	Sexually Transmitted Infections
STIHTB-SQ	Sexually Transmitted Infections Health and Treatment Behavior Seeking Questions
TPB	Theory of Planned Behavior
UNAIDS	Joint United Nations Programme on AIDS
UNICEF	United Nations International Children's Fund
USA	United States of America
UWC	University of the Western Cape
VCT	Voluntary Counselling and Testing
WCED	Western Cape Education Department
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION AND ORIENTATION

1.1 Introduction

A statement like: "I don't want my family to mix with gays and blacks because they are the ones that bring HIV/AIDS to our communities," is common among people living in impoverished, previously coloured-only communities like Valhalla Park, Hanover Park, Manenberg and Mitchell's Plain (to name but a few) on the Cape Flats. It seems that perceptions and beliefs in these areas support the idea that people living there, are in general, still in denial of their own vulnerability to HIV/AIDS by believing that the disease is among others not belonging to 'their' group. They are seemingly unaware of their susceptibility to HIV/AIDS, even when confronted with it in their own communities. People thus tend to avoid high-risk groups rather than high-risk behaviour. From this observation the research questions were formulated, namely to what extent the knowledge, attitudes and behaviour of young people in coloured communities regarding sexual behaviour and Aids may place them at risk and therefore contribute to the current Aids epidemic in South Africa.

To investigate this question, this study attempted to examine the knowledge which adolescents in Valhalla Park have about HIV/AIDS and also explored and examined the perceptions, beliefs and attitudes which motivate their behaviour towards HIV/AIDS.

Chapter 1 firstly focuses and draws together some definitions and conceptual issues surrounding the central keywords that form the basis of the study, before moving on to explore - through further discussion and analysis- the background and rationale of this research. After a reflection on the research methodology, the township profile gives the reader an idea of the location of the study area. The research problem statement and questions are followed by the guiding objectives and purpose of this study. The summary concludes the chapter by providing a brief outline of the chapters to follow.

1.2 Clarification of Concepts Used.

1.2.1 Community:

For Barton, the concept of community[1] has two distinct characteristics. Firstly, a community cannot exist without a web of effect – laden relationships among a group of individuals (rather than merely one-on-one or a chain of individuals, interaction). These relationships often criss-cross and reinforce the other. Secondly, being a community entails having a measure of commitment to a set of shared values, norms and meanings (Barton, 2002: 12-20).

1.2. 2 HIV / Aids:

According to Conlon et al. (2004: 9 - 15), HIV[2] (Human Immune-Deficiency Virus) is a virus made up of protein and contains ribonucleic acid- or 'RNA'- to reproduce itself. It infects the immune system by attacking the white blood cells. Aids (Acquired Immune Deficiency Syndrome) is the developed disease once the virus has destroyed the white blood cells to the extent that the T-cell count is below 200ml.

1.2.3 Poverty:

"Poverty[3] has various manifestations, including lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from

[1] In South Africa, the apartheid government's usage of *community* ranges from generic labels for official racial categories like " Indian community", " Coloured community", "White community" or " Black community" , and extends to include administrative or regional entities, such as "Lebowa community", which coincide with official labels for "ethnic groups". It thus used the term inter-changeably with "race", "ethnic group", "nation" or "people", and in doing so, appears to justify its insistence that since each is a distinct "community" it must develop "separately" (Boonzaaier and Sharp, 1988:30).

[2] The virus can be passed from one person to another through: sexual intercourse; HIV - positive pregnant women to their babies, sharing used needles (or knives), and the transfusion of infected blood.

[3] The 1995 World Summit for Social Development in Copenhagen's definition of poverty. Chronic poverty is the most terminal condition. Chronic poverty exists in all regions, and chronically poor people live in many different situations. If and when they have work, it is insecure, casual and at extremely low rates of pay. Many live in remote rural areas, urban slums or conflict zones; suffer from chronic health or other impairments (Shepherd, 1998).

illness; homelessness and inadequate housing; unsafe environments; and social discrimination, marginalization and exclusion. Being spiritually and psychologically poor is also "characterised by a lack of participation in the decision-making process in civil, non-civil, social and cultural life" (United Nations, 1995: 41).

1.2.4 Stigma:

HIV/AIDS-related stigma refers to prejudice, discounting, discrediting and discrimination against and directed at people perceived to have Aids or HIV, and the groups and communities with whom they are associated (Herek, 1999:1102). Closely tied in is the concept of discrimination, referring to the unfair and unjust treatment of an individual based on his or her real or perceived HIV status (UNAIDS, 2003). Goffman (1963) defines stigma as an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society. Stigma can result from a particular characteristic, such as a physical deformity, or it can stem from negative attitudes towards the behavior of a group, such as homosexuals or prostitutes. Under Goffman's definition, stigmatization is the societal labeling of an individual or group as different or deviant. Others have defined stigma as social processes that are linked to societal power structures (Link, 2001; Parker, 2001 as cited in Brown et al, 2001:4).

1.2.5 Denial:

Denial is a psychological defense mechanism in which a person faced with a fact that is too uncomfortable or painful to accept, rejects it instead, insisting that it is not true despite what may be overwhelming evidence to the contrary. The subject may deny the reality of the unpleasant fact altogether (simple denial), admit the fact but deny its seriousness (minimization) or admit both the fact and seriousness but deny responsibility (Columbia Encyclopedia, 2003).

1.2.6 Vulnerability:

The Readers Digest Universal Dictionary (Ilson et al., 1988:1648) defines vulnerable as: “susceptible to injury, physical or emotional, unprotected from danger; susceptible to physical attack; insufficiently defended; liable to censure or criticism; assailable; liable to succumb to persuasion or temptation." It is also interesting to note that ‘vulnerable’ originated from the Latin word ‘*vulnerare*’ which means to ‘wound’ (Van den Berg, 2004:26). The Collins Cobuild English Dictionary (1998:1874) defines ‘vulnerability’ as follows: "someone who is vulnerable is weak and is without protection with the result that they are easily hurt physically and emotionally; If someone is vulnerable to a particular illnesses, they are more likely to get it than other people; if someone is vulnerability[4] to doing something wrong, they are easily influenced to do it because they are weak, innocent or in a difficult position."

1.2.7 Risk Behaviour:

Specific forms of behavior which are proven to be associated with increased susceptibility to a specific injury, disease or ill health (Ministry of Health, 2000), but Flisher et al. has a neat summary: this is behavior that places a person at risk for “adverse consequences”, whether psychological, social or physical (Flisher et al., 1993:15). The Readers Digest Universal Dictionary (1988:1321) defines ‘risk’ as: “the possibility of suffering harm or loss; a factor, element or course of uncertain danger; a hazard; synonym for danger."

[4] State of being vulnerable, i.e. exposed to suffering, needs or threats while lacking abilities and/or resources to cope with these. "Vulnerability means not lack or wants but exposure and defenselessness. It has two sides: the external side of exposure to shocks, stress and risk; and the internal side of defenselessness, meaning a lack of means to cope without damaging loss." Available [Online] (www.undp.org/rbec/nhdr/1996/georgia/glossary.htm) (Accessed: 2007/04/02).

1.2.8 Attitudes:

Attitudes[5] involve what people think (cognition) feel (affect) and how they would like to behave toward an attitude object (connotation) (Triandis, 1971 as cited in Pötsönen and Kontula, 1999:6). Behavior is not only what people would like to do but also what they think they should do, i.e. social norms, habits and the expected consequences of their behavior (Rosenberg and Hovland, 1960 as cited in Pötsönen and Kontula, 1999:6). An attitude contains beliefs, evaluations and action intentions that may affect behavior (Uutela, 1985 as cited in Pötsönen and Kontula, 1999:6).

1.2.9 Perceptions:

Perception is, "in both a colloquial and neuro-psychological sense, what your mind tells you something[6] is." It is "the process of receiving information about, and making sense of the world around us. Perception does not only involved deciding which information to notice and how to categorize the information, but also how to interpret this information within the framework of our existing knowledge" (McShane and Travaglione, 2003:74). Bergh and Theron (2003:104) define perception as: "A selective process by which people interpret and give meaning to external factors."

1.2.10 Adolescence:

Adolescence, which is a transitional period between childhood and adulthood, begins with biological changes associated with puberty and proceeds through a process of psychosocial changes, influenced by cultural factors, which, to a large extent, determine the identity and

[5] "People's biases, inclinations, or tendencies that influence their response to situations, activities and other people" Available [Online] (www.cdc.gov/tobacco/evaluation_manual/glossary.html)(Accessed: 2007/03/26).

[6] Available [Online] (www.oup.com/uk/booksites/content/0199274894/student/glossary/glossary.htm) (Accessed: 2007/04/21)

sexuality of the adolescent (WHO, 2000). Adolescence can be further explained in terms of its onset at puberty, and ending at the time when adult responsibilities are taken on (Terblache, 1999 as cited in Van Dijk, 2002:13). Adolescence is often described as a period of rapid physical, emotional, social, and sexual maturing (Ibid, 2002:14). During adolescence, girls' hips widen and boys develop longer and larger bone structure (Ibid, 2002:14). External signs of sexual maturation are growth and maturation of the sex organs, appearance of pubic hair, developing of breasts in females and deepening of the voice in males (Van Dijk, 2002:13).

For the purpose of this study adolescent/s[7] is referred to the ages between 15- and 18 years.

1.2.11 Adolescents' Sexual Awakening

Sexual awakening differs between and in male and female adolescents. It starts for boys with spontaneous erections and first ejaculation. Sexual awakening for girls starts, according to Terblanche, 1999 as cited in Van Dijk, (2002:13), with the onset of menstruation. However, "sexual awakening is more about the onset of sexual feelings" (Van Dijk, 2002:14).

1.2.12 Coloured Identity

Pre-apartheid conceptualisations understood coloured identities[8] in terms of 'mixed race'

[7] The term "adolescents" is often used to refer to those between the ages 12 and 19. "However, it is not always clear when the period of adolescence starts and when it ends" (Van Dijk, 2002:14).

[8] "The Coloured population of South Africa has its origin in the processes of contact and assimilation between various ethnic and racial groups at the southern tip of the African continent for a period of more than 300 years. Generally speaking, it can be said that various elements were involved in the formation of the Coloured population, normally a Hottentot aboriginal element, a slave element of Dutch East Indian and West African origin, an element of white admixture, a Bushman aboriginal element, and a fifth element in the form of assimilation between coloured and Bantu" (Cilliers, 1963: 9). In terms of the Population Registration Act, 'Coloureds' were defined as 'those who cannot be defined as either white or African' (Wilson and Ramphele 1989; Western, 1996). Yet, despite this negative definition the category was sub-divided into seven sub-categories that included group designations such as 'Cape Coloured' and 'Other Coloured'. South Africa's population of 48 million is made up of Africans/Blacks (79, 4%), Whites (9,2%), Coloureds (8,9%) and Indians (2,5%) (Stats SA, 2006).

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referring to ‘race mixture’ specifically between white masters and black female slaves. ‘Miscegenation,’ a nineteenth century European eugenist concept meant that ‘white’ children with ‘black blood’ came into the world with shame and sorrow coursing in their blood (Mullin, 1924: 251). ‘Blood mixing’ was argued to lead to the degeneration and loss of morals of poor whites in the cities. “As the commission on Mixed Marriages 1939 concluded, ‘mixed’ marriages lead to the infiltration of Non-European blood into the European population” (Norval, 1996: 23-24).

1.3 Background and Rationale

Initially, Aids was linked with high-risk groups such as homosexual men, prostitutes and drug users. In South Africa Aids was seen as a ‘gay’ disease, then a ‘black’ disease. One got the impression that the Apartheid Government didn’t really go out of its way to deal with the situation” (HIV/Aids Leadership, 2005:14). This perception occurred as a result of initial responses to the disease as well as early prevention programmes. The social construction of Aids as a homosexual male disease was based on the factual prevalence of Aids among homosexuals, in places such as San Francisco, USA. People in general denied their own vulnerability by displacing the disease to an ‘other’ who did not belong to ‘their’ group (Miles, 1992: 14-27).

Although HIV infection has affected far fewer people than gonorrhea, syphilis, genital herpes and other sexually transmitted diseases (STDs), it has become more of a public concern for several reasons. Firstly, there is no known cure for full-blown AIDS. The head of the MRC (Medical Research Council of South Africa) has stated that AIDS killed around 336,000 South Africans between mid-2005 and mid-2006 (Washington Post, 2006). However, this figure is probably a massive underestimate, because the majority of deaths due to HIV are misclassified (UNAIDS, 2000).

Secondly, public perceptions of those infected with HIV are often negative, condemning, blaming and stigmatizing. Many people mistakenly assume that someone with HIV infection is gay, is black, uses drugs, is a prostitute, or engages in immoral sexual acts (UNAIDS, 2000).Such misguided reactions often blame the victims and force them to hide their condition in shame and despair at a time when both medical and psychological help is sorely needed (Sue et al., 1994:22). Such beliefs have proved to be a major barrier in educating the public to facts concerning HIV/AIDS, and instituting prevention practices. Although it is true that certain high-risk groups have been identified[9], HIV infection is not limited to any group, but is the result of practices that lead to the infection. The belief that HIV is limited to only homosexual contact is a myth, as one-third of the women who had AIDS in the early 1990's were infected via heterosexual contact (Douce, 1993: 60-64).

In 1982 the first two South African Aids cases were identified amongst white homosexual men (Whiteside and Lunter, 2002: 47). Between 1987 and 1989, the Chamber of Mines conducted a major study in which about 30 000 mine workers were tested for HIV. Malawian miners were the only group where there was significant HIV infection – about 3,76 % were HIV - positive (HIV/AIDS Leadership, 2005: 18). However, by July 1991, the number of heterosexually transmitted cases equalled the number of homosexually transmitted cases, and by 2002 the majority of HIV infections were amongst heterosexual men (UNAIDS, 2002: 190).

South Africa is currently in the process of a demographic transition and a high percentage of the population now live in urban and peri-urban areas, which tend to have a high prevalence of HIV infection. By 1998, although people from more affluent, largely white societies were starting to come out as being HIV positive, stigmatization, denial and fear of the condition remained still deeply rooted in township areas (Inter Press Service, 2000). This phenomenon created the need for a study that would allow the researcher to tap into the depth of cultural knowledge and behavior, particularly of groups that may be of particular interest in relation

[9] Gays, intravenous drug abusers, prostitutes, and people receiving HIV-contaminated blood.

to the spreading of HIV/AIDS, such as amongst adolescents of a community like Valhalla Park. Three factors, namely knowledge, attitudes and practice influence an individual's risk of HIV-infection (Van Dijk, 2002:2). This study was not only designed to get a clearer picture of the township adolescent's perceptions of HIV/Aids and how it influences risk-related behavior, but also to investigate these factors and to gain insight into factors that impact the broader picture of South Africa's high HIV/AIDS prevalence rate.

1.4 Methodology

This research is an exploratory study that includes a survey undertaken by means of a semi-structured questionnaire, with 20 school-going adolescents (15 to 18 year olds) at Beauvallon High School which is situated in Valhalla Park. The group of 20 adolescents were divided into 10 females and 10 males for population representation and convenience. The findings were analysed within an interpretative research paradigm as the research seeks to understand the respondents' definitions and understanding of HIV/AIDS and how it influences their behaviour. A variety of research tools were used in order to gather the necessary data, which will be further discussed in chapter 4:

1. This included a literature review, which is the secondary document analysis.
2. A semi-structured questionnaire was administered to the 20 adolescents. The questionnaire (see Appendix 1), was analysed using the interpretative model and the researcher examined the ways in which the respondents construct their own understanding of HIV/AIDS within their culture. "Survey research, is probably the best method available in collecting original data, and an excellent vehicle for measuring attitudes and orientations" (Babbie and Mouton 2001:232). While quantitative methodologies emphasize the necessity for objectivity, qualitative methodologies have embraced the idea and values of subjectivity that were essentially important for unfolding insights in the developing of themes.

1.5 Profile of Valhalla Park

This council housing estate was built in response to the needs arising from the Group Areas Act No. 36 of 1966, an amended act of the Group Areas Act of 1950[10] (Festenstein et al,1987: 36 - 37). When District Six near Cape Town was declared a 'white' area, all non-whites, specifically 'coloureds,' were relocated to the Cape Flats. The first coloured residents started moving into Valhalla Park in 1979. One third of the residents were relocated from District Six, one third was previous squatters in the Retreat area and the remaining third was taken from the waiting list for council housing. Valhalla Park is situated on Modderdam Road on the northern side of Montana and the south-western side of Bishop Lavis, between Nooitgedacht and Valhalla Drive reaching towards the N2 Highway.

The infrastructure has a typical Cape Flats township character where the roads are narrow (tarred but with potholes and brick-paved) and houses are small and dilapidated. Apart from the council low-cost houses, there are two squatter-settlements (7de Laan situated in Agnes Street and Greenvale, a settlement next to the grounds of Beauvallon High School). The community has a clinic, two primary schools, (Valpark Primary and Parkvale Primary School), a high school (Beauvallon High School), a library, a few crèches, a grocer, a general store, a take-away, a municipal office, a few churches, a few shebeens and an underdeveloped sports field.

The housing office estimates from their records that the current population is close to 21 400. A large percentage (29, 7%) of the population is between 5 and 20 years. Only 4% of the population is over 65 years and the major concentration (58, 8%) is in the 20-44 year's bracket. The township experiences severe socio–economic problems, e.g. teenage pregnancy, a high school dropout rate, unemployment, drug-abuse and -peddling, women and child abuse, domestic violence, prostitution, poverty, gangsterism, a lack of housing,

[10] The Group Areas Act legislated race-based residential segregation in 1950 and caused the forced removal of approximately 750 000 people in urban areas between the 1960s and 1980s.

water and sanitation facilities. This is an ideal breeding ground for any opportunistic disease like HIV/AIDS. Although the clinic attends to the rendering of general community health care since 1988, inclusive of Aids and VCT (voluntary counselling and testing) since 1993, this researcher could not obtain statistics regarding the current HIV infection in Valhalla Park.

1.6 Research Problem Statement and Questions

A number of knowledge, attitude, behaviour and practice (KABP) studies have been carried out on various groups on the issue of HIV and sexual-related matters (Mbanya et al., 2001; Mbago and Sichona, 2003). In South Africa, such studies have involved youth on a national level (Pettifor et al., 2004), commercial sex workers, AIDS patients, university students (Friedland et al., 1991), and even high school students (Flisher et al., 1993; Viljoen, 2001), but less research attention has been given to adolescents between the ages of 15 and 18 years old in an impoverished peri-urban and previously coloured community like Valhalla Park.

1.6.1 Research Problem Statement

The research is based on the following problem statement:
Alongside the scourge of poverty, the devastating impact of the HIV/AIDS pandemic reported by LOVELIFE estimated that HIV infects at least six people between the ages of 15 and 24 years every minute (Lovelife, 2004). Despite this rapid increase of HIV infections among South Africa's adolescent population, many teenagers continue to partake in sexually risky behavior (Aitken, 2005) which is fanned by their knowledge, perceptions, beliefs and attitudes towards HIV/AIDS. As they have become a vulnerable group, "one has to recognize that HIV/Aids is not only a health issue, but a social, economical and cultural issue which is battering the very foundations of our communities and governments" (Coombe, 2000:2).

1.6.2 Research Questions

- How do adolescents in Valhalla Park regard HIV/Aids and how does that influence their behaviour?
- Are myths that include denial and stigma surrounding HIV/Aids prevalent amongst adolescents in Valhalla Park, and used as barriers to safe sex and condom use?
- Is HIV/Aids regarded as a black or gay disease that is distant to most adolescents of Valhalla Park?

1.6.3 Research Objectives/Aims

The specific aims of the study were:

1. To conduct an exploration of the groups' knowledge, perceptions, beliefs, attitudes and behaviour towards HIV/AIDS.
2. To establish, explore and examine factors that influence the group of 20 adolescents' perceptions, beliefs, attitudes and behaviour towards HIV/AIDS.
3. The researcher aimed to interpret these findings against this study's literature review and theoretical framework and to analyse the findings, with recommendation for policy reviews.

1.7 Ethical Considerations

A research study of this nature involves touching on sensitive and emotional issues. This study was conducted once the University had approved the proposal. The following ethical rules for all the parties involved in the research were strictly adhered to:

- Firstly, informed consent was obtained from respondents who participated in the completion of the questionnaire by means of a signed letter of consent and a confidentiality clause in order to keep the content of the investigation private. The letter was pre-drafted by the researcher and approved by the supervisor. Informed

consent was obtained from the Western Cape Education Department, as well as the principal of Beauvallon High School, prior to the student conducting the study.

- Participation in the research study was voluntary, with no form of coercion of participants. Confidentiality was guaranteed, and they could withdraw from the research at any stage.
- The researcher took responsibility for ensuring that all the information gathered was treated sensitively and confidentially.
- Participants were given the option and permission to skip any question on the questionnaire.
- Ethical standards as prescribed by the university were adhered to in all the stages of the research.

1.8 Limitations of the Research

Although HIV/AIDS and related issues surrounding this disease are of a very sensitive nature, it was therefore understood that, because of the suppressed nature of this topic, many adolescents might be reluctant to voice true attitudes or feelings. As this in itself was a limitation on the study, it was seen as a challenge by the researcher. The relatively small sample sizes also limited precision. Unfortunately the small selection of school-going adolescent pupils rather than a larger and more representative group of adolescent males and females meant that the results of the study would not be representative of adolescent females and males who are not at school. It can nevertheless give an indication of possible trends in similar communities and groups which might be used for further research on the characteristics of the Aids epidemic in South Africa.

1.9 Summary

Like previous sexuality related studies (Pettifor et al., 2004; Viljoen, 2001), the motivation for this research is supported by the need to target research interventions in high-risk groups.

This research has as the secondary aim, an exploration and analysis of factors that influence the group of adolescents' attitudes, perceptions and behaviour towards HIV/AIDS in Valhalla Park. The mixed research design was also utilized to explore participants' experience of how living in the AIDS era has impacted on their sexual behaviour.

This chapter is concluded with an outline of the remaining chapters:

Chapter Two focuses on the theoretical framework that forms the basis of this research. For the purpose of this study, social constructionism that is situated in an interpretative research paradigm with its emphasis on meaning of adolescents' behaviour and experiences is used as a theoretical model. This chapter also explains and analyses the application of this paradigm in the empirical research of this endeavour.

Chapter Three presents a review of relevant literature and research that has been published in the field of HIV/AIDS, with reference to the prevalence rate in South Africa, adolescents' HIV-related stigmatisation, fear, blaming and denial, and adolescents' HIV/AIDS related poverty and substance abuse that influences risk behaviour.

Chapter Four describes the relevant methodology that was used in the study. This chapter will outline the method of data collection, data gathering procedures and sample population/participants.

Chapter Five presents and discusses the answers of the questionnaire, providing descriptive and comparative results.

Chapter Six summarizes the findings against the literature review and the theoretical framework of the research, identifying and describing the main themes that emerged from the findings and concludes with recommendations.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 Introduction

The interpretative perspective was used as the theoretical framework for the purpose of this study. The interpretative paradigm is well established and renders the meaning and interpretation of people's views and behaviour.

The disadvantage of the interpretive framework is that it emphasises the meaning that the individual attaches to his/her reality, excluding the structural forces in society. This will, however, be taken into account by the researcher by introducing a structural analysis which will serve to compliment the interpretative approach.

The first part of this section explains the reason for having and using social constructionism within an interpretative framework. In the discussion of the social construction of sexuality and sexual behavior, Miles (1995), recognized that heterosexual practice is strongly influenced by the social construction of sexuality, and thus by the power relations which form part of it.

In the discussion regarding adolescents' identity model and construction of meaning, Macloed and Austin (2003) emphasize that adolescence is a critical period for identity formation in which adolescents have a greater need to conform to the norms of their peers. It is on the basis of Montano et al.'s study (2001) and various others (e.g. Conner and Sparks, 1995; Conner et al., 2003) supporting the efficacy of the theory, that the theory of planned behavior has been chosen for the purpose of this study as an integrated behavioral model to assist when applying social constructionism in interpreting the adolescent's social behavior.

In the next part of this section, the focus is on the importance and value that the researcher attached to the research project. Lesko (2005) noted that when the researcher is involved with

his total human being-ness, it gives an extra value, quality and reality to the study. This passage briefly summarises an overview of the identity of Coloureds and the researcher's stigma-related experiences as an adolescent - which is closely related to that of the adolescents living in Valhalla Park. The last part of the section concludes with a brief summary of this chapter.

2.2 Social Constructionism in an Interpretative Framework

For the purpose of this study, social constructionism is situated in an interpretative research paradigm with its emphasis on the meaning of people's behaviour and experiences, although "the interpretative paradigm does not concern itself with the search for broadly applicable laws and rules, but rather seeks to produce descriptive analyses that emphasize deep, interpretive understanding of social phenomena" (Henning et al., 2005:21).

Social constructionism is accepted as being the theoretical perspective that accommodates and sheds more light on the diversity of human sexuality and behaviour (Tiefer, 1995; Weeks, 1986; Wyatt, 1994) as cited in Henning et al. (2005:21). Although social constructionism is not a homogeneous and singular framework, most social constructionist sexuality researchers (Kelly and Kaliehman, 1995; Mac Phail and Campbell, 2001; Shefer et al., 2000; Tiefer, 1995; Tolman et al., 2003; Vance, 1992) as cited in Henning et al. (2005:21), align themselves with the view that people's sexuality and sexual practices is not a self-contained, separate, independent and consistent experience or behaviour, but that it exists in practices and meanings that are influenced by a specific historical timeframe, culture, gender and class. "Socio-cultural practices and belief systems present the individual with constructs which makes her/his experiences meaningful" (Ibid, 2005:22). These constructs are developed in a person's daily interactions in specific relational contexts, e.g. parental, spousal, social, school, gang, etc. (Weeks, 1986), and "it gives meaning to human activities" (Weeks, 2003:19).

2.3 The Social Construction of Sexuality and Sexual Behavior

Oliver and Hyde (1993 in Browning et al, 1999:3) pointed out that neo-analytic, sociobiological, social learning, social role, and script theories all expect women to have more negative attitudes toward casual, premarital sex than do men. Miles therefore recognized that heterosexual practice is strongly influenced by the social construction of sexuality, and thus by the power relations which are part of this (Miles 1995:2). Sexual intercourse necessarily implies a social activity that includes negotiating sexual practices with a partner (Holland et al., 1994:62). These negotiations are, however, informed and constrained by the more general institutionalization of gendered power relations that occur within a patriarchal structure. It is then necessary to examine both the micro and macro levels that impact on sexual behavior in order to better understand how these might influence each other (Abrahams, 2001).

Culture is at the centre of the perceptions, interpretations and meaning of sexual relations. Young women are taught to approach sexual encounters in a particular way, which are shaped by their sex education, their understanding of male and female desires and their construction of their self-image (Holland et al., 1994:63-65). Thus, the social representations of women and the particular roles they are ascribed greatly influence the realities of many young women and provide the ideal against which they measure themselves (Ibid, 1994:63-65).

Unequal power relations between men and women may render especially vulnerable, young women to be coerced into unwanted sexual relations as well as impact on their capacity to have input as to the how, where and when sexual relations occur. This construction of women's sexuality often requires women to take responsibility for behavior change in an area where their power is limited (Strebel, 1993). As opposed to women, whose vulnerability derives from a lower power, men's vulnerability to HIV infection is caused by their greater power, mainly explained by the prevailing sexual script of male sexuality, which is often

defined as natural, impulsive and initiatory, and expected to be more active and in control (Menda, 2006:23). The proponents of condom-promotion strategies have failed to consider the gender-based power relationships and the way in which this influences a woman's ability to demand that her partner uses a condom. Men might use violence (both implicitly and explicitly) against their partners, and use it within a sexual context as a way of exercising power over women (Kitzinger, 1994), making it almost impossible for the women to successfully demand condom use in this context. Therefore it is assumed that interpersonal and power dynamics could be associated with condom use (Ibid, 1994).

Male sexuality is often construed as being biologically driven and assumed to be spontaneous. Men are perceived of and excused for being reckless and irresponsible in sexual encounters (Kelly and Kalichman, 1995). Attitudes, norms, intentions and behavior control and restraint are linked to men's use of condoms – this might also relate to the frequency and number of sexual partners they have. Women's sexuality, on the other hand, is seen as frigid and repressed, with the expectation that women are and should be better able to control and restrain themselves than men (Ibid, 1995).

According to Shefer "sexuality gets framed as a male domain, in which men control and set the terms, and to which women must be inducted and guided" (Shefer, 2001 in Roman, 2006:26). Miles describes this as the "male sexual drive discourse" in which men are especially driven by the sexual drive, and women are seen as the subject of this sexual drive (Miles 1995: 19). Male sexuality is seen here as active, out of control and initiatory. Men need sex, are focused on sex, are ever ready to have sex, and that is ultimately a biological urge outside their control (Shefer, 1999: 39).

Miles (1995: 42) also found that 'performance' is another important notion in discourses of male sexuality. Sexual performance meant -in her research- that men were able to satisfy women, by keeping their erection until women reach their orgasm. The idea is that men are responsible for the sexual pleasure of women, rather than that she might be responsible for

her own pleasure, or that sexual needs from both partners are negotiated and met as far as possible (Ibid, 1995: 43).

This idea is also prominent in the 'pseudo-reciprocal gift discourse', in which women are 'given' orgasms by men (Shefer, 1999: 122). To be able to 'give' a woman sexual pleasure is seen as proof that you are 'a man' (Shefer et al., 2000:14). Women, in this discourse, are constructed as 'giving' themselves to men, for men 'need' to satisfy their sexual urges. Male sexuality is seen as active and female sexuality as passive (Shefer, 1999:122).

These social prescriptions impose double standards which have a major impact on the way in which men and women relate to each other, and inevitably influence negotiations about condom use (Abrahams, 2001) and sexual behavior, setting the stage for conflict and behavioral inconsistency.

2.4 Adolescents' Identity Model and Construction of Meaning

Adolescents are in a state of transition, embarking on their sexual careers (laden with proscription and tension), developing their adult identity, and very sensitive to peer norms (MacLoed and Austin, 2003) and thus may be likely to both express and experience their encounters more deeply than both adults and younger children (Deacon and Stephney, 2007). "Adolescents may therefore experience more conflict around feelings of difference than younger children" (Ibid, 2007: 44) as it is a critical period for identity formation (MacLoed and Austin, 2003 as cited in Van Dijk, 2002:14).

For the adolescent, this process entails restructuring their network of significant others. In adolescence, the role models of identity and source of emotional dependency shift from parents to peers. At the start of adolescence, parents occupy the central position in their personal network (Meeus and Dekovic, 1995:4). Gradually friends and later even a partner become increasingly important in this network, and take the place of the parents as the most

important reference persons. Interaction among peers is based on the principle of symmetry and equality (Youniss and Smollar, 1985), as, during the course of adolescence youngsters are therefore learning to get along with each other on the basis of equality, replacing the dominance of the parents (Meeus and Dekovic, 1995:4). Adolescent identity formation and development is the period of the second separation-individuation process (Blos, 1967 in Meeus and Dekovic, 1995:4).The second separation-individuation involves a much more radical disengagement. They become independent and learn gradually to make their own decisions. The gang and the clique give adolescents the opportunity to practice trying on roles to see whether or to what extent they will fit them. Dependency on peers will give way to a mature identity and a sense of inner assurance (Eriskon, 1959 in Reyland et al., 2002: 292).This means that adolescents are more likely than younger children to use emotion-focused coping and thus try and avoid negative thoughts, a strategy that has been associated with greater distress than problem-focused coping or dual-focused coping (Worsham et al., 1997).

Although older children are less likely to become overwhelmed in stressful situations, they are more likely to internalize negative experiences and information and may be more realistic in their self-perception and in perceptions of the intentions and beliefs of others (Eisenberg et al., 1997). For example, in a research on children with parents who have cancer, adolescents were found to have greater adjustment problems than younger children (Compas et al., 1994 as cited in Forehand et al.,1998), perhaps because of more knowledge about illness or greater responsibilities in the family (Deacon and Stephney, 2007)[11].

But one primary risk factor that many adolescents face is negative peer influence. A clear relationship between negative peer influence and maladaptive outcomes has been established in the literature[12] on 'at-risk' youth of colour (Ary et al., 1999; Dishion et al., 1997;

[11] Available [Online] http://www.ingentaconnect.com/content/carfax/cadd/1995/00000090/00000003/art00002;jsessionid=4o200tagce4k1.alice?format=print (Accessed: 2007/04/04

[12] e.g., juvenile delinquency, substance use, and school dropout and high risk sexual behavior.

Fergusson and Horwood, 1998; Laird et al., 2001; Vitaro et al., 2000) in Meeus and Dekovic (1995). Yet, few studies demonstrate what resources might buffer or protect youth from the effects of negative peer norms on low-income racial and ethnic minority early adolescents. In the context of adolescence and HIV, peer norms impact perceptions, beliefs, attitudes and behaviors related to HIV/AIDS and peer support may serve as a protective function for youth at-risk. In a nutshell: "adolescence is a highly significant period in which individuals learn future roles, incorporating the norms and values of their society in their quest for personal identity and a sense of social meaning" (Nanyangwe, 2006: 14).

2.5 Adolescents' Social Behavior within an Interpretative Framework: An Integrated Behavioral Model Application

Numerous studies have shown that social cognitive models are the most effective and valuable theoretical tools in predicting HIV-preventive behaviors and can provide "theoretical guidance on psychological changes likely to result in HIV-preventive behavior change" (Abraham et al., 1998: 297) and interpreting social behavior.

It is on the basis of Montano et al.'s study (2001) and various others supporting the efficacy of the theory (e.g. Conner and Sparks, 1995; Conner et al., 2003) that the theory of planned behavior has been chosen for the purpose of this study as an integrated behavioral model to assist when applying social constructionism in interpreting the adolescent's social behavior. The theory of planned behavior (TPB) (Ajzen, 1991) as cited in Breslin et al. (2001: 424-425), is a successor to the theory of reasoned action. TPB holds that intentions, one's motivation to engage in a behavior (in this case to adopt the interventions), are directly related to the likelihood that that behavior will occur. The three primary determinants of intentions are one's attitude towards behavior, social norms and perceived behavioral control (Godin and Kok, 1996). In TPB, attitude, one's overall evaluation of the behavior, is determined by one's positive and negative beliefs about what will happen if one engages in the behavior. Attitudes become increasingly favorable to the degree that the expected

positive outcomes outweigh the negative outcomes (Kasprzyk et al., 1998).

The social context (e.g. culture, religion) can also influence the likelihood of adoption of behavior. In TPB, the subjective norm, the perceived social support for the behavior, is partly influenced by one's beliefs about what key social referents think about performing or not performing the behavior. These beliefs and one's interest in complying with the social referents jointly determine the overall subjective norm. Rogers also notes that the nature of the social system also affects an innovation's rate of adoption. As Conner and Sparks (1995:127) confirmed, while the theory of planned behavior is considered to be a comprehensive theory of behavior, it can be more accurately be regarded as a theory of the 'proximal determinants of behavior.' It, therefore, lends itself well to an extensive range of behaviors (Ibid, 1995).

According to Abraham et al. (1998) and Sheeran and Orbell (1998) as cited in Aitken, (2005: 31-32), perceived behavioral control is closely related to the term perceived 'self-efficacy.' It refers to the level of confidence the adolescent has and that s/he will behave according to her/his intentions. The theory of planned behavior hypothesizes that the intention to act is higher if the adolescent has a positive attitude about the behavior as well as believing that significant others will approve of the decision to act (Abraham et al., 1998). An adolescent with high self-efficacy will set high goals, exert greater effort, persevere for longer despite obstacles or errors, and be less prone to anxiety and self-doubt when performing the required action (Ibid, 1998). The inclusion of perceived behavior control was found to have been a significant contribution to the predictions of intentions to use condoms and actual condom use (Conner and Sparks, 1995) and refraining from high risk behavior.

2.6 Emphatical Framework: Making Sense and Attaching Value

The perspectives in this study draws heavily from the personal experience of the researcher as he also had his 'fair' share of discrimination and stigma as an adolescent. Lesko noted in

his thesis that the researcher "thus moves further into a methodological reality where the importance of the 'personal' in one's research is viewed as the most important component in the journey for quality in one's research" (Lesko,2005:13). “We, as the researchers, know that we have to be involved in our research with our total human being-ness. We need the freedom to bring our being in. Only out of that freedom can we create and reach out to the other research actors" (Buskens, 2002:12).Buskens further concludes that: “the research situation is the context in which scientific norms find personal justification, while methological discourse is the context in which personal discovery finds scientific justification" (Lesko,2005:13).

For me, growing up ‘coloured’ meant knowing that I[13] was not only not white, but less than white, not only not black, but better than black (as we referred to African people). At the same time, the shape of my nose and texture of my hair placed me in the middle on the continuum of beauty as defined by both men and women in my community. I had neither ‘sleek’ hair nor ‘Boesman korrels (Bushmen corns)’ (Erasmus, 2001:13 -14). When one lives aspects of both black and white cultural identities, having to choose one means the denial of some part of (me) the self.

Being classified a coloured (of which I was in total denial throughout my childhood and teenage years) I awoke to the harsh socio-economic realities of the Cape Flats that was in turmoil due to the apartheid struggle. Not only did I have to cope with racial identity, but my sense of self and my identity took a battering through various personal losses, betrayals, failures and other disappointing experiences. The process of growing up and maturing was consequently unsettled, dysfunctional and dislocated.

Our family of nine members were forced to become backyard squatters “due to the relatively slow expansion of the provision of low rent housing for coloureds in the main urban areas

[13] ‘I’ and ‘Me’refers to the researcher.

during the 1950's" (Cilliers, 1963:19), and the inequality of labour remuneration[14]. Both my parents were forced to work for a meagre weekly wage that compelled us to live in a one-roomed 'iron-shack cottage' in my paternal grandparents' backyard, where we as children had to endure severe hardships and survival trauma. During this time, economic conditions were bad and tough as "roughly 50% of coloured families lived below the need level" (Ibid, 1963: 28).

At high school I was the 'odd one out' or 'the loner' as everyone was aware of the shambles that was called my home. Ironically, I was blamed for the situation that I found myself in, for being a 'victim' of social-economic circumstances that were beyond my control. Needless to say that I was an under achiever for the most part of my high school years…

The grim and violent political character of the country made me realize the truth. I, as a 'coloured adolescent', had to 'accept' that we as 'coloureds' were stigmatized as 'second class' citizens and had to deal with the reality of having to face discriminatory actions by whites and the de-humanizing policies of the then apartheid government. Goffman (1963:12) in Lesco (2005:14), states that stigma reduces the bearer "from a whole and usual person to a tainted, discounted one." Discrimination and stigma were the egotistical 'voice of the oppressor' (South African Apartheid Government). Freire (1970:46) alluded that the "oppressor, who oppress, exploit, and rape by virtue of their power, express their 'generosity' by perpetuating injustice". As a coloured, I, as well as the rest of my clan, was part of an unjust social order that was the recipient of this "generosity, which was nourished by death, despair and poverty" (Ibid, 1970:46).The South African 'apartheid regime' forced me to internalise 'oppression' by taking away my dignity and making me feel ashamed and worthless as an adolescent.

Living as we did, as part of the developing White-dominated South African society, we

[14] In terms of apartheid, Africans could have "no right of existence in the Western Cape" which was the natural labour field of the White and Coloured man (Labour policy of 1955) (Wilson and Thompson, 1978: 193).

internalised white values and behaviour. Those coloureds that were poor did not have long and sleek hair and whose skin was not 'white' enough, were discriminated against and looked down upon as 'others' by their own and treated as such. Instead of striving for liberation the oppressed tended to become 'oppressors' or 'sub-oppressors,' as this was their model of humanity (Freire, 1970:47).

In the wage to transform towards fuller humanity, coupled with my mother's strong belief in me, I enrolled for and completed a two-year Teacher's Certificate course at Bellville Teachers' College, which was reserved only for coloureds,[15] after matriculating in 1974, with an exemption at a public high school in Caledon. Even in the face of oppression by the ruling regime, a disease as destructive as HIV/Aids, or poverty, can be functionally domesticated. "To be no longer the prey to its force one must emerge from it, and turn upon it, in order to transform it" (Freire, 1970:53). I, as the 'victim,' had been empowered enough to change myself, which in turn, forced me to interpret my surroundings differently and ascribe to it meaning. My legacy must be about how and what I changed and made a difference in, and not about my oppressors.

I purposefully embarked on this study in the hope that it would help me deal with the 'past phobia' of ill-feelings and thoughts of rejection, helplessness and fear that I experienced as an adolescent – issues which I have tried sweeping under the carpet for a number of years. The harsh socio-economic conditions that most of the adolescents of Valhalla Park find themselves in I can personally relate to as it echoes and serves as a vivid reminder of my roots, of where I come from and of a way of life that ripped out a part of my soul.

2.7 Summary

The relationship between the adolescents' knowledge, perceptions, beliefs and attitudes that

[15] Under the Group Areas Act, welfare services and education for coloureds was transferred according to the Government Policy of 7 December 1960 to the Department of Coloured Affairs (Cilliers, 1963: 39 – 53). Coloured matriculants' career options were limited to the nursing or teaching professions.

motivates their behaviors is complex. Therefore, an approach to research these influences that impacted behavior towards HIV/Aids is more meaningful when it also explores meanings to practises as an agent of social control.

Given the present spread of AIDS, it has become also more urgent now than before to examine the extent to which the vulnerability of women to STDs and related diseases, such as AIDS, is reinforced by social values (Awusabo-Asare et al., 1993), culture, and women's control over their sexuality, power relationships, and economic relationship dependency. It seems that for most male adolescents sexual intercourse is a prerequisite for a relationship and it is the partner's duty to comply. It is inconceivable for a woman in such a relationship to refuse to sexual intercourse and possible protected sex. Pellow (1977) pointed out that, although African women do not trust their boyfriends, they believed that several are needed as a financial insurance. This perception of and attitude to relationships begins during adolescence when young girls sleep with their boyfriends in return for small gifts and presents (Akuffo, 1987), even though their partners may be involved in promiscuous practices.

To summarize then, adolescence identity formation and development is the period of the second separation-individuation process (Blos, 1967). This process entails restructuring their network of significant others. At the start of adolescence, parents occupy the central position in their personal network (Meeus and Dekovic, 1995:4). Gradually friends and later even a partner become increasingly important in this network, and take the place of the parents as the most important reference persons.

The theory of planned behavior recognizes implicitly the importance of perceived social support for behavior and incorporate normative beliefs or similar constructs to represent such influences; the assumption of this is that attitudes and perceived social support are interdependent and interactive in the expressed adolescent's behavior "when it is supported by a favorable environment" (Grube and Morgan, 1990:329). The effect of these variables on

the adolescent can increase or decrease his/her involvement in high risk behavior. The outcomes of this behavior are considered to be one way for adolescents to cope with the challenges of everyday life.

Being empathetic and attaching value to the study gives the researcher the added advantage of taking the respondent's personal information and ascribing insight and understanding to it (Neuman, 2000). The researcher was acutely aware of the attitudes he brought to the research but stayed as closed and objective as possible to how the respondents made meaning of their lived experience. His discipline, own experiences, values and priorities partly determined the research questions and partly determined which categories and themes in the data focused on.

The interpretative perspective as a theoretical framework represents of a school of thought that suits this research as it focuses on understanding " social reality and society from the perspective of the actors who interpret their world through and in social interaction" (DeMarrais and Lapan, 2003:6), the ' actors' being adolescents and 'social reality' being their knowledge and perception of HIV/AIDS which is reflected in their daily behaviour and social interaction.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

The statistical presentation of the HIV prevalence rate at the macro and micro levels in South Africa shows that HIV should be of a serious concern and serves as an introduction to the discussion of the other themes in this section. The reason for this approach is to argue that such an emphasis leads to the understanding of poverty, knowledge and perceptions, substance abuse, risk behaviour, blaming and denial, and stigmatization as static and non-static factors which can be attributed to the adolescents' HIV prevalence rate of 16,2%. This devastating HIV quake has thus resulted in more than a 1000 daily deaths locally according to an UNAIDS estimation, an effect far worst than a Tsunami!

In a local study done by Van Dijk (2002), she discovered that most strategies that aimed to prevent the further spread of HIV/AIDS among adolescents have concentrated on the promotion and spread of condoms but neglected to take account of relevant social, cultural, and economic factors. The literature further attempts to confirm that knowledge and perception regarding HIV/AIDS, STDs, risk-reduction and contraceptives, are important factors in HIV-risk.

The UNAIDS (1997) introduces the literature on adolescents' risk behaviour and attitudes by stating that the majority of adolescents have been initiated into sexual intercourse before they leave their teens, and at least half by the age of 16. The passage further interprets facts that Van den Berg (2004) cited in his thesis about the Kaiser Family Foundation study and conclusions arrived at regarding South African youth and sexual behaviour. Statistical data related to adolescent behaviour and the pregnancy rate in the study is presented and discussed. Van Dijk concludes that many young people in South Africa practice 'serial monogamy,' which means that they have one partner at a time, but new partners, follow up soon, hence their exposure to high risk behaviour and STI's.

Martin (1986) introduces the concept of stigma from a social learning perspective and argues that learning to stigmatise is part of the adolescents' upbringing. In the literature regarding HIV/AIDS fear, denial and blaming, Sondag theorizes that fear was the cause that prompted denialism by various governments with the initial dealing of the Aids epidemic in their countries. Denialism resulted in time consuming and ineffective management of the disease with disastrous outcomes. On the other hand, for many adolescents affected by HIV, denial is a natural response to news of an HIV diagnosis. Blaming which constituted the second phase in dealing with the disease became the substitute for acknowledgement and action. Crew suggests that blaming others has no purpose and only puts everyone at risk.

The next part of the chapter involves discussion on the impact of HIV related poverty and the role unemployment plays in the adolescent's behaviour. As HIV/AIDS incidence in South Africa is amongst the highest in the world, it is noted that HIV/AIDS related deaths are now a major cause of chronic poverty and therefore a potential cause to increase malnutrition. At the same time the alarming accelerating rate of the epidemic is also tied to poverty. This passage further investigates survival strategies of young urban school-going females in alleviating poverty by being exposed to and exposing themselves to high risk behavior.

The literature on adolescents' substance abuse and HIV/Aids briefly discusses various research done on this topic by Lovelife (2004); Fergusson and Lynskey (1998); Donovan and McEwan (1995); Cooper et al. (1990), and Strunin and Hingson (1992). Some of these researchers have, over a long time, hypothesized that the consumption of alcohol (Strunin and Hingson, 1993), smoking and drug intake increased the likelihood of sexual risk-taking behavior or unsafe sexual practices, by influencing young people's judgment and ability to make responsible decisions. Due to time constraints, the aim or focus in this part of the literature is not on identifying various drugs and to relay the behavioral consequences and influences thereof, but rather it is an attempt in providing an overall insight of substance consumption and abuse as contributing factors to the spread of HIV-infections amongst adolescents. The last section is tailored to summarize the chapter.

3.2. Adolescents' HIV/AIDS Prevalence Rate in South Africa

The HIV/AIDS epidemic is the most deadly and devastating epidemic in recent history. By 2000 nearly 58 million people had been infected by HIV and 22 million had already died (Whiteside, 2002:313)."Twenty years into the epidemic Africa is the epicentre, having 26 of the 28 worst affected countries" (Ibid, 2002:315). In less than two decades, HIV/AIDS has been transformed from a medical curiosity to an international emergency[16] (UNESCO, 2001).

In 1990, the first antenatal survey conducted in South Africa found that 0,8% of women attending state clinics were HIV positive, and by the end of 2001 the national prevalence rate of South Africa as a whole was 20, 1 % (UNAIDS, 2002: 190) with the highest rate (21%) occurring among people living in townships and informal settlements (Shisana and Simbayi, 2002 as cited in Mlobeli,2007:18).

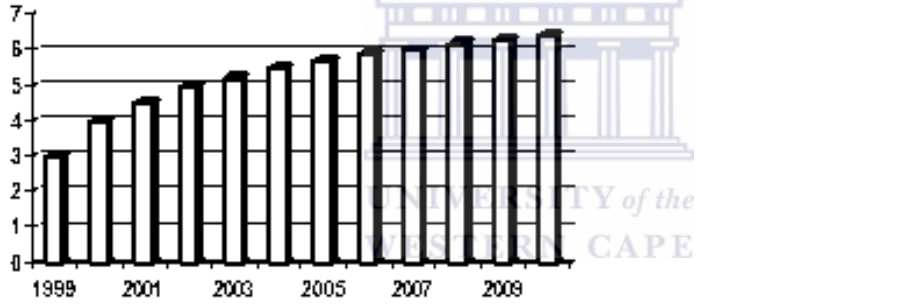
The tenth year of South Africa's democracy was the twenty- third year since the first AIDS case was noted in medical journals. Unfortunately, however, HIV has always been ahead of attempts to contain it - the situation has intensified rather than diminished. In 'Towards a Ten Year Review,' published in early 2004 by the Presidency of the South African Government, it is recorded that 'the prevalence of HIV/ AIDS' as estimated from public antenatal clinics shows an increase from 0.7 per cent in 1990 to 26.5 per cent in 2002' (Department of Health, 2002, 2003:22). What is not noted is the rapid increase in HIV-related deaths. In April 2004, the SA Medical Journal reported that between 1997 and 2003 adult mortality had undergone a 'real increase of more than 40 per cent' (Bradshaw et al., 2004: 278-279). Thus, by 2000 (as in Figure 1) the HIV/AIDS epidemic in South Africa has emerged as one of the greatest threats to post-apartheid reconstruction and development.

[16] Records have indicated that the highest HIV prevalence in the world is found in the countries of Southern Africa, East Africa and the West African countries (Akinade, 2001).

By the end of 2005, there were five and a half million people living with HIV in South Africa, and almost 1,000 AIDS deaths occurring every day, according to UNAIDS estimates (UNAIDS, 2006). Since the primary mode of HIV transmission is penetrative heterosexual sex, assumptions have been made that South Africans engage in more sexual activity than residents of other countries (Whiteside and Lunter, 2002: 59). However, there are no statistics available to support this belief.

The graph below (Figure 1) projects the total number of HIV – positive South Africans up to 2010 as cited in Lesejane, (2004:2).

Figure 1



Total number of HIV-infected South Africans in millions (Whiteside et al, 2000:53)

Young people are the age group most severely affected by AIDS in South Africa, with the largest proportion of HIV infections in the country occurring amongst people between the ages of 15 and 24 (UNAIDS, 2006). The level of HIV infection amongst pregnant adolescents younger than 20 years was 6,7% in 1994 and rose to 12,7% in 1997, and to an alarming 21% in 1998, an increase of 65% within one year (Department of Education, 2001). Furthermore, more than 60% of new infections occur among 15 to 24 year olds, with adolescent girls most frequently diagnosed (Call et al., 2002).The estimated HIV prevalence during 2000 in females (15-24) was between 22,51% and 27,13%, in males (15-24) 7,56% to 15,11% (UNAIDS, 2000: 125). In 2002 the estimated national South African HIV prevalence

rate among 15- to 19-year-olds was 6% (4% in males and 7% in females), 20- to 24-year-olds 13% (8% in males and 17% in females) and 25 to 29-year-olds 28% (22% in males and 32% in females), and among African/Black youth 15-24 years) 10.2%, Coloured youth 6.4%, Indian youth 0.3% and Whites (15-49 years) 6.2% (Shisana and Simbayi, 2002: 47-51). Apart from the fact that HIV/AIDS is a disease of choice the HIV epidemic among young people aged 15 to 24 seem to also be gender biased, based on the large discrepancy in infection rate of males and females of that age group.

Based on The National HIV Survey of 2005, for those between 15 and older, the estimated HIV prevalence was 16.2% in 2005 (UNAIDS/WHO, 2006). In mid-2007, following the latest antenatal survey, the Department of Health, in collaboration with UNAIDS, WHO and other groups, published an updated estimate of 18.34% prevalence in people aged 15 and older (Noble, 2007:10). Predictions that are made by various research organizations, e.g., Reproductive Health Care Unit (2004), based on current trends among adolescents estimate that by 2010, 50% of the current 15 year old adolescents will be HIV positive and by 2015, around 5.4 million South Africans will have died of AIDS (Noble, 2007:12).

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3.3 Adolescents' HIV/Aids Knowledge, Perception and Risk Behaviour

Earlier international studies have found that young people, despite good HIV/AIDS knowledge, underestimate their own risk of becoming infected with HIV. Adolescents believe themselves to be less promiscuous than average (Abrams et al., 1990 as cited in Pötsönen and Kontula, 1999:6), and they believe that their -and their partners' sexual behavior- is responsible[17]. Woodcock et al. (1992 as cited in Pötsönen and Kontula, 1999:7) argued that some adolescents did not trust the information in mass media and believed that the risk of infection was exaggerated compared to other risks of life. Knowledge and perception, regarding HIV/AIDS, STDs, risk-reduction and contraceptives, are important factors in HIV-risk. For example, in order to practice safe sex adolescents should know how

[17] Regarding e.g., condom use, HIV testing, knowing the partner, faithful and long relationships.

to use condoms. Knowledge about sex and sexuality is also important as to how adolescents view, experience and practice sex. Adolescent women who believe that sexual pleasure is more important for men might be less tended to negotiate their own sexual desires and needs (Van Dijk, 2002:22).

Nightingale and Fischhoff (2001:1) postulate that adolescents obviously do not always act in ways that serve their own best interests, even as defined by them. Sometimes their perception of their own risks, even of survival to adulthood, is larger than the reality; in other cases, they underestimate the risks of particular actions or behaviors (Ibid, 2001:1). It is possible, indeed likely, that some adolescents engage in risky behaviors because of a perception of invulnerability - the current conventional wisdom of adults' views of adolescent behavior. Others, however, take risks because they feel vulnerable to a point approaching hopelessness (Fischhoff et al., 2000). In either case, these perceptions can prompt adolescents to make poor decisions that can put them at risk and leave them vulnerable to physical or psychological harm that may have a negative impact on their long-term health and viability (Nightingale and Fischhoff, 2001:1).

In South Africa a number of studies have been conducted into students' and adolescents' knowledge, attitudes and behavior with specific reference to sex, contraceptives, condoms, STD's and HIV/AIDS. Scholars such as Peltzer (2003), UNAIDS (2004), Shisana and Simbayi (2002), have found knowledge of HIV to be an important factor in the cognitive processing of information and therefore important in influencing the attitudes and the behavior of individuals and groups. These studies found that students tend to have a high degree of knowledge and awareness of HIV infection and AIDS (Oswalt and Matson, 1993). However, this knowledge does not translate into an accurate perception of their own risk, despite the fact that they participate in high-risk behaviors. The main reason for this appears to be that students felt sure that they were not at risk of being infected with the HI-virus, and that they appeared to be more concerned about the fear of pregnancy than the fear of AIDS (Ibid, 1993). This is also partly because of the tendency to project susceptibility to infection

onto stigmatized others (Friedland et al., 1991).

According to Perkel et al. (1991:1) - who explored students' knowledge, attitudes, practices and psychological factors such as self-concept, denial and repression - students with a poor self- concept in the area of sexuality are more prone to have been involved in sexual relations, more likely to have had sex with someone other than their steady partners, and also more likely to have an unsafe sex score. These people are also less likely to have good knowledge about AIDS, and are also more likely to have a negative attitude to the use of condoms (Ibid, 1991:1).

Most strategies aimed at preventing the further spread of HIV/AIDS have concentrated on the promotion and issuing of condoms and often did not take into account relevant social, cultural, and economic factors (Van Dijk, 2002:1). There are many socio-cultural barriers to safer sex options in townships across South Africa. Because of the lack of information and access to relevant health services in most communities, adolescents have become particularly vulnerable to HIV-infection. Premarital adolescent sexuality is also a taboo subject in most township societies and “reproductive needs are often denied or ignored, resulting in a high rate of HIV-infections, STDs and teenage pregnancies" (Ibid, 2002:1).

3.4 Adolescents’ Attitudes and Risk Behaviour

In literature it is argued that adolescents, due to their attitude towards life, tended to be more likely to engage in risk behavior, like the practice of unsafe sex, alcohol or drug intoxication, and others (Fischhoff et al., 1998; Lindberg et al., 2000 as cited in Nightingale and Fischhoff, 2001:1). The age at which intercourse first occurs varies considerably between countries, but the majority of adolescents around the world have been initiated into sexual intercourse before they leave their teens, and at least half by the age of 16 (UNAIDS, 1997: 7), or before the age of 15 (WHO 2002:11).

But other problems remain. In their anxiety and embarrassment about sex, young people

-especially young men - are reluctant to present themselves for medical attention when they experience sexually-related problems. It has also been found that adolescents who have low self-esteem report relatively more sexual behaviours, which place them at risk of HIV infection (Di Clemente et al., 2002:13). In a local survey, young men reported starting sex at an earlier age than females and international research demonstrates that the earlier the age of first sex the more likely it is that sex is unprotected. Further, young men were more likely to report feeling peer pressure to have sex than young women, which may influence early age at first sex (Lovelife, 2004:74).

With regard to South African youth and sexual behaviour, a research conducted in 2000 by the Kaiser Family Foundation (2001:23) as cited in Van den Berg (2004:2-3), presents the following facts:

- It was found that 33% of the youths between the ages of 12 and 17 years have already had intercourse.
- Young girls that have already been pregnant amounted to 4%.
- Of the sexually active girls, 16% acknowledged the fact that they had exchanged sexual favours for money, food, drinks or other gifts.
- The research indicated that 25% of the girls and 7% of the boys admitted that they had been forced into having sexual intercourse. Gangs often regard the girls in their areas as their property and therefore available for sexual intercourse.

Mac Phail and Campbell also reported that many young men believe that if sex is not willingly offered they can force their partners, sex being a necessary part of a relationship (Mac Phail and Campbell, 2001:1623). In a study done by Van Dijk with adolescent-scholars at two schools in the Eastern Cape, the female participants said that they did not call it rape, because they - the boys - were their boyfriends (Van Dijk, 2002:91).

Another research conducted locally found that adolescents were aware of the effectiveness of condoms, but have negative attitudes towards using them for some of the following reasons:

alternative methods of contraception are available and deemed to be more desirable; contraception is a woman's concern; the nature of sex as being unplanned and spontaneous; the unavailability of condoms; the stigma attached to using condoms, as well as the idea that condoms decrease sexual sensation and pleasure (Preston-Whyte and Gcadinja, 1993). "The use of condoms is often viewed as an insult and proof of distrust. The believe is that the person who's using it, or requesting its use, probably already has a sexually transmitted disease" (Le Roux, 1994:266). Research has also found that negative attitudes towards condoms are related to the notion that 'real men' do not use condoms, and that condoms do not belong in a trusting relationship (Abdool Karim et al., 1992), and underestimating the relationship of contracting the disease and having fun.

It is also clear that many young people, who do use condoms, use them wrongly or inconsistently. Consequently, a lot of young people have STDs, are infected with HIV, or have an unintended pregnancy (Van Dijk, 2002:82). Teenage pregnancy is regarded as a major problem in South Africa. Young people practice 'serial monogamy', which means that they have one partner at a time, but new partners follow up soon. Nevertheless, adolescents may asses each relationship as 'steady' (Ibid, 2002:81), thus giving way to risky sexual behaviour. Thirty-five percent of women younger than 20 years of age have been pregnant or have a child (Jewkes, 2001:733). Most of these young women are unmarried and still at school. The high figures of teenage pregnancies reflect a pattern of high-risk sexual behaviour.

3.5 Adolescents and HIV / AIDS related Stigma

More than a century ago, Louis Pasteur, the father of bacteriology, stated that "the microbe is nothing; the terrain is everything" (Stillwagon, 2000:5). HIV transmission amongst adolescents cannot be reduced simply to only sexual or drug-using behaviour. As with any other infectious disease, transmission is also greatly influenced by the 'terrain', which is primarily the social and economic in context. Each human environment has characteristics

that affect the behavior of adolescents in many subtle ways. Aspects of this context that are relevant to the susceptibility to HIV infection include "gender, stigmatisation, denial, poverty, culture, family norms and values, religion, and the standards that society sets for itself" (Kelly, 2004:9).

Each society defines instruments of social control in a form of laws to ensure adherence to social norms that society sets (Becker and Arnold, 1986:39-40). Punishment is imposed when even adolescents break or deviate from norms. According to Link and Phelan (2001) in Lesko (2005:22), "stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination." Stigma related to HIV/AIDS appears to be more severe than those associated with other life-threatening conditions (Ibid, 2005:22).

HIV/AIDS-related stigma is often expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, and injection drug use. People with certain religious beliefs and less educated people may be likely to harbor HIV/AIDS-related stigma (Herek et al., 2002: 375).Stigma has been defined as a significantly discrediting attribute and is a common human reaction to disease (Goffman, 1963). Historically, people with diseases like leprosy, tuberculosis, cancer, mental illness and sexually transmitted diseases have been discriminated against and stigmatized. However, in the latter part of the 20th century, people living with HIV/AIDS have been subjected to the cruelest form of discrimination and stigma (Brown et al., 2001:2).

Stigma is a powerful tool of social control. Stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics (Fredriksson and Kanabus 2007:1).In a study of young gay and bisexual men who were unaware of their HIV status, two-thirds of the participants expressed a fear of discrimination against people with HIV and

said it was a reason for not getting tested (Stall et al., 1996). Herek observed that gay men and injection drug users are disproportionately susceptible to HIV-related stigma and discrimination (Herek, 1993 as cited in Brown et al, 2001:5). He has found that HIV-related stigma is not necessarily a stigma of the diseased; rather, it is often related to the perceived lifestyle 'choices' of infected populations or to perceptions about racial and ethnic minorities (Herek, 1999 as cited in Nick, 2007:5).

Much of the adolescents' "social learning of stigma occurs during elementary and secondary school years, when they observe who is best treated by teachers, who is not much liked in their small reference groups or gang, and against whom the rules of social conduct work" (Martin, 1986:149). Goffman (1963) as cited in Lesko, (2005:34), also noted "that school entrance is often reported as an occasion of stigma learning, with taunts, teasing, ostracism, bullying and fights" being the order of the day.

Adolescents experience stigma that can be either 'internal' or 'external' (UNAIDS, 2002). External stigma has a "powerful capacity to produce internalization and acceptance of inferiority by the oppressed group and justification of discrimination by the dominant group" (Policy Project, 2003 as cited in Lesko, 2005:34). Internal stigma is the "shame associated with HIV & AIDS and fear of being discriminated against. Internal stigma is a powerful survival mechanism to protect oneself from external stigma and often results in the refusal or reluctance to disclose HIV status or the denial of HIV&AIDS and unwillingness to seek help" (Ibid, 2005:34) or to be tested.

Stigma has also been divided into *felt* or *perceived* stigma and *enacted* stigma by some authors e.g. Jacoby, 1994; Malcolm et al., 1998; Scrambler, 1998 in Brown et al. (2001:4). Felt stigma refers to real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group. For example, an adolescent may deny his/her risk of HIV, refuse to use condoms, or refuse to disclose HIV status for fear of the possible negative reactions of

family, friends, and community. Enacted stigma, on the other hand, refers to the real experience of discrimination. For example, the disclosure of an individual's HIV-positive status could lead to loss of a job, health benefits, or social ostracism (Ibid, 2001:4). These factors also influence adolescents' responses to testing positive. It aggravates the psychological burden of receiving a positive HIV test (Chesney and Smith, 1999). Earlier in the epidemic, there were reports of severe psychological responses to notification, including denial, anxiety, depression, and suicidal ideation (Coates et al., 1987). Felt stigma can be seen as a survival strategy to limit the occurrence of enacted stigma, such as when someone deny their risk of infection or fails to disclose HIV status in order to avoid being ostracized (Brown et al., 2001:4).

Unfortunately, after being tested positive, the adolescent not only faces decisions that include how to enter and adhere to care and whether to disclose HIV seropositivity, but also having to fall prey to stigmatization.

3.6 Adolescent and HIV/AIDS related Fear, Denial and Blaming

The first phase of the HIV/Aids - pandemic was fear, a not unreasonable reaction to a disease, as Sontag observes, 'that doesn't knock before it enters' (Sontag, 1978).This fear prompted denial by most African governments (Fredland, 1998). Some combination of fear and denial must explain the situation in the 1980s of a Zimbabwean minister of health ordering physicians not to report AIDS as a cause of death (Ibid, 1998).

From the first cases of Aids in the early 1980s, affected people had to battle government denial to get their health and social needs recognized and attended to[18]. Many people argue that the response to HIV/AIDS in South Africa has been hampered by 'AIDS denialism', a minority quasi-scientific movement that refutes the conventional idea that HIV causes AIDS.

[18] This is evident in the slogan ' Silence = Death', popularized by the Aids Coalition To Unleash Power (ACT- UP), one of the first Aids activist organizations in the USA, and in the angry essays of people like Larry Kramer, who in the early 1980s shattered polite silence about HIV with newspaper articles (Kramer, 1997).

Some leading figures in South Africa have flirted with this school of thought, much to the dismay of AIDS activists. The previous president, Thabo Mbeki has consistently refused to acknowledge that HIV is the cause of AIDS. He argued that HIV is just one factor among many that might contribute to deaths resulting from immunodeficiency, alongside others such as poverty and poor nutrition (Iclinic, 2000). But due to international pressure, the president "officially accepted the need to combat AIDS/ HIV with the anti-retroviral drugs that have proved successful elsewhere in the world" (The Gazette, 2007:18).

Individual and psycho-social denial about HIV must be distinguished from the various manifestation of political denial that has characterized responses to HIV.

For the adolescent, denial creates a 'comfort' zone where commitment and responsibility for their actions and behavior are neglected. By doing so, ideal conditions are created for the disease to spread (Lesko, 2005:30). For the youth, denial takes on a specific form: “The disease will not reach 'me', or it will not touch my strata or group" (as cited by Doka, 1997 in Lesko, 2005:30). Denial for many adolescents affected by HIV is a natural response to news of an HIV diagnosis, just as it may be to a diagnosis of any other life-threatening illness. Where adolescents do not receive counseling, information and support, denial may persist over many years (Heywood, 2004).

Blaming became the substitute for acknowledgement and action; this constituted the second phase. Virtually from the outset, productive dialogue was stalled. This came as no surprise, for 'blaming the victim' has a long pedigree in South Africa's epidemic history. In South Africa, a newspaper headline stated in about 1985, 'African AIDS comes to South Africa' (HIV/AIDS Leadership, 2005:18). Conversely, Africans blamed the CIA, the US military, and others for causing the epidemic (Ibid, 2005). Around the world, leaders concomitantly placed blame on various segments of the population for bringing about the problem.

Within local poor communities, adults blame adolescents for high risk behavior, although

adolescents are the 'victims'. For them, 'blaming the victim' serves as a warning to other adolescents to practice restraint and control. To blame ‘others’ is psychologically reassuring (Crew, 1992 as cited in Lesko, 2005:34). The fact that: it is 'their' fault; 'we' are innocent and they are guilty because they have behaved in such a way as to put us all at risk (Ibid, 2005:34). People are "motivated to believe that others deserve or bring upon themselves the unpleasant events that befall them because the belief that 'bad things happen to good people' would lead to uncomfortable feelings of vulnerability" (Crocker and Lutsky, 1986 in Lesko, 2005:30). Thirty-two HIV positive youth, who were interviewed by Travers and Paoletti, reported initial periods of denial subsequent to testing positive for HIV, self-blame and shame regarding the infection, judgments by family and peers, issues concerning disclosure, social isolation and loneliness (Travers and Paoletti, 1999).

Blaming thus became the opportunity to avoid accepting responsibility by adults for seeking collective indigenous solutions (TAC, 2005) and provision of much needed support and care for the adolescents.

3.7 HIV/Aids Related Poverty and Its Effect on Adolescents’ Behaviour

South Africa has both very high-income inequality (with the richest fifth of households receiving over 70% of income, and the poorest two-fifths less than 4 percent), and highly radicalized economic geographies due to apartheid spatial planning. South Africa's longer-term aims with the implementation of its economic model ASGISA, is to provide free education until 16 years of age, and to half unemployment[19] and poverty by 2014 (Brady et al., 2003) as unemployment has placed a burden on a sizeable segment of our population. In fact, unemployment can be as debilitating psychologically as it is financially (Nelson, 1974) – along with an increased sense of misery coupled with a diminishing rate of resources, however little. As an indication of the toll that unemployment and the absence of access to

[19] South Africa’s unemployment rate sank to 23 percent in September 2007, a record low since the inception of the Labour Force Survey in 2001 (Stats SA, 2008).

sustainable livelihoods exact, periods of extensive unemployment are typically accompanied by increases in certain types of maladaptive behavior, such as depression, suicide, crime (Brenner, 1993) and engaging in risky sexual behavior that leads to HIV infection.

In the Carltonville area for example, infection rates among the employed during the period 1998 and 1999 have been found to be 26% lower than among the unemployed (Williams et al., 1999:12). The "immediate conditions of daily life are so adverse for some people that they outweigh concerns about contracting HIV/AIDS" (Kiragu, 2001: 54). The causal relationship between AIDS and chronic poverty is complex and controversial, but there is some evidence that chronic poverty makes households more susceptible to HIV/AIDS exposure and thus infection" (De Swardt, 2004:12).

Although the local social grant programme[20] (ASGISA) has given some impetus to poverty reduction and income redistribution, there is still a significant part of the population that is excluded from the mainstream economy (Brady et al., 2003). Economic hardship and social instability brings about self-devaluation that have pushed more and more young men and women into multiple sexual relationships that carry the risk of HIV and thus transmit the virus from one to another (GoB, 2004 as cited in BOTA, 2005:24).

In many urban and peri-urban areas young adolescent women, lacking opportunities, seek support from men, trading sex for security - and thus the risk of contracting HIV infection. The risks are greater when the men are older. In Tanzania, for example, where growing poverty has made traditional marriages more difficult to arrange, young women compete for the attention of older men, who are better established than younger men and thus more attractive as potential husbands (Mzinga, 2002 as cited in BOTA, 2005:24), increasing gender power differentials, which make it more difficult for women to refuse unwanted sex or negotiate condom use. In a survey conducted by LOVELIFE locally, forty-three percent of

[20] At present, nearly 12 million people receive social grants, and 3.2% of gross domestic product (GDP) is spent on social grant assistance. Available [Online] http://www.sagoodnews.co.za/newsletter_archive (Accessed: 2007/04/04).

all women agreed that it is harder to refuse sex with a sexual partner who is older compared to someone the same age (Lovelife, 2004:73). Often, this practice is driven by parental expectation of financial support from their children (Mzinga, 2002 as cited in BOTA, 2005:24).

Similarly, in Nicaragua economic upheavals have caused many young women to prefer older men who can take better care of them (Leete et al., 2003 as cited in BOTA, 2005:25). In Botswana, young women sometimes enter into relationships with older men, called 'sugar daddies' that pay their school fees, buy gifts, and offer other inducements (GoB, 2004 as cited in BOTA, 2005:25).

In South Africa, specifically in the Western Cape and Eastern Cape, young urban school-going females becomes 'taxi queens' when they pursue sexual relationships with taxi drivers in exchange for free lifts to and from school and for other financial favors (Labor News, 1996:1). 'Rent Boys' have been operating for years in downtown Cape Town and street children of both sexes, have often turned to prostitution as a way of earning money. David Fortune, Project Manager of STREETS, an organization working with street children in Cape Town, agreed that many girls living on the streets turn to prostitution as a way of making money quickly. They believe they're enjoying some form of elusive freedom and that they are in control of their own lives without parental authority. Unfortunately, when they fall pregnant on the streets, that myth is shattered (Ibid, 1996: 2-3).

But poverty and its effect on the adolescent go beyond just economic disposition. A core belief of western society, which is also one of the cornerstones of South Africa's Children's Bill of Rights, has been that all children deserve to grow up free from hunger and violence in an atmosphere of warmth and love while receiving a stimulating education. However, disadvantaged youths cannot be given such opportunities as long as they are growing up in deprived and dysfunctional families and communities (Geiger and Fischer, 1999).

Parents living in poverty lack confidence in their parenting abilities (Banyard and Olson, 1991). They are five times more likely to maltreat their children than families with a higher income and are more likely to have experienced maltreatment in their own childhood (Olds, 1988; Sedlack, 1989 as cited in Geiger and Fischer, 1999). Lower-class mothers are more likely to adopt attitudes of fatalism and helplessness toward life (Steinberg and Belsky, 1991), which in turn is adopted and internalized by their children. These mothers are less responsive to their children's needs (Gaudin, 1993), and more often have bleak prospects and low expectations for their children's future (Hawley, 1993 as cited in Geiger and Fischer, 1999)[21].

Adolescents born in poverty therefore develop attitudes of helplessness and defeat which impairs their ability to interpret and deal with life realities in an acceptable way. As cited in Geiger and Fischer (1999), they are more likely to be retained in class (Boals et al., 1990), to be underachievers (McLanahan, 1985), to drop out of high school (Stedman et al, 1988), and to experience behavior problems (Zill et al., 1991). Poor children usually live in unsafe and depressed neighbourhoods lacking nurturance, structure and support, which in turn expose them to teenage pregnancy, gangsterism, drugs, violence, and, in general, to violence as a way of life (Gore, 1991 in Geiger and Fischer, 1999) and social exclusion.

Rape and gang rape in these socio-economic deprived societies have become significant avenues for the spreading of HIV and have made a significant impact on South Africa's prevalence rate. RAPE CRISIS in Cape Town estimates that the actual figure for sexual crimes is over one million per annum, even if only one in twenty cases is reported (Whiteside and Sunter, 2000: 66). A study done by Whelan has uncovered that 71% of girls had experienced sex against their will, and 11% had been raped (Whelan, 1999: 11) and another study on adolescent sexuality in South Africa found that almost one third of teenage girls indicated that they were forced into sexual initiation (Jekwes, 2001: 734). Adolescents'

[21] Available [Online] http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=153924 (Accessed: 2007/04/04)

involvement in risky sexual behavior or other forms of deviant actions, serve as a coping mechanism to deal with the shocks and trends of daily life. Not that they aren't aware of the disease or the messages warning them of the consequences of such behaviours, it's just that such messages are often irrelevant and inapplicable given the reality of their lives.

The tragedy of this situation is that the children of the poor often become the poor of succeeding generations (Blanden and Gibbons, 2006:27) – worsened by the fact that they find themselves socially and politically excluded and marginalized. Cohen (2005) is of the opinion that for many there are no incentive or resources to adopt the correct and recommended behaviour – it is the here and now that matters as future prospects are bleak.

3.8 Adolescents' Substance Abuse and HIV/Aids Risk Behaviour

Epidemiologically speaking, the situation in South Africa regarding adolescents, are not so good. Research has confirmed the connection between substance abuse, high-risk sexual behavior and HIV/AIDS infection (American Federation of AIDS Research, 2001). Behavior of adolescents is influenced by the use of substances, which places them at risk of HIV/AIDS infection.

Within the broader area of younger people and HIV/Aids, a growing body of research focusing on young people and substance abuse has emerged, and more especially what role alcohol plays in unsafe sexual practices (Donovan and McEwan, 1995). Researchers have over a long time hypothesized that the consumption of alcohol (Strunin and Hingson, 1993), smoking and drug intake increases the likelihood of sexual risk-taking behavior or unsafe sexual practices, by influencing young people's judgment and ability to make decisions (Lovelife, 2004:75). Many young people report that the likelihood of having sex is larger if either they or a potential sex partner has been drinking. They also report that they are less likely to use condoms when they have sex after they have been drinking than if they were sober (Strunin and Hingson, 1993). The reason for this may lie in the fact that alcohol and

other substance abuse have been demonstrated as to lessening inhibitions; to be used as a reason or excuse for socially unacceptable behavior, for example driving under the influence of alcohol (Cooper et al., 1990)[22]; and to occur with various behaviors that constitute health risks, such as smoking, drug use and violent behavior (Strunin and Hingson, 1993).

A study conducted by Fergusson and Lynskey (1998), confirms the associations between alcohol abuse and measures of early onset sexual activity and multiple partners, as well as unsafe sex. Another study conducted by Luster and Small (1994) into factors associated with risky sexual behaviors among adolescents reported that the females would usually have below-average academic performance, frequently consume alcohol, have low levels of parental monitoring and lack communication with their mothers about contraceptives, while males also have below average academic performance and frequently consume alcohol, they also exhibit suicidal ideation, low levels of parental support, as well as have a history of sexual abuse. However, according to Donovan and McEwan (1995)[23], who reviewed the literature investigating the association between alcohol use and HIV-related sexual risk-taking in young people, the relationship between substance abuse and sexual risk-taking behavior is very complex, with methodological problems making the clarification of this relationship difficult.

3.9 Summary

The literature review confirms the many myths surrounding HIV/Aids are still prevalent, and used as barriers to safe sex and condom use. These include denialism, blaming and stigma. In the context of HIV, adolescents' dangerous decision-taking in life, or vulnerability to risk of infection, is greatly influenced by poverty, peer pressure, gender inequalities and -power relationships, family and religious orientations, HIV knowledge and education, and access to

[22] Available [Online] http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=153924 (Accessed: 2007/04/04)

[23] Available [Online] http://www.ingentaconnect.com/content/carfax/cadd/1995/00000090/00000003/art00002;jsessionid=4o200tagce4k1.alice?format=print (Accessed: 2007/04/04**)**

treatment and healthcare.

HIV has evolved in to an epidemic whose primary burden now rests on South Africa's adolescents. Focus to curb the epidemic has been shifted from adults and mother to child HIV transmission, to include our current adolescent generation as a desperate bid in securing an investment for a sustainable economic force for the future. It was a case of bad “law being unable to thwart natural behavior when the old apartheid state passed its Immorality Act to prohibit sex between races" (Sisask, 2004:26). Similarly, in the context of HIV/Aids, good policy will only succeed if it is supported by meaningful and quality education, communication and other visible community based strategies that involve and focuses on the youth. Knowledge acquired by both formal and informal education, good policy and “human rights have an important part to play in trying to break this equation" (Sisask, 2004:25). Their use can restore adolescents' individual and collective senses of self-worth. Using the law can remedy injuries such as unfair exclusion from employment for matriculants or the refusal to admit children to school. Advocacy for human rights can inform policy development and offer a framework for law - so as to protect adolescents from legalized assaults on their rights (Ibid, 2004:26).

However, whilst knowledge in HIV has advanced in leaps and bounds since the virus was isolated in South Africa in 1982 and named in 1983, adolescent's attitudes to it have not. In fact, South Africa's high prevalence rate amongst adolescents of 16, 2% serves as proof that they have hardly changed at all. But, at the outset it is important to remind ourselves that HIV is not the first cause of illness in history that has been so stigmatized. As the literature review revealed, its predecessors include syphilis, tuberculosis, cancer and other illnesses like leprosy.

Stigma, prejudice, unfair discrimination, denial, fear and human rights violations are a very serious barrier to HIV prevention and management because they deter adolescents from voluntary testing and counseling as well as from seeking treatment. And, if anything, the

problems amongst adolescents seem to be worsening as participation in risk behaviour increases, like the practice of unsafe sex and involving in sexual encounters under the influence of substances that impairs their judgments. The literature also confirms what toll poverty and unemployment exact from the youth. Periods of extensive unemployment are typically accompanied by increases in certain types of maladaptive behavior, such as depression, suicide, crime (Brenner, 1993) and engaging in risky sexual behavior.

It would appear as if culture is at the centre of the youth's perceptions and interpretations of the world around them and the meaning they ascribe to it. The research literature on the subject points to a situation where most youth are uninformed or have serious misconceptions regarding pathways of HIV transmission, the relationship between fun and risk while people in general also harbour negative attitudes and perceptions towards the seropositive population which influence and motivate their own behaviour. Adolescents' emerging sexuality poses fundamental challenges and along with this, confronting and dealing with cultural and societal challenges, their own vulnerability as they struggle to come to terms with the many conflicts posed by society, amongst others, society's double standards. The adolescent's response to these challenges are profoundly influenced by the social and cultural context they live in – often calling on them to practice restraint and control thus setting the stage for behavioural inconsistency and conflict.

Thus, in conclusion, this chapter has argued that one of the greatest barriers to control the global AIDS epidemic among the youth remains stigma, denial and blaming. An understandable fear of other people's prejudice, of how 'I' will be seen by their peers, the desire to protect their dignity and 'self' from various forms of assault, undermines HIV prevention by deterring adolescent from seeking care and counseling (Sisask, 2004:25).

This research then is important in that it further refutes the idea that knowledge leads to a direct change in behavior. It also looks at the factors that may be involved as to why adolescents do not alter their sexual practices, and therefore marked the turn towards

quantitative, as well as qualitative research. For the purpose of this research, all the above approaches of adolescent and their risk behavior, their knowledge and perception, fear, denial and blaming, stigma, poverty and substance abuse, was utilized and situated against the scholars' answers from the questionnaire. The researcher examined whether this information supported, contradicted or advanced the literature review.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This chapter focuses firstly on the research design used in this study; the study stages and sample population/participants, then serves to motivate the relevant methodology that was used in the study and thereafter it will outline the method of data collection and data gathering procedures. The findings will be analysed within an interpretative research paradigm as the research seeks to understand the respondents' definitions and understanding of HIV/AIDS and how it influences their behaviour. Furthermore, the chapter clarifies time and setting of the sessions in the pilot study as well as in the main study phase, and describes in detail how each one was conducted. Issues of trustworthiness, validity and reliability, as well as the credibility and ethical considerations of the research enquiry, are also discussed. The summary concludes the chapter after the data analyses process have been explained.

4.2 The Research Design

Thyer defines a research design as a template or "being a blueprint or detailed plan for higher research studies to be conducted" (Thyer, 1993 as cited in Schurink, 1998:60). Mouton added in refining this definition by specifying a research design as also being a set of guidelines and instructions to be followed in addressing the research problem in the most economical way (Mouton, 1996 as cited in Schurink, 1998:60). This includes the researcher, the selection and design of a particular method, the participants and considerations of reliability and validity. To integrate with the problem as set in chapter 1, the research design used was within an interpretive framework as discussed in chapter 2 and of an exploratory nature and serves as an exploratory venture.

4.2.1 The Interpretive Research Perspective

The primary objective of interpretive research is to establish the meaning of circumstances, event, or social situation. It goes beyond simple description or explanation in aiming to enhance people's understanding of the symbols, artifacts, beliefs, meanings and feelings in the study situation (White, 1999 in McNabb, 2004:106). An interpretive research is characterized by a strong sense of connection between the researcher and the subjects who are part of the study (Ibid, 2004:106).
A public administration theorist, Camilla Stivers (2000:132) provided this view:

> "To me, interpretation entails sense-making; taking a more or less inchoate bundle of events and processes – what might be thought of a situation – and putting a frame around them based on more or less conscious assumption about what is likely to be important, significant or meaningful."

4.2.2 An Exploratory Study

Exploratory studies are small-sample designs used primarily for gaining insights and ideas about research problems and the variables and issues associated with those problems (McNabb, 2002:85).These studies seldom stand alone and help the researcher gain greater understanding of the problem for which more information is needed. Data gathering in exploratory research may involve quantitative, qualitative, or a combination of strategies (Ibid, 2002:85). For the purpose of this research, quantitative as well as qualitative methods were administered.

As this research is of an exploratory nature and focuses on adolescent scholars between the ages of 15 and 18 years, it included two stages:

Stage 1: A pilot survey was conducted at St Theresa's Roman Catholic Parish in Heideveldt with 6 current final year confirmation candidates, who are adolescent scholars at various high schools across the Cape Peninsula.

Stage 2: The main or actual study consisted of a survey with one group of 20 school-going adolescents that was held at Beauvallon High School in Valhalla Park. The school is under the auspices of the Western Cape Education Department.

4.3 The Research Methodology

A variety of research tools was used in order to gather the necessary data:
1. This included the literature review, which is the secondary document analysis.
2. A semi-structured questionnaire, in the form of the quantitative and qualitative research tool. While quantitative methodologies emphasize the necessity for objectivity, qualitative methodologies have embraced the idea and values for subjectivity that is essentially important when reading unfolding insights in the developing of themes. The findings of the questionnaire was also further deepened and tested by the application of a qualitative methodology and Guba and Lincoln (1981) confirmed that quantitative and qualitative research methods complement each other in several ways even though they are used in different ways in a single study.

4.3.1 Literature Review

The purpose of the literature review is to orientate the researcher towards the postulated problem of the study as described in chapter 1. The view that Strydom advocates is that: “The prospective researcher can only hope to undertake meaningful research if he/she is fully up to date with existing knowledge of the prospective subject” (Strydom, 1998 as cited in Schurink, 1998:62).

On the other hand, De Vos holds the view that a literature review not only encompasses an examination of selected empirical research, reported practice and identified innovations relevant to the particular topic under study, but also assists the researcher to formulate the problem statement and to design questions (De Vos, 1998 as cited in Schurink, 1998:62). In this way the researcher will attain a well-defined direction as to what comes next and be able to draw a proper conclusion about the problem at the end (Best 1977:27). It was for this reason then that the literature study in Chapter Three was undertaken. The questions for the questionnaire were

designed and formulated on that basis.

4.3.2 The Questionnaire - The Quantitative Method

For the purpose of the two phases [in stage 1 (pilot study) as well as in stage 2 (main study)] of this investigation, an anonymous, self-administered questionnaire was used as the method of data collection which implies a quantitative descriptive design. The explorative and descriptive design is best suited to answer the research questions and to realize the research objectives.

When using a questionnaire in research, Chavez et al. (2003: 89) pointed out that it must be produced, interpreted, and disseminated in clear, useful, and respectful language. This design is also useful for issues that may not require as much depth of analysis as other research methods and it would also allow respondents ample time to consider their responses and would provide respondents with a sense of privacy and confidentiality (Wikipedia, 2006).The questionnaire was useful in that it allowed collection of information, opinions and perceptions of school-going adolescents so that space can be created for generalization and it explored all the necessary information in regard to the study objectives.

The validated semi-structured questionnaire (see Appendix 1) was adopted, developed and modified to suit the purpose of this study based on a review of nationally comparable surveys (Pettifor et al., 2004), and from questions used in youth studies in South Africa (Abrahams, 2006; Van Dijk, 2002; Flisher et al., 1993; Viljoen, 2001). The questionnaire was analyzed and approved by the Board of Postgraduate Studies of the Arts Faculty at the University of the Western Cape. It was designed to cover the themes discussed in the literature review and to realize the study objectives. The questions were divided into six categories with individual variables:

Section I: Socio demographical Profile

- Gender; Age; Grade-level; Religion orientation; Institutional details;
- Family and Housing status;

Section II: Knowledge and Perception of HIV/AIDS Risk Factors, Modes of Transmission, STI and ARV's

- Education and Awareness of HIV/AIDS; AIDS and its Symptoms;

- Sources of Information about HIV/AIDS; Ways of Avoiding HIV Infection;

Section III: Sexual Behavior, Meaning and Substance Abuse

- Sexual Activity and Substance Intake; Access to and use of Condoms;

- Relationships and – cohesion; Sexual Practices;

- Number of Sexual Partners; Trust in Relationships;

- Capacity to Adopt HIV Risk Prevention Measures;

Section IV: HIV and Treatment

- Health seeking Advice; Access to Services; Pre- and Post-testing;

- Reasons for Testing;

Section V: Blaming, Stigma and Attitudes

- Reason for blaming; Perceptions and attitudes towards PLA's.

Section VI: Opinions of living in current HIV/AIDS era.

- Reasons for opinions.

The following question had to be replaced as the original question was discovered to be vague and confusing during the pilot study: -

Section IV: Question 23 (iii): 'Plan for the future' was replaced with: 'Being intimate without a condom'.

To gain additional insights, the following sections and/or questions were added:

Section I: (iv) Section III: (16.5); (17.5) Section IV: 25 (vii); 26 (vii);

Section VI: 34; 35. (See Appendix 1 for the above changes).

4.3.3 Thematic Approach - The Qualitative Method

This phase of the research is based within the qualitative research paradigm, which involved the systematic collection, organization, and interpretation of material derived from the questionnaire. Although it is difficult to describe what qualitative research methodology is, Sherman and Webb (1988:7) are of the opinion that "qualitative implies a direct concern with experience as it is 'lived' or 'felt' or 'undergone.' Qualitative research then has the aim of understanding experience as nearly

as possible as its participants feel it or live it."

Furthermore, qualitative research methodology also gives the researcher the added advantage of taking the respondent's personal information and attaching insight and understanding to it as well as undertakes and gives detailed descriptions of the phenomena within the community (Neuman, 2000), thus enabling the developing of the required themes that addresses the study's objectives. The methodology of qualitative research then, demands an inductive form of reasoning to develop concepts, insights and understanding the patterns in the data (Schurink, 1998:242). By using this form of methodology, the researcher's aim was to identify themes, motifs and categories in the experiences emerging from the questionnaire data, which has not been covered. The researcher broadly followed the three steps of data analysis as described and summarized by Taylor and Bogdan (1984), and further explained in this chapter.

4.4 The Pilot Study

The pilot study is necessary because, according to De Vos (1998:179), it is a rehearsal of the main study or investigation. In reality, it assists and allows the researcher to obtain a picture of the real practical situation where the prospective investigation will be carried out. It also helps the researcher to address the resources, research population and procedures of data collection, the data gathering, and possible errors, which may occur (Strydom, 1998: 181). To get meaningful information, "certain problems can be identified during the pilot-testing, and can usually be resolved with rewording or with a set of probing items instead of a single item" (Rosnow and Rosenthal, 1996: 111). "The purpose of piloting the instrument was to obtain clarity, find out its appropriateness and obtain direction to the main study" (Annet, 2004:37). The pilot study also provided the researcher with orientation and experience in conducting the research procedure and "determining the length of time needed to complete the questionnaire" (Ibid, 2004:37). Results of the pilot study were excluded from the findings of the main study.

The questionnaire was pilot-tested on six final year confirmation candidates at St Theresa's Roman Catholic Parish in Heideveldt. They were scholars at various affluent high schools across the Cape Peninsula. The questions was designed to be respondent-friendly. The questions were

varied and were closed- as well as open-ended, making the answering short and easy to complete.

The candidates-coordinator was thoroughly informed as to the procedure and requirements needed for the administering of the questionnaire. She randomly selected six respondents from those candidates who volunteered and distributed the questionnaire to the group at the end of that catechism period on that given Sunday. No prior planning was done. The unit as a group was also chosen owing to the convenience of administering the questionnaire. She facilitated the completion of the questionnaire on behalf and in the presence of the researcher.

The coordinator distributed the questionnaire and read the confidentiality statement and instructions on the cover page to the respondents. The respondents were given five minutes to peruse the questionnaire and it took them 45 minutes to complete the answers. The questionnaire was completed without discussion as there were no uncertainties experienced by the respondents. The researcher limited his own contribution while the coordinator remained in the background and, at the most, encouraged the respondents with a few words to continue with the contribution, thus reducing prejudice.

4.5 The Main Study

4.5.1 Selection of Sampling Population

The main or actual study consisted of:

A survey with one group of 20 school-going adolescents was held at Beauvallon High School in Valhalla Park. The sample was homogenous in the sense that all the participants were Afrikaans speaking students from the same socio-economic and cultural contexts.

A non-probability sampling technique was applied for the purpose of this research. This meant that a purposive sampling design was applied in which the researcher handpicks the cases to be included in order to build up a sample satisfactory for the specific needs (Cohen et al., 2001:102). Strydom and De Vos (1998:189) comment that the researcher uses his judgment to select the participants when employing this selection technique. With purposive sampling, the disadvantage

is that the researcher never knows whether the cases selected represent the broader population (Cohen et al., 2001:103). Since the sample of this study was chosen for the sake of convenience and for the specific need of the study, it does not represent the adolescent scholar population enrolled at Beauvallon High from which the data was collected.

The individuals were also identified according to the criteria for inclusion. Criteria for inclusion were the following:

- Have to agree to volunteer to participate in the study
- Be a registered student at Beauvallon High School
- Be at least between the ages of 15 and 18 years of age
- Must be residing in Valhalla Park

The number of learners per grade was determined according to the availability of the student volunteers in the target age groups. With the assistance of the Life Orientation teacher, the learners were selected from the volunteers as follows:

Scholars per grade:
Grade 10: 3 (2 males + 1 female); Grade 11: 9 (6 males + 3 females);
Grade 12: 8 (2 males + 6 females).
It was evident that there were 8 Grade 12 learners as opposed to 3 learners from Grade 10 and 9 from Grade 11 respectively participating in the study (Total: 20).

Scholars per age group:
15 years: 6 (4 males + 2 females); 16 years: 4 (2 males + 2 females);
17 years: 7 (3 males + 4 females); 18 years: 3 (1 male + 2 females).

4.5.2 Procedure and Time Setting in Conducting of the Questionnaire Session

Only one session of sixty minutes was required for the mixed gender group of 20 participants to complete the questionnaire. This session was held during the Life Orientation period on a Monday

during the normal school hours. As Afrikaans was the medium of instruction at the school, the questionnaire had to be translated into Afrikaans to have it respondent friendly.

The researcher welcomed the respondents and introduced himself at the opening of the session. He explained the purpose of the research and expressed his gratitude for their truthful contribution and unconditional participation. The researcher distributed the respondents' consent letters and read the confidentiality clause before the participants provided their endorsement. After the questionnaire was distributed, the instructions on the cover page were read to the respondents. The researcher facilitated the completion of the questionnaire while the Life Orientation educator observed.

Although some of the questions were of a very personal and sensitive nature (e.g. Questions: 14; 15; 16; 17; 18 and 28), the respondents completed the questionnaire without any discussions or uncertainties.

4.6 Credibility and Trustworthiness

A research process was followed that, according to Krueger and Casey (2000), would ensure the results were trustworthy and an accurate reflection of how the participants felt and thought, hence, lending credibility to the research findings, as per Terre Blanche and Wassenaar (as cited in Abrahams, 2006:32), who posit that credible research produced findings that are convincing and believable. Furthermore, the researcher followed and adopted the principles of the Guba model which identifies four criteria that must be applied to the data elicited in the investigation: Truth-value (or validity), applicability, consistency and neutrality (Lincoln and Guba, 1985:192).

4.6.1 Truth-value and Validity

Truth-value reflects the confidence that the researcher has in the results extracted from the respondents in the study. Transparency within the data analysis with clear and detailed descriptions of the purpose of the study, how the sample was selected; methods of data collection

and analysis contribute to this confidence (Maykut and Morehouse, 1994 as cited in Schurink, 1998:73).

Gall et al. (1996: 130) argued that the researcher can only claim and ensured validity of the questionnaire if it was pilot-tested. The pilot study with the six final year confirmation candidates ensured increased truth-value and validity, hence the changes and alterations to the questionnaire. The manner in which the questionnaire session was conducted: the researcher was relaxed and in a non-threatening position and the fact that all the respondents completed the questionnaire, contributed to the claim of truth value and validity for this research. Anonymity: they did not put their names on the questionnaire, and the questionnaire was group-administered.

Discretion: apart from the adolescent scholars, the researcher and the Life Orientation teacher, there were no other people in the classroom. The scholars sat on desks chairs far enough apart, such that they did not see each others answers; Appropriate wording of questions, using colloquial, easily understood Afrikaans.

4.6.2 Applicability

Poggenpoel writes that applicability refers to the degree to which the findings can be applied to other contexts and settings. It is the ability to generalize from the findings to larger populations. She also suggests that the criterion, against which applicability of the data is assessed, is referred to as transferability (Poggenpoel ,1998 as cited in Schurink,1998:73).

If sufficient descriptive data is presented which allows comparison between the different respondents in the sample it can be taken that the researcher has addressed the dilemma of applicability (Ibid, 1998:73). Since the sample of this study was chosen for the sake of convenience, it does not represent the adolescent scholars from which it was collected, although the method used can be repeated (standardized questionnaire).This study can be generalized within the same context to adolescent girls and boys schooling in similar peri-urban areas in South Africa.

4.6.3 Consistency

Consistency refers to whether the information obtained from the respondents would be the same if the study were to be replicated in another setting with a different sample (Poggenpoel, 1998 as cited in Schurink, 1998:74). It should be noted that the sample was selected to negate such externalities as gender, socio-economic status and the geography of the adolescents. In this case consistency can be assumed as each adolescent experienced the same problems and the sample was judged saturated.

4.6.4 Neutrality

The last criterion of credibility and trustworthiness is neutrality. Neutrality refers to the degree to which others could confirm the findings. The neutrality of the data is achieved by using strategies of conformability that captures the traditional concept of objectivity. Poggenpoel further suggests that this is achieved when truth-value and applicability are established (Poggenpoel ,1998 as cited in Schurink,1998:74).

4.7 Data Analysis

Thematic content analysis, which falls under the umbrella of interpretive methods, was used to analyze the research material. Terre Blanche et al. (2006) in Abrahams (2006:32), postulate that interpretive methods assume people's subjective experiences are real and should be regarded seriously. The researcher broadly followed the three steps of analysis as described and summarized by Taylor and Bogdan (1984)[24], although Terre Blance et al. in Abrahams (2006:32) argue that in reality, interpretive analysis rarely proceeds in an orderly manner as suggested by Taylor and Bogdan's step-wise presentation:

Step One: Discovery is basically for the purpose of seeing, in a general sense, what's in your data.

[24] Available [Online] http://www.amazon.co.uk/Introduction-Qualitative-Research-Methods-Meanings/dp/0471889474 (Accessed: 2007/06/04).

The researcher was the facilitator at the questionnaire session of the main study. After the research material was collected, the researcher checked the answers of the questionnaire. This meant reading and rereading of the data so that the researcher became very familiar with it and could develop and make ideas of various interpretations. While doing so, the researcher noticed things that are repeating and made a note of it. Out of this process some new units emerged. These units later formed a set of categories and sub-categories which the researcher developed into themes. Then the themes was organized and contrasted in relation to the existing research literature as Taylor and Bogdan (1984) suggest.

Step Two: Coding, according to Taylor and Bogdan (1984), is the process of marking all the data: coding of a word, phrase, line, sentence, or paragraph that fits with particular themes. This process enabled the researcher to pick examples (or vignettes) from the data that best illustrated or related to a specific theme or a sub-theme. As the researcher coded the data, he continually refined, changed, or added to the categories. The researcher discovered that coding is a process of continues data analysis as to see what is accounted for and at the same time to refine the analysis.

Step Three: Discounting data might, as Taylor and Bogdan (1984) pointed out, sound negative, but it is essentially an opportunity to consider the context in which different kinds of data were collected and to notice what difference that context might make on what was learned. This phase served to provide the researcher needed space for checking and interpreting the emerging themes. The researcher checked the quotes that he wrote up that were linked to these themes, to identify whether the quotes matched and explained the themes optimally. To ensure that the interpretation of the research material would optimally reflect the respondents' knowledge, beliefs, perceptions and attitudes related to HIV/AIDS that motivates their behaviors, the researcher had to do reflection on how his biases might have impacted on the interpretation process.

4.8 Ethics

As the topic of HIV/AIDS among adolescents is of a very sensitive nature, the researcher adhered strongly to the ethical rules at all times. Firstly, ethical clearance was obtained from the Board of Post Graduate Studies of the Arts Faculty at the University of the Western Cape. Secondly, the

required informed consent to conduct the empirical investigation was also obtained from the HIV/Aids departmental head at the Western Cape Education Department; and the school principal and staff members involved who represented the minors' parents.

Thirdly, a letter of consent (Appendix 2), which was drafted by the researcher and approved by the supervisor, was signed by the 20 participants. Before the commencement of the introductory session, the researcher informed the scholars the research purpose and also explained to them their rights. Together with the pupils, the researcher systematically went through all the points on the consent letter, and ensured them of the confidentiality, anonymity, and highlighted the aspect of voluntary participation. The choice of withdrawing without obligations at any point of the research was emphasized., After ensuring that everyone understood the content of the consent letter, and as the scholars all showed their eagerness to participate in the study in the absence of any duress, the researcher allowed the pupils to sign it in the presence of the Life Orientation teacher.

4.9 Summary

This chapter firstly discussed the research design and methods used in the present study. The study worked within social constructionism, the methodological framework that lies within an interpretive research paradigm that seeks to understand the participating adolescents' definitions and understanding of HIV/AIDS and how it influence their behaviour. As this study has an explorative and descriptive design primarily used for gaining insights and ideas about the research problem (as outlined in chapter 1), a variety of research tools was used in order to gather the necessary data. This included the literature review as the secondary document analysis and a structured questionnaire in the form of a quantitative and qualitative research tool. While quantitative methodologies emphasize the necessity for objectivity, the qualitative methodology that was used have embraced the idea and values for subjectivity that is essentially important when reading unfolding insights in the developing of themes.

Although there were very few guidelines for the design of the questionnaire for this study and that both the reliability and the validity of this questionnaire was assessed by being pilot-tested, the questionnaire could help to provide an indication or general description of the knowledge,

perceptions, beliefs, attitude and behavior towards HIV/Aids of adolescents in Valhalla Park.

As this research is of an exploratory nature, it included two stages:

Stage 1: A pilot survey which was held at St Theresa's Roman Catholic Parish in Heideveldt with 6 current final year confirmation candidates; and

Stage 2: The main or actual study consisted of a survey-session. The researcher was the facilitator at the questionnaire session. A semi-structured questionnaire was administered to a mix gendered group of 20 school-going adolescents (between 15 and 18 years of age) at Beauvallon High School**.**

The chapter clarified the time and setting of the various sessions in the two stages and describes in detail how each one was conducted. The researcher ensured the trustworthiness and credibility of the data that emerged from the study and issues of validity and reliability; as well as the ethical considerations of the research enquiry were motivated and discussed. To analyse the data, the researcher broadly followed the three steps of thematic content analysis as described and summarized by Taylor and Bogdan (1984), namely: discovering, coding and discounting of the data. Chapter five will deal with the results of the study.

CHAPTER 5: RESULTS PRESENTATION

5.1 Introduction

5.1.1 General

This chapter presents the findings in their original form as they emerged from the data based on the empirical analyses of the study which primarily aimed to:

1. Conduct an exploration of the groups' knowledge, beliefs, attitudes and behaviour towards HIV/AIDS
2. Establish, explore and examine factors that influenced the group of twenty adolescents' beliefs, attitudes and behaviour towards HIV/AIDS.

The chapter firstly provides an overview of the research findings obtained, highlighting the key themes and findings that emerged from the analysis. Those results believed most pertinent to the study were selected from the extensive quantitative data that was generated from the questionnaire. Results are presented according to key discussion areas that were identified during the study design and used to inform the data collection process. The findings of the administered questionnaire are interpreted by integrating the information gathered from the literature reviewed in the study. The researcher examined whether this information supported, contradicted or advanced the literature review.

To gather the necessary data, the following research tools were used: this included the literature review, which is the secondary document analysis, with the theoretical framework underpinning this study; as this research is an exploratory study, it included a semi-structured questionnaire (see Appendix 1), with twenty school-going adolescents (15 to 18 year olds) at Beauvallon High School which is situated in Valhalla Park. The group of 20 adolescents were divided into 10 females and 10 males for population representation and convenience. The findings were analysed within an interpretative research paradigm as the study's primary aim was to seek an understanding of the respondents' definitions and understanding of HIV/AIDS within their culture

and how it influences their behaviour. The questionnaire, as a quantitative and qualitative tool, was furthermore used to provide additional insight into the research problem. While quantitative methodologies emphasize the necessity for objectivity, a qualitative methodology have embraced the idea and values for subjectivity and was used essentially for unfolding insights in the developing of themes.

5.1.2 Thematic Analysis

In addition, six themes are identified and will parallel the three research questions with each theme having various sub-themes. The three research questions are:

- How do adolescents in Valhalla Park regard HIV/Aids and how does that influences their behaviour?
- Are myths that include silence, denial and stigma surrounding HIV/Aids prevalent amongst adolescents in Valhalla Park, and used as barriers to safe sex and condom use?
- Is HIV/Aids regarded as a black or gay disease that is distant to most adolescents of Valhalla Park?

Furthermore, the chapter is divided into seven main sections which enable the presentation and discussion of each theme. The last six themes are identical to some of the themes reviewed in the literature review. Firstly, the focus will be on the presentation and description of the sample realization. Thereafter, the frequency distribution of the pupils' socio-demographic and socio-economic characteristics and profile will be shown. An assessment of the group's knowledge and perception of HIV/Aids as well as their main sources of HIV/Aids information is provided followed by a look at the scholars' relationships status, their sexual behavior and substance intake, access to and their use of condoms, trust in relationships and relationship cohesion, and their main reasons for engaging in sexual activity.

The fifth section will elaborate on HIV and treatment in their area of residence, pertaining to aspects like health seeking advice and access to health services, pre- and post-testing and reasons for HIV testing. The section on the scholars' opinions regarding stigmatization, blaming, perceptions and attitudes towards people living with Aids (PLA's) will precede the last section that

interprets the group's opinions of how living in the current Aids era impacts on their state of wellbeing. The chapter concludes with a brief summary that will attempt to answer the three research questions and to highlight the main discussion points of this chapter.

5.2 Sample Realization

The researcher determined the number of learners per grade according to the availability of the student volunteers in the target age groups. With the assistance of the Life Orientation teacher, the learners were selected from the volunteers as follows:

Table 1: Scholars per Grade:

Grade 10: 3 (2 males + 1 female) Grade 11: 9 (6 males + 3 females)
Grade 12: 8 (2 males + 6 females)
It was evident that there were 8 Grade 12 learners opposed to 3 learners from Grade 10 and 9 from Grade11 respectively participating in the study. (Total (n): 20)

Table 2: Scholars per Age Group:

15 years: 6 (4 males + 2 females) 16 years: 4 (2 males + 2 females)
17 years: 7 (3 males + 4 females) 18 years: 3 (1 male + 2 females) (Total (n): 20)

Table 3: Adolescent Scholars Within the Same Age Groups Registered for 2008 at Beauvallon High School:

15 year old:	**116 - Males: 55; Females: 61;**	**Sample size: 5, 17%**
16 year old:	**107 - Males: 63; Females: 44;**	**Sample size: 3, 74%**
17 year old:	**67 - Males: 34; Females: 33;**	**Sample size: 10, 45%**
18 year old:	**26 - Males: 12; Females: 14;**	**Sample size: 11, 59%**
Total Population: 316 :– Males: 164; Females: 152; Total Sample size: 6, 33%		

Table 1 and Table 2 indicate the breakdown of the study population per grade and per age group respectively and Table 3 provides an age breakdown of the number of adolescent scholars within the same age groups enrolled for 2008 at Beauvallon High School as that of the study's target population.

5.3 Socio-economic and Socio-demographic Profile

This section looks at the socio-economic and socio-demographic background of the surveyed scholars, in relation to their age, religion, number of children they have, the type of house they live in and their caregiver/s.

Table 4: **Socio-Economic and Socio-Demographic Profile**

Age Group	15	16	17	18	Tot	%
Number of Respondents	6	4	7	3	20	100
Religion:						
1.Christian	4	3	7	2	16	80
2.Moslem	2	1	0	0	3	15
3.Other	0	0	0	1	1	5
Number of Children	0	0	0	0	0	100
Housing Status:						
1.Parent's Brick House	3	2	6	2	13	65
2.Council House	1	2	1	1	5	25
3.Rented House	1	0	0	0	1	5
4.Informal House	1	0	0	0	0	5
Living Arrangement:						
1.With Parents	4	2	4	1	11	55
2.With Mom	1	2	0	0	3	15
3.With other family	1	0	3	2	6	30

Table 4 indicates that: 100% of the scholars do not have an offspring are single[25], and 11 are in the care of both parents. Although this section did not make provision for the employment status and employment type of the main provider (colloquially called the 'broodwinner') within the household where the adolescent lived, it shows that the majority of the participants in the group are from a relatively affluent part of Valhalla Park as 13 are living in their parents' brick house and a mere 5% of them are residing in an informal house (corrugated shelter or 'wendy' wooden house). Only 3 of the participants in the sample were in the care of a female-headed household (their mom), as apposed to 6 of the participants staying with other family members, who is neither their mother nor father.

Research Question 1:" How do adolescents in Valhalla Park regard HIV/Aids and how does that influences their behaviour?"

5.4 Knowledge and Perception of HIV/AIDS

This section examines the scholars' HIV knowledge, their perceptions regarding their risk of contracting HIV and their main sources of information about sexual matters. The HIV Knowledge Perceptions Questions (HIVK-PQ- 1-13) were designed to measure HIV related knowledge, and ask how much the respondent agrees or disagrees with particularly in relation to the modes of transmission, the characteristics of the disease, STI's and ARV's information and treatment, main sources of information and prevention measures, as well as their attendance of awareness sessions. These are also the subtopics considered in this section.

5.4.1 Knowledge about the Modes of Transmission

Table 5 provides a closer look of how the group perceived HIV transmission. Eighty-five percent (17) of the group knew that HIV causes Aids but only 11 agreed that HIV was spread through unprotected sex. Inconsistently, a 100% (even amongst those who 'are not sexually active' and those who 'are sexually active') agreed that HIV is transmitted through blood, semen, vaginal

[25] Marital status confirmed by the teacher in charge of the school's registers.

secretion, and breast milk. Fifty-five (11) agreed that HIV is commonly spread by sharing needles or syringes with someone who has the virus. A small proportion (5%) of the scholars in the group thought that HIV is transmitted by simple casual contact such as kissing, sharing water glasses, cutlery or hugging and 19 disagreed that HIV is spread by eating food prepared by a HIV infected person. Scholars such as Peltzer (2003), UNAIDS (2004), Shisana and Simbayi (2002), have found knowledge of HIV to be an important factor in the cognitive processing of information and therefore important in influencing the attitudes and the behavior of individuals and groups. It is evident, according to these results that a very large percentage of the scholars had a 'high knowledge' on how HIV is being transmitted, but maybe for some reason denied it as far as sexual activity goes.

Table 5: **Transmission (n=20)**

Statement/ Question:1.1 – 1.8	**Agree**		**Disagree**		**Missing**
	%	**n**	**%**	**n**	**%**
AIDS is caused by HIV - the human immunodeficiency virus.	**85**	**17**	**10**	**2**	**5**
HIV is transmitted through blood, semen, vaginal fluids, and breast milk	**100**	**20**	**0**	**0**	**0**
HIV cannot be spread by having unprotected sexual intercourse with someone infected with the HIV virus.	**45**	**9**	**55**	**11**	**0**
HIV is not commonly spread by sharing needles or syringes with someone who has the virus.	**45**	**9**	**55**	**11**	**0**
HIV is transmitted by simple casual contact such as kissing, sharing water glasses, cutlery or hugging.	**5**	**1**	**95**	**19**	**0**
Eating food prepared by a HIV+ person	**5**	**1**	**95**	**19**	**0**

5.4.2 Knowledge regarding the Characteristics of the Disease

This section includes information on the nature of the disease, such as the definition (Table 6.1), detection, signs and symptoms of infection (Table 6.2), cause of the virus, treatment, and who the victims are (Table 6.3). This section also inquired about the adolescents' knowledge regarding STI's and condom use. Generally, the scholars (85% and 75% respectively) displayed a very good understanding of the definition of the disease, with most of them showing adequate knowledge on items such as the signs and symptoms of AIDS, but showed an inconsistent knowledge regarding a cure and treatment for AIDS. About 11 were completely certain that a person living with AIDS cannot gain weight rapidly and 11 agreed that long-lasting diarrhea could follow after an infection. While 17 respondents acknowledged that recurring fevers and/or night sweats and unusual skin rashes are visible signs when one is infected, half (10) strongly disagreed with the statement that there is a development of muscular strength after an infection.

Ten of the participants acknowledged that a person with HIV could look very healthy and about 13 are sure that there is a known cure for HIV/AIDS as 60% confirmed that traditional healers can cure HIV/AIDS and 10% of the students said that sex with a virgin can also remedy HIV/AIDS. Only a small portion of the group (15%) completely agreed that ART delays the developing of HIV while less than half of the students (8) agreed that the possibility is great for a person to get a STI from having sexual intercourse once without a condom.

Table 6.1: Definition of the Disease (n=20)

Statement/Question	Agree		Disagree		Missing
2	%	n	%	n	%
AIDS is short for Acquired Immune Deficiency Syndrome	85	17	10	2	5
It is the most advanced stage of HIV infection	75	15	15	3	10

Table 6.2: **Signs and Symptoms of Infection (n=20)**

Statement/Question 3	Agree %	n	Disagree %	n	Missing %
-Rapid gaining of weight:	35	7	50	10	3
-Long-lasting diarrhea:	55	11	20	4	5
-Recurring fevers and/or night sweats:	85	17	5	1	2
-Recurring or unusual skin rashes:	85	17	5	1	2
-Development of muscular strength:	35	7	50	10	3

Table 6.3: **Cause of the Virus and Treatment (n=20)**

Statement/Question 9-13	Agree %	n	Disagree %	n	Unsure %	n	Tot %
*Most people who have the HIV/AIDS virus show signs immediately:	20	4	50	10	30	6	100
*There is a cure for HIV/AIDS:	15	3	65	13	20	4	100
*Traditional healers can cure HIV/AIDS:	10	2	60	12	25	5	95
*Sex with a virgin can cure HIV/AIDS:	10	2	85	17	5	1	100
*It is possible for a person to get a STI from having sexual intercourse once without a condom:	40	8	15	3	35	7	90
*ART delays developing of HIV:	15	3	15	3	65	13	95

5.4.3 Knowledge about HIV Prevention

Table 7 shows what the scholars believed were ways of preventing HIV infection. Twenty-five percent of scholars thought that a monogamous sexual relationship with one partner (partner who has no other partners) would prevent them contracting HIV. Similarly, only 5 participants mentioned that total sexual abstinence would prevent HIV infection and 8 of the scholars responded that the use of condoms could prevent HIV infection. Sixty-five percent (13) felt that sex with a multitude of partners should be avoided. This means that an above average number of the respondents were aware that having sex with more than one partner increases the probability of HIV infection.

Forty percent (8) of the scholars believed that one must avoid sex with a prostitute and only 35% indicated that sex with a person who injects drugs should be avoided too. To refrain from getting HIV infected: 5 confirmed that sex with persons of the same sex is out of the question, ten percent of the scholars said that kissing, and 3 was sure that mosquito bites should be avoided. Six respondents was quite convinced that one must seek protection from traditional healers against HIV infection and 7 scholars said that doctors who help HIV positive people must be avoided for safeguarding against HIV infection. These results proposed that a relatively small percentage of scholars had 'an average level of knowledge' on how to prevent being infected by HIV.

Table 7: Measurers to Avoid Getting HIV/AIDS

Measure	(n=20=100 %)		Missing %
-Limit sex to one partner:	5	25	75
-Having sex with prostitutes:	8	40	60
-Avoid sex with a person with many bed partners:	13	65	35
-Avoid sex with persons of same sex:	5	25	75
-Avoid sex with person who inject drugs:	7	35	65
-Use condoms:	8	40	60
-Avoid kissing:	2	10	90
-Avoid mosquito bites:	3	15	85
-Seek protection from traditional healers:	6	30	70
-Abstain from sex:	5	25	75
-Avoid doctors who help HIV positive people:	7	35	65

5.4.4 Main Sources of HIV Information and Sexual Related Matters

As shown in Table 8, the adolescents draw information from a very broad variety base as the television received the largest (90%) number of votes and their friends the lowest number (60%) of votes as the main sources on HIV information and sexual related matters. Woodcock et al. (1992 as cited in Pötsönen and Kontula, 1999:6) argued that some adolescents did not trust the information in mass media and believed that the risk of infection was exaggerated compared to other risks of life.

Table 8: **Main Sources of HIV/AIDS Information (N=20)**

	Age Group				
Source	**15**	**16**	**17**	**18**	**%**
Television	5	3	7	3	90
Parents	3	3	7	3	80
Magazines	5	3	6	2	80
Friends	2	3	5	2	60
Relatives	3	4	6	3	80
Teachers	4	3	7	3	85
Doctor	3	3	6	2	70
Clinic	5	3	5	3	80

5.4.5 Attending of HIV Awareness Sessions

Of the 20 participants, 17 knew where to get treatment for a STI and less than half (9) attended any HIV awareness sessions at school (Table 9).

Table 9 **Awareness of HIV/AIDS and STI's**

Statement/Question 10,11,13	**Yes**		**No**		**n=20=100%**
	%	**n**	**%**	**n**	
***To get treatment for a STI:**	85	17	15	3	100
***Attended any HIV school awareness sessions:**	45	9	55	11	100

Research Question 2:- "Are myths that include silence, denial and stigma surrounding HIV/Aids prevalent amongst adolescents in Valhalla Park, and used as barriers to safe sex and condom use?"

5.5 Sexual Behavior, Meaning Attachment and Substance Abuse

The Sexual Risk Behavior Beliefs and Self-Efficacy Questions (SRBB-SEQ:14-19) of the questionnaire attempts to assess the scholars' relationships status, their sexual behavior and substance intake, relationship coercion, main reasons for engaging in sexual activity, norms about

condom use, self-efficacy in refusing sex, self-efficacy in communication in using condoms, and perceptions and beliefs of risk behavior. The latter also constitutes the subtopics for this section.

5.5.1 Coercion When Being Alone

Forty-five percent (9) of the responses revealed that an opportunity to be alone and together with a partner meant being coerced into only talking, kissing and touching one-another without any sexual intercourse but 10 (Table 10) responses revealed that being alone and together meant going beyond just talking and kissing, it is also then that they are intimate. Earlier international studies have found that young people, despite good HIV/AIDS knowledge, underestimate their own risk of becoming infected with HIV (Abrams et al., 1990). When they are alone, the sense of belonging and the acknowledgement of physical togetherness surpass any knowledge or logic or common sense. Sexual intercourse is an expression and a confirmation of their feelings for one-another that cannot be verbally communicated. Adolescents believe themselves to be less promiscuous than average (Ibid, 1990), and they believe that their and their partners' sexual behaviour is responsible.

Nightingale and Fischhoff (2001:1) postulate that adolescents obviously do not always act in ways that serve their own best interests, even as defined by them. Sometimes their perception of their own risks, even of survival to adulthood, is larger than the reality; in other cases, they underestimate the risks of particular actions or behaviors (Ibid, 2001:1).

Table10: Being Alone with a Partner

Statement/Question 14			
	n=20	%	Missing
Reason/s			%
- Talking and kissing:	12	60	40
- Talking, kissing and touching one-another:	9	45	55
- Talking, kissing and being intimate:	10	50	50

5.5.2 Reasons for Being Sexually Active

Table 11 outlines the variables regarding attitudes and norms about sexual intercourse, attitudes

about condom use and sexual coercion. An attempt is made to assess these variables affecting sexual risk-taking behavior and reasons for and if being sexually active. It can be seen in Table 11 that 90% of the respondents noted that using a condom would be the most sensible thing to do when being sexually active as 45% of them prefers penetrative sex.

Fifteen percent (3) of the respondents will have sex due to peer pressure. This study theorizes that adolescence is a critical period for identity formation[26] in which adolescents have a greater need to conform to the norms of their peers (Macloed and Austin, 2003). The gang and the clique give adolescents the opportunity to practice trying on roles to see whether or to what extent they will fit them. Dependency on peers will give way to a mature identity and a sense of inner assurance (Eriskon, 1959 in Reyland et al., 2002: 292). Other most popular reasons for having sex are: due to a desire to experience it (30%); does it with someone that appeal physically (25%) and for mere pleasure and enjoyment (30%). Thirty percent (6) admits that they will only have sex if their partners insist on it as MacPhail and Campbell reported that many young men believe that if sex is not willingly offered they can force their partners, sex being a necessary part of a relationship (Mac Phail and Campbell, 2001: 1623). In a study done by Van Dijk with adolescent-scholars at two schools in the Eastern Cape, the female participants said that they did not call it rape, because they - the boys - were their boyfriends (Van Dijk, 2002:91).

The theoretical interpretation of this phenomena confirms that unequal power relations[27] between men and women may render especially vulnerable young women - to be coerced into unwanted sexual relations as well as impact on their capacity to have input as to the how, where and when sexual relations occur. This construction of women's sexuality often requires women to take responsibility for behavior change in an area where their power is limited (Strebel, 1993). As opposed to women, whose vulnerability derives from a lower power, men's vulnerability to HIV infection is caused by their greater power, mainly explained by the prevailing sexual script of male sexuality, which is often defined as natural, impulsive and initiatory, and expected to be more active and in control (Menda, 2006:23).

[26] Refer: Chapter 2, Theoretical Framework pg. 19
[27] Refer: Chapter 2, Theoretical Framework pg. 17

These social prescriptions[28] impose double standards which have a major impact on the way in which young men and a woman relate to each other, and inevitably influence negotiations about condom use (Abrahams, 2001) and sexual behavior, setting the stage for conflict and behavioral inconsistency. Miles (1995: 19) describes several discourses of sexuality among which she describes the 'male sexual drive discourse'. In this discourse, men are especially driven by the sexual drive, and women are seen as the subject of this sexual drive. Male sexuality is seen here as active, out of control and initiatory. Men need sex, are focused on sex, are ever ready to have sex, and that is ultimately a biological urge outside their control (Shefer, 1999: 39).

Also, according to the data in Table 11, 10% will do it for fear of losing their partners and 15% will have sex with more than one partner. These reasons can however pose barriers to safe sex as it was found that adolescents are aware of the effectiveness of condoms, but have negative attitudes towards using them for some of the following reasons: the nature of sex as being unplanned and spontaneous; the unavailability of condoms; the stigma attached to using condoms, as well as the idea that condoms decrease sexual sensation and pleasure (Preston-Whyte and Gcadinja, 1993).

It is evident in Table 11 that there is a significant difference in attitudes about condom 'use' and 'self-efficacy' in using it when comparing those respondents who prefer to have penetrative sex against the reasons for having sex. This shows that those who would rather have penetrative sex would lower their norms and would be involve in risk behavior unintentionally or intentionally, for the cited sexual reasons, as they would be less stricter as apposed to the 11 respondents who outright denied wanting penetrative sex.

[28] Refer: Chapter 2, Theoretical Framework pg. 19

Table11: Reasons for Being Sexually Active

Statement/Question 15	Yes %	Yes n	No %	No n	n=20=100%	Missing %
*Because you really want to experience it:	30	6	70	14	100	0
*To have penetrative sex:	45	9	55	11	100	0
*Using a condom:	90	18	5	1	95	5
*Your partner insists on having sex:	30	6	60	12	90	10
*Do it with anyone that appeals physical:	25	5	65	13	90	10
*Your friends/peers are having sex:	15	3	75	15	90	10
*For fear of losing your partner:	10	2	85	17	95	5
*For fun and enjoyment:	30	6	65	13	95	5
*With more than one partner:	15	3	80	16	95	5

5.5.3 Sexual Risk Behaviour and Substance Abuse

Of the 20 scholars, 14 exhibited sexual behaviors (Table 12), 10% reported using drugs only sometimes and (1) 5% indicated that they used drugs once or twice to some extent when they were intimate with someone.

The results also show that a greater proportion (55%) of the sexually active participants never indulges in drugs when being intimate. Of this group, 4 are 15 years old and 16 years old respectively, 2 are 17 years old and 5% are 18 years old. The data also provide insights to the scholars' extent of vulnerability and the link between their drug use and unsafe sex practices such as unplanned and unprotected sex, and multiple partners as researchers have over a long time hypothesized that the consumption of alcohol (Strunin and Hingson, 1993), smoking and drug intake increases the likelihood of sexual risk-taking behavior or unsafe sexual practices, by influencing young people's judgment and ability to make decisions (Lovelife, 2004:75).

The trend for the student population in this age group (15 and18 years respectively) indicates that 10% (Table 12) used drugs sometimes and 5% once or twice when they are intimately engaged

with someone. Many young people report that the likelihood of having sex is larger if either they or a potential sex partner has been drinking. They also report that they are less likely to use condoms when they have sex after they have been drinking than if they were sober (Strunin and Hingson, 1993). The reason for this may lie in the fact that alcohol and other substance abuse have been demonstrated as to lessening inhibitions; to be used as a reason or excuse for socially unacceptable behavior, for example driving under the influence of alcohol (Cooper et al., 1990) and to occur with various behaviors that constitute health risks, such as smoking, drug use and violent behavior (Strunin and Hingson, 1993).

Table12: Own Sexual Risk Behaviour

		Age Group					
Statement/Question 16		15	16	17	18	TOT	%
Using of drugs when you are intimate with someone:	1. Always:	0	0	0	0	0	0
	2. Sometimes:	1	0	0	1	2	10
	3. Once or twice:	0	0	1	0	1	5
	4. Never:	4	4	2	1	11	55
	5. Am not intimate:	1	0	4	1	6	30

Although the questionnaire did not provide the participants an opportunity to specify their partner (regular or casual one), of the 14 (Table 13) sexually active students, 10% (2) reported that their partners used drugs sometimes and 15% indicated that their partners used drugs once or twice to some extent when they were intimate. A study conducted by Fergusson and Lynskey (1998), confirms the associations between alcohol abuse and multiple partners, measures of early onset sexual activity as well as unsafe sex. Another study conducted by Luster and Small (1994) into factors associated with risky sexual behaviors among adolescents reported that the females would usually have below-average academic performance, frequently consume alcohol, have low levels of parental monitoring and lack communication with their mothers about contraceptives, while males also have below average academic performance and frequently consume alcohol, they also exhibit suicidal ideation, low levels of parental support, as well as have a history of sexual abuse and multiple partners.

According to the data in Table 13, the partner of a greater proportion (45%) of the sexually active

participants never indulges in drugs when they are intimate. Both tables confirm that 30% (6) of the participants maintain sexual abstinence.

Table13: Sexual Risk Behaviour of Partner

Statement/Question 17		Age 15	16	17	18	Group n=20	%
Does your partner use drugs when you are intimate?	1. Always:	0	0	0	0	0	0
	2. Sometimes:	0	0	1	1	2	10
	3. Once or twice:	1	0	2	0	3	15
	4. Never:	4	3	1	1	9	45
	5. Am not intimate:	1	1	3	1	6	30

5.5.4 Relationship Status

For the adolescent, trust is a mandatory prerequisite for a relationship with a partner as it adds value and meaning to it. Only one out of the 19 scholars who are involved with someone knew of their partner's sexual relationship with others, 9 (Table 14) are quite sure that they are not deceived by their partners, but 45% admitted that they really do not know if their partners are having other sexual relationships. Theory has it that young men need sex, are focused on sex, are ever ready to have sex, and that is ultimately a biological urge outside their control (Shefer, 1999: 39). Miles (1995: 42) found that 'performance' is another important notion in discourses of male sexuality Sexual performance meant in her research that men were able to satisfy women, by keeping their erection until women reach their orgasm. This idea is also prominent in the 'pseudo-reciprocal gift discourse'[29], in which women are 'given' orgasms by men (Shefer, 1999: 122). To be able to 'give' a woman sexual pleasure is seen as proof that you are 'a man' (Shefer et al., 2000: 14). Women, in this discourse, are constructed as 'giving' themselves to men, for men 'need' to satisfy their sexual urges (Shefer, 1999:122), even if it meant being sexually involved with multiple partners without the knowledge or consent of the regular partner.

[29] Refer: Chapter 2, Theoretical Framework pg. 18

Table14: Trust and Risk Behaviour of Partner

Statement/Question 18	Age Group	15	16	17	18	n=20	%
Is your partner intimate with others?	1.Yes:	0	0	1	0	1	5
	2. No:	4	2	3	0	9	45
	3. Do not know:	2	2	2	3	9	45
	4. Do not have a partner:	0	0	1	0	1	5

5.5.5 Risk Perception

In South Africa a number of studies have been conducted into students' and adolescents' knowledge, attitudes and behavior with specific reference to sex, contraceptives, condoms, STD's and HIV/AIDS. These studies found that students tend to have a high degree of knowledge and awareness of HIV infection and Aids. However, this knowledge does not translate into an accurate perception of their own risk, despite the fact that they participate in high-risk behaviors.

When asked if they considered themselves at risk of contracting HIV/AIDS, 4 of the scholars (Table 15) in the group answered ‘yes’ but a very large percentage (75%) believed that they were not at risk. For the adolescent, denial creates a 'comfort' zone where commitment and responsibility for their actions and behavior are neglected. By doing so, ideal conditions are created for the disease to spread (Lesko, 2005:30). For the youth, denial takes on a specific form: “The disease will not reach 'me', or it will not touch my strata or group" (Doka, 1997 as cited in Lesko, 2005:30). Another confirmed reason that shows students felt sure that they were not at risk of being infected with the HI-virus, is that they appeared to be more concerned about the fear of pregnancy (Table 4 indicates that 100% of the scholars do not have an offspring) than by the fear of AIDS (Abrams, et al., 1990). This is also partly because of the tendency to project susceptibility to infection onto stigmatized others (Friedland et al., 1991).

Table15: Chances of Being Infected

Statement/Question 19	Age Group	15	16	17	18	n=20	%
Chances of getting HIV:	1.Yes;	1	0	1	2	4	20
	2. No:	5	4	5	1	15	75
	Missing % :	0	0	1	0	1	5

5.6 Sexually Transmitted Infections Health and Treatment Seeking Behavior

The Sexually Transmitted Infections Health and Treatment Behavior Seeking Questions (STIHTB-SQ: 20-28) of the questionnaire examines the scholars' attitudes regarding health seeing advice and treatment for STI's and HIV. Furthermore, the following additional themes also serve as subtopics of this section as it assess: their reasons for and not to get a HIV test; who will they be taking into confidence before and after a HIV test and actual enquiry if they are tested for HIV.

5.6.1 Health Seeking Advice for STI's

Most of the respondents (17) said that they would rather use a condom when being intimate to curb infections, 9 will discontinue intimacy entirely and 16 would go to a health worker at the hospital or clinic for treatment when suspecting that they had an STI. Although the perception for some adolescents are that health seeking advice for STI's confirms high risk behavior, 8 respondents would prefer to seek advice and obtain medicine from a traditional healer, 12 indicated that they would prefer a shop or pharmacy to do that. 70% would also prefer to communicate and seek advice from friends or relatives (Table 16).

Table16: **Health Seeking Advice for STI's (n=20=100%)**

Statement/Question 20	Age Group 15	16	17	18	TOT	%
-Seek advice from a health worker in a clinic/hospital	5	3	5	3	16	80
-Seek advice/medicine from a traditional healer.	2	1	4	1	8	40
-Seek advice/buy medicines in a shop/pharmacy	4	3	3	2	12	60
-From friends or relatives	5	3	4	2	14	70
-Stop being intimate	3	1	3	2	9	45
-Use a condom when being intimate	6	4	4	3	17	85

5.6.2 Assessment of the Local Counseling Service

The majority of the respondents (85% as in Table 16) indicated their willingness to seek treatment and advice from a health worker in a hospital or clinic, but this may be counteracted by the mistrust of almost two thirds of the students (13) in health workers at the local health facilities to be confidential and voiced that they are not happy with the counseling service in Valhalla Park (Table 17). In their anxiety and embarrassment about sex, young people -especially young men - are reluctant to present themselves for medical attention when they experience sexually - related problems. It has also been found that adolescents who have low self-esteem report relatively more sexual behaviours, which place them at risk of HIV infection (Di Clemente et al., 2002:13). Even when adolescents suspect they are HIV-positive, they may not seek a test or treatment if it means going to a known AIDS clinic or a community doctor (Muyinda et al., 1997 as cited in Brown et al., 2001:4-6).

Table17: **Assessment of Counseling Service in Community**

Statement/Question 21	Age Group 15	16	17	18	n=20	%
Yes:	2	1	3	1	7	35
No:	4	3	4	2	13	65

5.6.3 Reasons to Get an HIV test

From the data (Table 18) it emerged that there is a significant incline to submit to voluntary

HIV/AIDS due to the following reasons: marriage (85%), being intimate without a condom (85%) or if you are feeling sick (45%) after such an intervention, then it would be sensible to know one's status (80%). Other valid reasons that justified the necessity of an HIV test are: to protect your child (65%) if you are expecting one (65%) to protect your partner (60%) and when you are in the process of planning a family (55%).

Table18: Reason/s to Get a HIV Test

Statement/Question 23			
	n=20	%	Missing
Reason/s			%
-Marriage	17	85	15
-Family planning	11	55	45
-Being intimate without a condom	17	85	15
-Protect partner	12	60	40
-Protect child	13	65	35
-If I'm feeling sick	9	45	55
-Know my status	16	80	20

5.6.4 Reasons not to get an HIV test

Silence and denial may be the most pervasive reactions to stigma. For some adolescents (as seen in Table 19) the complex of shame and fear of knowing (65%) forces non-testing. Not knowing one's HIV serostatus is far preferable to being tested (Cameron, 2000).

The Theory of Planned Behavior[30] holds that intentions, one's motivation to engage in a behavior are directly related to the likelihood that that behavior will occur. The three primary determinants of intentions are one's attitude towards behavior, social norms and perceived behavioral control (Godin and Kok, 1996). In TPB, attitude, one's overall evaluation of the behavior, is determined by one's positive and negative beliefs about what will happen if one engages in the behavior. For the scholars, pride and embarrassment combined with mistrust in confidentiality of health workers (as seen in Table 17) forces disclosure and that individuals, according to the data shown in Table 19, can then face prejudice, discrimination and stigma (65%), strains on or the breakup of relationships (70%), social ostracism, or violence (Macintyre et al, 2001 cited in Brown et al., 2001:4-6) in the event of an HIV test.

[30] Refer: Chapter 2, Theoretical Framework pg. 21

Adolescents experience stigma that can be either 'internal' or 'external' (UNAIDS, 2002). External stigma has a "powerful capacity to produce internalization and acceptance of inferiority by the oppressed group and justification of discrimination by the dominant group" (Policy Project, 2003 as cited in Lesko, 2005:34). Internal stigma is the "shame associated with HIV & AIDS and fear of being discriminated against. Internal stigma is a powerful survival mechanism to protect oneself from external stigma and often results in the refusal or reluctance to disclose HIV status or the denial of HIV&AIDS and unwillingness to seek help" (Ibid, 2005: 34) or to be tested. HIV/AIDS-related stigma also influences adolescents' responses to testing positive. It aggravates the psychological burden of receiving a positive HIV test (Chesney and Smith, 1999). These are seemingly the dominating barriers for the participants not to be tested.

Table19: Reasons Not to Get an HIV Test

Statement/Question 24			
	n=20	%	Missing %
Reason/s			
-Fear of Losing partner	6	30	70
-Fear of knowing	7	35	65
-Stigma	7	35	65

5.6.5 Taking into Confidence after an HIV test

Eighty-five percent (17) of the participants reported positively that they would take their parents into confidence regarding the outcome of an HIV test. This is based on the assumption that their parents will be the ones to take care of them in the event of a positive outcome or when they are sick (Table 20). Forty five percent (8) indicated that other family members were another option, while only 10 felt that their partner has the right to know. Six respondents said that they will inform nobody and only a small proportion (30%) will tell their friends as the majority of the group fears exclusion.

Table 20: Confidentiality After an HIV Test

Statement/Question 26	Age Group 15	16	17	18	%	Missing %
-Parents:	6	3	5	3	85	15
-Partner:	4	1	3	2	50	50
-Peers/ Friends:	1	0	4	1	30	70
-Nobody:	1	0	5	0	30	70
-Teacher:	2	1	3	2	40	60
-Priest:	2	1	3	1	35	65
-Family:	3	0	4	2	45	55

5.6.6 HIV Testing Behavior

Although knowledge of HIV is strongly associated with attitudes towards voluntary testing, there is no relationship between reasons or attitude towards voluntary HIV/AIDS testing (Table18) and testing behavior as the evidence for HIV/AIDS testing behavior is somewhat lower then expected as only 5 participants of the group went for a test prior to this research intervention (Table 21), although 70% of the group confirmed that they are sexually active (as seen in Table 12 and Table 13).

Table 21: Tested for HIV

Statement/Question	Age Group					
28	15	16	17	18	n=20	%
Yes:	2	1	0	2	5	25
No:	4	3	7	1	15	75

Research Question 3:- "Is HIV/Aids regarded as a black or gay disease that is distant to most of Valhalla Park?"

5.7 HIV Blaming, Stigma and Attitudes

The HIV Blaming, Stigma and Attitudes Questions (HIVBS-AQ: 29-33) of the questionnaire examines the scholars' perception of whose accountable for spreading the disease, their knowledge of people living with HIV/AIDS (PLA's) and attitudes towards them. These themes serve also as subtopics of this section.

HIV/AIDS-related stigma is often expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, and injection drug use and foreigners. People with certain religious beliefs and less educated people may be more likely to harbor HIV/AIDS- related stigma (Herek et al., 2002: 375). Herek observed that gay men and injection drug users are disproportionately susceptible to HIV-related stigma and discrimination (Herek, 1993 as cited in Brown et al, 2001:5). He has found that HIV-related stigma is not necessarily a stigma of the diseased; rather, it is often related to the perceived lifestyle 'choices' of infected populations or to perceptions about racial and ethnic minorities (Herek, 1999 as cited in Nick, 2007:5)

5.7.1 Accountability for Spreading HIV

A striking aspect of the data as depicted in Table 22 is that none of the participants hold white people accountable for the spreading of the disease, but blamed prostitutes (55%), foreigners (35%), gay men (25%), lesbians (15%), black people (10%) and animals (5%) for it. Seemingly, to blame "others" is psychologically reassuring (Crew, 1992 as cited in Lesko, 2005:34) for this group of adolescents. The fact that: it is 'their' fault; 'we' are innocent and they are guilty as they have behaved in such a way as to put us all at risk (Ibid, 14).Instead of striving for liberation the oppressed tended to become 'oppressors' or 'sub-oppressors,' as this was their model of humanity (Freire, 1970:47) inherited from previous generations who suffered at the hands of colonist and the apartheid regime. Such misguided reactions often blame the victims and force them to hide their

condition in shame and despair at a time when both medical and psychological help is sorely needed (Sue et al., 1994:22). Furthermore, negative attitudes to those having HIV/AIDS became more pronounced the more socially distant the infected person was to the respondent (Pötsönen and Kontula, 1999:4).

Table 22: Who do You Blame for the Spread of HIV/AIDS?

Statement/Question 29	Age Group 15	16	17	18	%	n=20	Missing %
-Prostitutes:	5	3	2	1	55	11	45
-White People:	0	0	0	0	0	0	100
-Black People:	0	0	1	1	10	2	20
-Gay Men:	1	2	1	1	25	5	15
-Foreigners:	3	0	2	2	35	7	65
-Animals:	0	0	0	1	5	1	95
-Lesbians:	1	1	0	1	15	3	85

5.7.2 Knowledge of People Living with HIV/AIDS

The 11 of the 20 respondents in Table 23, who said they personally known somebody who was HIV-positive, showed high levels of HIV knowledge on how it is being transmitted (Table 5) when compared to the scholars (8) who said that they did not know anybody living with HIV/AIDS. These 11 adolescents did not, however, differ to the remaining population in their beliefs regarding sexual risk and behavior, knowledge regarding STI's, attitudes towards HIV testing and condom use.

Table 23: Knowledge of PLA's

Statement/Question 31	Age Group 15	16	17	18	n=20	%
Yes:	2	2	6	1	11	55
No:	3	2	1	2	8	40
Missing % :	5	0	0	0	1	5

5.7.3 Personal Liability

There was an overwhelming concurrence (as in Table 24) on the part of the respondents (55%) that HIV infected people have to take full responsibility and bear the consequences for their situation and health position as the perception is that they are at fault. People are "motivated to believe that others deserve or bring upon themselves the unpleasant events that befall them because the belief that 'bad things' happen to good people would lead to uncomfortable feelings of vulnerability" (Crocker and Lutsky, 1986 as cited in Lesko, 2005:30).

Table 24: Are the Victims to Blame?

Statement/Question	Age Group					
32	15	16	17	18	n=20	%
Yes:	4	3	4	0	11	55
No:	1	1	3	3	8	40
Missing % :	5	0	0	0	1	5

5.8 Adolescents' Challenges of Living in the HIV/AIDS era.

The Adolescents' HIV/AIDS Challenges Questions (AHIV C-Q: 34-35) aimed to get an understanding and an opinion of what the group experiences as the current generation living in the Aids era and how it impacts their state of wellbeing. Table 25 outlines the variables of challenges that face the adolescent currently. Forty five percent (9) of the respondents are worried; 7 are experiencing fear and unhappiness. In either cases, these perceptions and emotions can prompt adolescents to make poor decisions that can put them at risk and leave them vulnerable to physical or psychological harm that may have a negative impact on their long-term health and viability (Nightingale and Fischhoff, 2001:1), while others (10%), take risks because they feel vulnerable to a point approaching lost and hopelessness (Fischhoff et al., 2000).This however, greatly impairs their ability to interpret and deal with life realities in an acceptable way. As cited in Geiger and Fischer (1999), they are more likely to be retained in class (Boals et al., 1990), to be underachievers (McLanahan, 1985), to drop out of high school (Stedman et al, 1988), and to experience behavior problems (Zill et al., 1991).

The theory of planned behavior[31] recognizes explicitly the importance of perceived social support for behavior and incorporate normative beliefs or similar constructs to represents such influences; the assumption of this is that attitudes and perceived social support are interdependent and interactive in the expressed adolescent's behavior "when it is supported by a favorable environment" (Grube and Morgan, 1990:329). The effect of these variables on the adolescent can increase or decrease his/her involvement in high-risk behavior. The outcomes of this behavior are considered to be one way for adolescents to cope with the challenges of everyday life.

Table 25: Opinions of Living in the AIDS Era

Statement/Question 34	Age Group 15	16	17	18	%	n=20	Missing %
-Fearful:	1	2	4	0	35	7	65
-Fearless:	1	0	0	0	5	1	95
-Lost and hopelessness:	1	0	0	1	10	2	80
-Worried:	2	1	4	2	45	9	55
-Not Worried:	0	0	0	0	0	0	100
-Unhappy:	1	2	2	2	35	7	65
-Happy:	0	0	0	0	0	0	100

5.9 Summary

This chapter began by providing an overview of the research findings obtained, highlighting and discussing the six themes that emerged from the analysis. By weighing the findings against the literature review, the researcher also examined whether this information supported, contradicted or advanced the literature review in dialogue with the theoretical framework.

Furthermore, the chapter also attempted to answer the three research questions and demonstrated the extent to which the groups' knowledge, perceptions, beliefs and attitudes influenced their behaviour towards HIV/AIDS. To summarize, with regard to the three research questions, the following was confirmed from the data:

[31] Refer: Chapter 2, Theoretical Framework pg. 22

Research question 1:"How do adolescents in Valhalla Park regard HIV/Aids and how does that influences their behaviour?

There is convincing evidence that emerged clearly from the study that the group of scholars have the correct knowledge about HIV on how it is transmitted (Table 5) and displayed a very good understanding of the definition of the disease, with most of them showing adequate knowledge on items such as the signs and symptoms of AIDS (Tables 6.1, 6.2+6.3), but exhibited an inconsistent knowledge regarding a cure and treatment for AIDS. Simultaneously, the data also shows in Table 7 that there is a significant percentage that does not have knowledge on how to prevent HIV infection as less than half (45%) attended any HIV awareness sessions at school (Table 9). These factors, therefore, translated into the high-risk sexual behavior exhibited by 70% of the 20 scholars (Table 12) of which 10% reported using drugs sometimes and 5% used drugs once or twice or to some extent when they were intimate with someone.

Although it is encouraging to note in Table 11 that 90% (18) of the respondents cited that using a condom would be the most sensible thing to do when being sexually active, reasons like sexual peer pressure, a desire to experience sexual intercourse, having sex with someone who appeals physically, having sex for mere pleasure and enjoyment and only because your partner insists on it, can however, lead to an increased vulnerability to be susceptible to and exposed to HIV infection as well as a tendency towards unsafe sexual practices.

Perpetuation of high-risk behavior is confirmed by 5% of the scholars in that they are aware of their partner's sexual relationship with others, which is further compounded by the fact that of the (14) 70% (Table 13) sexually active students, 10% reported that their partners used drugs and 15% indicated that their partners used drugs once or twice or to some extent when they were intimate. Even more troubling is the fact that only 25% (5) of the group went for an HIV test (Table 21) as a very large percentage (75%) of the scholars believed and are convinced that they were not at risk (Table 15) of contracting HIV/AIDS.

Research question 2: Are myths that include silence, denial and stigma surrounding HIV/Aids prevalent amongst adolescents in Valhalla Park, and used as barriers to safe sex and condom use?

For the scholars, the HIV/AIDS epidemic has contextually engineered silence, denial and stigma socially and culturally. If an infection is suspected, silence is preferred. In the event of an HIV test being taken, pride and embarrassment combined with mistrust in and breach of confidentiality of health workers (as seen in Table 17) often forces disclosure. Individuals, according to the data shown in Table 19, can then face prejudice, discrimination and stigma (65%), strains on or the breakup of relationships (70%), social ostracism, or violence (Macintyre et al, 2001 cited in Brown et al., 2001:4-6). A confirmed reason that shows of how scholars in the group are denying their risk of being infected with the HIV-virus, is that they appeared to be more concerned about the fear of pregnancy (Table 4 indicates that 100% of the scholars do not have offspring) than by the fear of AIDS (Abrams et al., 1990).

Most of the respondents (85%) said that they would rather use a condom when being intimate to curb infections. This result, however, might be slightly over-scored. Evidence from this study's data of high-risk sexual behavior includes multiple sexual partners, sexual and relationship coercion, substance abuse, unequal power relationships, deceitful partners and penetrative sex which are perpetuated by factors such as lack of knowledge on prevention of HIV infection, biological urges, peer pressure, fear of losing a partner, own and social identity, low self-esteem (Table 25), silence, denial, stigma and blaming. These reasons can however pose barriers to safe sex as it was found that the adolescents are aware of the effectiveness of condoms (Table 11), but have negative attitudes towards using them for some of the following reasons: the nature of sex as being unplanned and spontaneous; the unavailability of condoms; the stigma attached to using condoms, as well as the idea that condoms decrease sexual sensation and pleasure (Abdool Karim et al., 1992).

Research question 3: Is HIV/Aids regarded as a black or gay disease that is distant to most adolescents of Valhalla Park?

The outcomes of the HIV Blaming, Stigma and Attitudes Questions (HIVBS-AQ: 29-33) of the questionnaire showed (Table 22) that the scholars found it psychologically reassuring to hold prostitutes (55%), foreigners (35%), gay men (25%), lesbians (15%) and black people (10%) accountable for the spreading of the disease, and regarded it as such. Denial takes on a specific form for the youth: “The disease will not reach 'me’ or it will not touch my strata or group" (Doka, 1997:16). For them, blaming others becomes a substitute for bearing the consequences and responsibility for deviant behavior. People are "motivated to believe that others deserve or bring upon themselves the unpleasant events that befall them because the belief that 'bad things happen to good people' would lead to uncomfortable feelings of vulnerability" (Crocker and Lutsky, 1986 as cited in Lesko, 2005:30). For the scholars, blaming also acts as a needed moral pillar and shelter in a world where they experience feelings of excessive unhappiness, fear and helplessness (Table 25).

Stigmatization of others, personal attitudes and beliefs however, affect the adolescents’ access to HIV prevention, testing, disclosure, healthcare and support efforts as 35% of the scholars in the study would also avoid doctors at all cost who help HIV positive people. Unfortunately, this approach has impacted negatively on the group’s HIV testing behavior as 75% confirmed as not having been tested prior to this study intervention.

The next chapter will include a discussion of the main findings in relation to the research objectives. It will also address the question of the findings’ validity, the study’s overall limitations and subsequent implications, followed by the recommendations, such as interventions that can be done in response to the main themes that emerged from the results.

CHAPTER 6: DISCUSSION AND RECOMMENDATIONS

6.1 Introduction

This chapter includes a brief discussion and summary of the main findings in relation to theory and literature and will parallel the research's objectives. It will also address the question of the findings' validity, the study's overall limitations and subsequent implications, followed by the suggestions and recommendations, such as interventions that can be done in response to the main themes that emerged from the results. A brief summary and concluding remarks constitute the conclusion of the chapter.

6.2 Validity of Data

The validity of data has to be assured before any further discussion and summary of the results can be done. As shown in the previous chapter, this research's findings supported and advanced the literature review. The validity and reliability of the data is further enhanced as it is in agreement with the findings of KAB-studies conducted locally and internationally. In the comparative analysis, emphasis leans more towards similarities rather than the differences between the three studies for the purpose of confirming validity. Here follows a brief comparison between the findings of this study and two other similar studies:

6.2.1 Current Study

According to this study's results, a very large percentage of the scholars had a 'high knowledge' of how HIV is being transmitted, as they draw information on HIV and sexual related matters from a very broad variety base such as the television, parents, teachers and magazines – the latter receiving the largest number of votes, but for some reason this knowledge was denied as far as sexual activity goes. A relatively small percentage of scholars had 'an average level of knowledge' on how to prevent being infected by HIV. Seventeen participants knew where to get treatment for a STI, but less than half attended any HIV awareness sessions at school. Almost two thirds of the respondents indicated their unwillingness to seek treatment and advice from the local health facilities due to the mistrust in health workers at the local health facilities in Valhalla Park.

Evidence from this study's data of high-risk sexual behavior includes multiple sexual partners, sexual and relationship cohesion, substance abuse, unequal power relationships, deceitful partners and penetrative sex which are perpetuated by factors such as lack of knowledge on prevention of HIV infection, biological urges, peer pressure, fear of losing a partner, own and social identity, low self-esteem, silence, denial, stigma and blaming of others as well as intolerance towards PLA's. These reasons can, however, pose barriers to safe sex as it was found that 17 (85%) of the adolescents are aware of the effectiveness of condoms against HIV-infection, but have negative attitudes towards using them. Only five scholars in the group had been for an HIV test as a very large percentage of them were (at that stage) convinced that they were not at risk of contracting HIV/AIDS.

6.2.2 A Local Study

In a research conducted with learners at three different secondary schools in the Bojanala region of North West Province in South Africa, Lesejane (2004) concluded that HIV-knowledge is not sufficient to change adolescents' high-risk behaviour. According to her research, most of the cases reported from the three different schools about the behaviours of learners, which are considered risky in terms of contracting HIV/AIDS, are alcohol and drug taking, and lack of condom use (Lesejane, 2004:49). Furthermore, social influences like poverty, poor living conditions, peer pressure (belonging to the group), lack of parental guidance and multiple sex partners has an impact on adolescent sexual and other high-risk behaviours that may result in HIV infection. These learners have a sound knowledge of STI'S and related illnesses, but focus only on birth control, denying their risk to HIV-infection (Ibid, 2004:50-65).

6.2.3 An International Study

In Botswana, a national survey that was commissioned by Botswana Training Authority (BOTA) was conducted by Botswana Institute for Development Policy Analysis (BIDPA) from January to March 2005 among a nationally representative sample of 1297 learners. The survey, in the form of a questionnaire, was designed to shed light on the level of knowledge, attitude, sexual behaviour and practices towards HIV/AIDS among learners in vocational training institutions in Botswana,

and to come up with recommendations to guide implementers on HIV/AIDS interventions in vocational training institutions (BOTA, 2005:4). The analysis of the field survey data shows high levels of HIV/AIDS awareness among learners in the vocational training sector. However, awareness and knowledge of some learners are not linked to behavioural change. There are strong indications that the learners in this study have good access to accurate HIV/AIDS information and that they are regularly being exposed to HIV/AIDS media from a range of different sources. Learners' major sources of HIV/AIDS information are TV, magazines and parents. Learners correctly selected things a person can do to avoid getting infected with the HIV as follows: at least 90 percent of learners correctly selected abstinence; condom use by about 80% of learners; whilst sticking to one partner was selected by 50%; and followed by avoiding sex with prostitutes and many partners. Almost half of learners (49%), who have never been tested for HIV/AIDS, cited fear of being stigmatized and discriminated against (Ibid, 2005:4-5).

6.3 Discussion of Main Findings

This section will provide a brief discussion and summary of the main findings in relation to theory and literature in recognition of the research's objectives. As the primary research objective was addressed and reported in the summary of Chapter Five, a brief summary is again provided. To summarize, with regard to the research objectives, the following information emerged from the data:

Objective 1: To explore the groups' knowledge, perceptions, beliefs, attitudes and behaviour towards HIV/AIDS.

It emerged clearly from the study that the group of scholars have the correct knowledge about HIV on how it is transmitted (Table 5) and displayed a very good understanding of the definition of the disease, with most of them showing adequate knowledge on items such as the signs and symptoms of AIDS (Tables 6.1, 6.2+6.3), but exhibited an inconsistent knowledge regarding a cure and treatment for AIDS. Simultaneously, the data also shows in Table 7 that there is a significant percentage that does not have knowledge on how to prevent HIV infection as less than half (9 participants) attended any HIV awareness sessions at school (Table 9). These factors, therefore,

translated into high-risk sexual behaviour as exhibited by 14 of the 20 scholars (Table 12) that can accelerate being prone to HIV infection.

Although 18 of the respondents noted that using a condom would be the most sensible thing to do when being sexually active, reasons like sexual peer pressure, a desire to experience sexual intercourse, having sex with someone who appeals physically, having sex for mere pleasure and enjoyment and only because your partner insists on it, can however, lead to an increased vulnerability to being susceptible to contracting the disease as well as increased exposure to HIV infection along with a tendency towards unsafe sexual practices. Evidence from this study's data of high-risk sexual behavior includes multiple sexual partners, sexual and relationship coercion, substance abuse, unequal power relationships, deceitful partners and penetrative sex which are perpetuated by factors such as lack of knowledge on prevention of HIV infection, submission to biological urges, peer pressure, fear of losing a partner, own and social identity, low self-esteem (Table 25), silence, denial, stigma and blaming.

Perpetuation of high-risk behavior is confirmed by scholars in that they are aware of their partner's sexual relationships with others, which is further compounded by the fact that of the 14 sexually active students, two reported that their partners used drugs and three indicated that their partners used drugs once or twice or to some extent when they were intimate.

These reasons can however pose barriers to safe sex as it was found that the adolescents are aware of the effectiveness of condoms (Table 11 and Table 16), but have negative attitudes towards using them for some or all of the following reasons: the nature of sex as being unplanned and spontaneous; the unavailability of condoms; the stigma attached to using condoms, as well as the idea that condoms decrease sexual sensation and pleasure (Abdool Karim et al., 1992).

Objective 2: **To establish, explore and examine factors that influenced the group of twenty adolescents' perceptions, beliefs, attitudes and behaviour towards HIV/AIDS.**

6.4 At risk youth in a 'Coloured' community in Cape Town: Compromising factors for HIV-infection

6.4.1 The After-effects of Oppressive Systems such as Colonialism and Apartheid

The 'logic' of slave-, colonial-, and apartheid economies was to displace non-white industrial workers into squalid, single-sex living conditions, and to foster migration between regions and unplanned urbanization. These conditions were forced on African communities and justified through racism - a racism that rationalized the even greater disruptions and dislocation of family structures (Bayer and Susser, (2000) as cited in Baker, 2001:5). As 90% (18) of the scholars in the group are classified Coloureds, it seems that their situation is exacerbated by the historical cross-generational 'trauma and pain' which is a result of apartheid and colonialism, and which can be said to be an unhealing and gaping 'soul wound' that they inherited. This is reflected in their approach and behaviour towards people living with HIV/AIDS and in their inability to cope with life conditions. Goffman (1963:12) in Lesko (2005:14), states that stigma reduces the bearer "from a whole and usual person to a tainted, discounted one." Instead of striving for liberation the oppressed tended to become 'oppressors' or 'sub-oppressors,' as this was their model of humanity (Freire, 1970:47). It seems that perceptions and beliefs amongst the scholars support the idea that adolescents living in Valhalla Park, are in general, still in denial of their own vulnerability to HIV/AIDS by believing that the disease is prevalent among others not belonging to 'their' group and must be discriminated against and looked down upon as 'other' by their own and treated as such. As depicted in Table 22, 11 participants hold prostitutes accountable for the spreading of the disease, 7 blamed foreigners, and 5 participants accused gay men, 3 noted lesbians and 2 participants pointed fingers at black people.

Most social constructionist sexuality researchers (Kelly and Kaliehman, 1995; Mac Phail and Campbell, 2001; Shefer et al., 2000; Tiefer, 1995; Tolman et al., 2003; Vance, 1992) as cited in Henning et al. (2005:21), align themselves with the view that people's sexuality and sexual

practice is not a self-contained, separate, independent and consistent experience or behaviour, but that it exists in practices and meanings that are influenced by a specific historical timeframe, culture, gender and class.

These adolescents of Valhalla Park are also 'victims' of socio-economic circumstances, which are beyond their control. Seemingly, these circumstances impact their identity development tremendously. They are forced to deal with the immediate harsh economic conditions while simultaneously having to face the reality of living in the HIV/AIDS era of which they are in total denial. Table 25 outlines the variables of challenges that face the adolescent currently. Forty five percent (9) of the respondents are worried; 7 are experiencing fear and unhappiness. In both cases, these perceptions and emotions can prompt adolescents to make poor decisions that can put them at risk and leave them vulnerable to physical or psychological harm – these in turn may have a negative impact on their long-term health and viability (Nightingale and Fischhoff, 2001:1), while others (10%), take risks because they feel vulnerable to a point approaching 'lost and hopeless' (Fischhoff et al., 2000). These factors, however, result in the development and perpetuation of a low self-esteem and consequently greatly impair the adolescent's ability to interpret and deal with life realities in an acceptable way. As cited in Geiger and Fischer (1999), these adolescents are more likely to be retained in class (Boals et al., 1990), be underachievers (McLanahan, 1985), drop out of high school (Stedman et al., 1988), and experience behavior problems (Zill et al., 1991).

Negative peer influence (as referred to in 6.5.1.4), however, is another primary risk factor that many adolescents face within a socio-economically deprived township like Valhalla Park. A clear relationship that exists between negative peer influence and maladaptive outcomes, e.g., juvenile delinquency, substance use, school dropout and high risk sexual behavior, has been established in the literature on 'at-risk' youth of colour (Ary et al., 1999; Dishion et al., 1997; Fergusson and Horwood, 1998; Laird et al., 2001; Vitaro et al., 2000) in Meeus and Dekovic (1995). The effect of these variables on the adolescent can increase or decrease his/her involvement in high risk behavior. The outcomes of this behavior are considered to be one patent way for adolescents to cope with the challenges of everyday life.

6.4.2 The Long-term Effects of Poverty and Deprivation

Poverty and unemployment have placed a burden on a sizeable segment of our population. The parents of 5% (Table 4) of the scholars in the group cannot afford the rental of a council house in Valhalla Park, and therefore, are forced to reside in an informal house (corrugated shelter or 'wendy' wooden house). The "immediate conditions of daily life are so adverse for some people that they outweigh concerns about contracting HIV/AIDS" (Kiragu, 2001:54). In fact, unemployment can be as debilitating psychologically as it is financially (Nelson, 1974) – an increased sense of misery along with a diminishing rate of resources, however little. As an indication of the toll that unemployment and the absence of access to sustainable livelihoods exact, poor living conditions and periods of extensive unemployment are typically accompanied by increases in certain types of maladaptive behaviour, such as depression, suicide, crime (Brenner, 1993) and engaging in risky sexual behaviour that leads to HIV infection.

For the adolescent, conditions of poverty also increase exposure to particularly debilitating diseases, e.g., tuberculosis, malaria, hepatitis, respiratory, and diarrheal disease, which in turn (in conjunction with generally poor health) may impact susceptibility to HIV transmission/infection. Even if the general degradation of health does not increase, susceptibility to HIV transmission/infection, the prevalence of untreated STDs and other genital infections/lesions substantially increase the risk of sexual transmission of HIV (Baker, 2001:5).

But the stark reality of poverty and its effect on the adolescent go beyond just economic and health dispositions. A core belief of western society, which is also one of the cornerstones of South Africa's Children's Bill of Rights, has been that all children deserve to grow up free from hunger and violence in an atmosphere of warmth and love while receiving a stimulating education. However, disadvantaged youths cannot be given such opportunities as long as they are growing up in deprived and dysfunctional families and communities (Geiger and Fischer, 1999). Parents in poverty lack confidence in their parenting abilities (Banyard and Olson, 1991). These parents experience problems that include irritability, avoidance behavior, physical abuse and divorce, a sense of helplessness about the future, and clinical depression. They are five times more likely to maltreat their children than families with a higher income and are more likely to have experienced

maltreatment in their own childhood (Olds 1988; Sedlack 1989, as cited in Geiger and Fischer, 1999). In a study done by Lehr et al. (2004:4) of youth attending alternative schools in the USA, adolescents from dysfunctional families in sub-economic areas reported higher rates of substance abuse, suicide attempts, sexual activity and pregnancy. In addition, they were more likely to have been physically or sexually abused or witnessed abuse within their families.

The concern about child poverty relates not just to the immediate effects of poverty. More importantly, the experience of poverty in childhood may influence social, economic and health outcomes throughout later life, leading to the 'persistence' of poverty into adulthood and consequences for the next generation (Blanden and Gibbons, 2006:27).

6.4.3 The Fast Changes in Society Re: Sexual Risk and Single Parenthood

Findings also confirmed that fifteen percent (3) of the participants in the sample were in the care of a female-headed household (their mother). In a study of women with young children in the USA, women in the lowest quintile of distribution of household income were at a substantially higher risk of depression and poor health which are perpetuated by a variety of mechanisms including lack of social support, demands of societal changes, poor nutrition, unhygienic living conditions and inadequate health care, lack of education and employment opportunities and debt (Kahn et al, 2000).

Lower-class mothers are more likely to adopt attitudes of fatalism and helplessness toward life (Steinberg and Belsky, 1991), which in turn are adopted and internalized by their children. These mothers are less responsive to their children's needs (Gaudin, 1993). According to Hawley (as cited in Geiger and Fischer, 1999), they more often have bleak prospects and low expectations for their children's future.

Of the 20 scholars, 14 confirmed being sexually active (Table 12), two reported using drugs sometimes and 10% (2) said that their partners used drugs when being sexually intimate. Many young people report that the likelihood of having sex is larger if either they or a potential sex partner had been drinking. They also report that they are less likely to use condoms when they have

sex after they had been drinking than if they were sober (Strunin and Hingson, 1993). A study conducted by Luster and Small (1994) into factors associated with risky sexual behaviours among adolescents reported that the females would usually have low levels of parental monitoring and lack communication with their mothers about contraceptives and other sexual related matters, have below-average academic performance, frequently consume alcohol and/or other forms of drugs. Meeus concluded in a study investigating risk behaviour amongst adolescents that female adolescents want to experience more social support from their mothers than males (Meeus, 1989). Low levels of parental monitoring for most adolescents residing in townships similar to Valhalla Park meant and constituted unskilled solitary maneuvering through daily challenges. Most decisions that are made which impact negatively on these adolescents can, however, without the required parental support, result in emotional and psychological harm that have a destructive effect on them.

6.4.4 The Problems Which Young People Experience with a Sense of Identity, Biological Changes and Self-confidence

"Socio-cultural practices and belief systems present the individual with constructs which make her/his experiences meaningful" (Henning et al., 2005:22). These constructs are developed in a person's daily interactions in specific relational contexts, e.g. parental, partner, social, school, gang, etc. (Weeks, 1986), and "it gives meaning to human activities" (Weeks, 2003:19). Three (3) of the adolescents (15%) acknowledged that they would submit to peer pressure by being sexually active (Table 11). Therefore, this study theorizes that adolescence is a critical period for identity formation in which youth have a greater need to conform to the norms of their peers (Macloed and Austin, 2003).The gang and the clique give adolescents the opportunity to practice trying on roles to see whether or to what extent they will fit them. Dependency on peers will give way to a mature identity and a sense of inner assurance (Eriskon 1959 in Reyland et al., 2002: 292).

Adolescence, which is a transitional period between childhood and adulthood, begins with biological changes associated with puberty and proceeds through a process of psychosocial changes, influenced by cultural and social factors, which, to a large extent, determine the identity and sexuality of the adolescent (WHO, 2000). This can be described as the sexual awakening

period for both genders that sets the stage for sexual experimenting (as confirmed by 6 respondents) and having sex, in responding to sexual urges, with someone that appeals physically as noted by 5 of the respondents. "Sexual awakening is more about the onset of sexual feelings" (Van Dijk, 2002:6) and differs between male and female adolescents. It starts for boys with spontaneous erections and first ejaculation. Sexual awakening for girls starts, according to Adams (as cited in Terblanche, 1999: 20), with the onset of menstruation. For the male adolescent, sexuality is often construed as being biologically driven and assumed to be spontaneous. They are perceived as -and excused for- being reckless and irresponsible in sexual encounters (Kelly and Kalichman, 1995) as 6 scholars (Table 11) acknowledged sexually activity that stems from mere pleasure and enjoyment.

Also, according to the data in Table 11, 10% (2 participants) will have sex for fear of losing their partners as a partner has become increasingly important in their emotional dependency network and in development of self-confidence, resulting in replacement of the parents as the most important reference person. Interaction among peers is based on the principle of symmetry and equality (Youniss and Smollar, 1985), as, during the course of adolescence, youngsters are learning to get along with each other on the basis of equality replacing the dominance of the parents (Meeus and Dekovic, 1995:4).

6.4.5 Social Construction and Prescription

Oliver and Hyde (1993 in Browning et al, 1999:3) pointed out that neo-analytic, sociobiological, social learning, social role, and script theories all expect women to have more negative attitudes toward casual, premarital sex than do men. Miles therefore recognized that heterosexual practice is strongly influenced by the social construction of sexuality, and thus by the power relations which are part of this (Miles 1995:2). Sexual intercourse necessarily implies a social activity that includes negotiating sexual practices with a partner (Holland et al., 1994). Thirty percent (6) respondents in this study (Table 11) admit that they will only have sex if their partners insist on it : as MacPhail and Campbell reported, many young men believe that if sex is not willingly offered they can force their partners, sex being a necessary part of a relationship (MacPhail and Campbell, 2001: 1623).

Culture is at the centre of such perceptions, interpretations and meaning with regard to sexual relations. Young women are taught to approach sexual encounters in a particular way, which are shaped by their sex education, their understanding of male and female desires and their construction of their self-image (Holland et al., 1994). Thus, the social representations of women and the particular roles they are ascribed greatly influence the realities of many young women and provide the ideal against which they measure themselves. The theoretical interpretation of this phenomenon confirms that unequal power relations between men and women may render young women especially vulnerable to being coerced into unwanted sexual relations as well as impact on their capacity to have input as to the how, where and when sexual relations will occur. According to Shefer 'sexuality gets framed as a male domain, in which men control and set the terms, and to which women must be inducted and guided' (Shefer, 2001 in Roman, 2006:26).Men might use violence (both implicitly and explicitly) against their partners, and use it within a sexual context as a way of exercising power over women (Kitzinger, 1994).

6.4.6 The Complex of Blame, Fear and Denial versus Risk Perception

The complex of shame and fear of knowing for 13 respondents (as seen in Table 19) forces non-testing. For the adolescent, according to Cameron (2000), not knowing one's HIV serostatus is far preferable to being tested.

People with certain religious beliefs and less educated people may be more likely to harbor negativity towards HIV/AIDS- related stigma (Herek et al., 2002: 375). Herek has found that HIV-related stigma is not necessarily a stigma of the diseased; rather, it is often related to perceived lifestyle "choices" of infected populations or to perceptions about racial and ethnic minorities (Herek, 1990).

To blame others is psychologically reassuring (Crew, 1992:14). The fact that: it is 'their' fault; 'we' are innocent and 'they' are guilty as 'they' have behaved in such a way as to put 'us' all at risk (Ibid, 1992:14), relieved one's responsibility from accepting the outcomes of risk behaviour. Eleven respondents (in Table 22.2) are convinced that HIV-infected people have to take full responsibility and bear the consequences for their situation and health position as the perception is

that they are at fault. People are "motivated to believe that others deserve or bring upon themselves the unpleasant events that befall them because the belief that 'bad things happen to good people' would lead to uncomfortable feelings of vulnerability" (Crocker and Lutsky, 1986:103) as cited in Lesko (2005:30) and fear of being discriminated against.

For the adolescent, denial creates a 'comfort' zone where commitment and responsibility for their actions and behavior are neglected. A confirmed reason that shows the scholars felt sure that they were not at risk of being infected with the HI-virus, is that they appeared to be more concerned about the fear of pregnancy (Table 4 indicates that none of the 20 scholars have any offspring) than by the fear of AIDS itself (Abrams, et al., 1990). The scholars' risk perception has a troubling effect on their HIV testing behaviour as only 5 scholars had been for an HIV test (Table 21), although 14 of the 20 scholars (Table 12) exhibited sexual behavior and a very large percentage- 15 scholars - believed and are convinced that they were not at risk (Table 15) of contracting HIV/AIDS.

6.5 Research Limitations and their Implications

As the text is reduced to only a few themes, the endeavor to pursue generalization of the results is restricted by the scope of the study.

Caution is also needed in the generalisability of the findings due to the lack of a focus group session. This in itself may have posed a limitation on the study. Babbie and Mouton (2001: 292) posited that "focus groups are useful in finding information you would not otherwise be able to access and they allow a space in which people may get together and create meaning among them." Unfortunately, this study has missed out on as Schurink believes "not only descriptive data in the participants' own written or spoken words and expressions, but also the involvement and identifying of their beliefs and values that underlie the research phenomena" (Schurink, 1998:242). A focus group session would have given the researcher the added advantage of taking the respondent's personal information and attaching insight and understanding to it as well as undertakes and gives detailed descriptions of the phenomena (Neuman, 2000).

Although an appeal for truthfulness has been made in answering the questionnaire, the possibility of dishonesty by the respondents' in their responses cannot be ignored. Given the sensitive nature of the subject matter (HIV/AIDS and risk related behaviours), the adolescent scholar might have been tempted to provide the answers that he/she thinks is expected of him/her. This in itself jeopardized the question of the reliability of the findings to a certain extent.

The aim of the administered questionnaire was to get a deeper understanding of HIV/AIDS related knowledge, attitudes, perception and behaviour amongst adolescents in Valhalla Park. Apart from the pilot study, the validity of this self constructed questionnaire was not determined by an independent contractor prior to the empirical phase of the research. This limitation, however, can be beneficial to future studies of a similar nature as the questionnaire can be used as a directive.

The results of the study are bound within a specific context and to a specific group of adolescent scholars at Beauvallon High School. To obtain a deeper understanding of HIV/AIDS related knowledge, attitudes, perception and behavior amongst adolescents in Valhalla Park, it would have been more meaningful if adolescents of other social strata within Valhalla Park were included in this study. Although caution must be upheld when an attempt is made to generalize from these findings outside of a similar population, other scholars will be able to use and analyze this information further in future; especially for comparative purposes and for ascertaining how attitudes may have changed over time.

Despite these weaknesses, this study is one of the first in Valhalla Park to provide a broad description and provided limited, though valuable and meaningful insight into adolescents' knowledge, perception, attitudes and behavior towards HIV/AIDS. As discussed earlier in this chapter, the validity and reliability of the data is further increased as it is also in agreement with the findings of KAB-studies conducted locally and internationally.

6.6 Recommendations and Suggestions

While the present study has made some progress in answering some pertinent questions relevant to understanding adolescents' behavior related to HIV/AIDS, it also would like to provide some

recommendations and suggestions in regard to the following valid questions:

What is expected from government and non government organizations (NGO's)? Relatively few interventions to reduce HIV risk behaviour amongst adolescents have been done, and not all types of interventions have been tested in all adolescents' settings or cultural groups. It is strongly recommended that future studies be done that include quantitative and qualitative methodologies to explore HIV/AIDS related knowledge, perceptions, beliefs, attitudes and behaviour amongst adolescents in the Western Cape. This should be done over a period of time combined with a range of educational programmes and interventions. These annually budgeted programmes and interventions should be a combined and concerned effort initiated by the Ministries of Education and Health and NGO's that should target schools, clinics, libraries, community halls, sports' clubs, centers for the destitute and abused, orphanages and churches in all townships on the Cape flats. These studies should include measuring of adolescents' actual behavioural change towards: Voluntary counseling and testing (VCT), people living with HIV/AIDS, health seeking information, stigmatizing attitudes, reducing of risk behaviours and social application of HIV/AIDS related knowledge. A network of regional and sub-offices should organize, manage, coach, train and lead competent people living with HIV/AIDS (PLA's) to run these programmes in their respective communities. These programmes and interventions should make allowance for peer education, must be functional, respondent friendly and should comply with the cultural, social, language, gender and religious context and environment.

High risk and defiant behaviour is 'driven' by the adolescent's increased access to drugs. Shebeens and other illegal liquor outlets have become a central part of township life providing recreation and relaxation for many South African youth. Subsequently, alcohol and drug intake has played a major role in the social disintegration of family and community life (Gumede, 1995; Parry and Bennetts, 1998 in Pithey and Morojele, 2002:7).It is also suggested that government should forcefully close down shebeens, taverns, bottle stores and drug merchants that sell alcohol and drugs to teenagers. These community members must be made aware of the powerful hand that they have in the risk behaviour of adolescents and the miscarriage of the social system.

What is expected from the local schools? The journey to self discovery and identity development

is greatly influence by the adolescent's social environment which has characteristics that affect the behavior of adolescents in many subtle ways. In this regard, the school environment and its role can neither be undervalued nor under-calculated. Curriculum compatibility to life changes has become of paramount importance that poses a challenge to principals' and teachers' leadership by testing their capacities and abilities.

It is this study's intention to recommend that future life skills curriculums at schools should be tailored to incorporate and pursue the following:

1) HIV/AIDS knowledge on transmission and infections should not be treated in isolation but incorporated as an element of other learning areas e.g.: Language and Literacy; Natural and Physical Science; Social Sciences; Religious Education; etc.
2) The life skills curriculum should target the adolescent by paying particular attention to the following themes:

   HIV/AIDS knowledge on transmission, infections and treatment; HIV/AIDS and teenage pregnancy; ARV application and benefits; Ethics: acquisition of norms and values; HIV/AIDS and culture; HIV/AIDS and social responsibility; HIV/AIDS and rights violation; Adolescents' behavioral changes and maintenance thereof; Identification and adoption of a behavioral model; Impact of behaviour changes translating into social transformation; Coping with myths of silence, denial, fear and stigma; Caring of and attitude change towards people living with HIV/AIDS; Sexual skills negotiation with emphasis on abstinence promotion; Male and female condom use and implications; Sex and sexuality; Adolescents' sexual risk behavior and its implications; Alcohol/drug abuse and its implications; Health and testing seeking advice and treatment; Adolescents' identity formation, biological and psychologically changes and challenges; Relationship coercion, vulnerability and gender equality; Importance and attendance of awareness sessions.

Within the current epidemic context, the task of HIV/AIDS coordinator cannot be assign to one or a group of teachers. Every staff member (inclusive with the estate managers and members of the

School Governing Body) should be empowered and positioned to identify HIV/AIDS related symptoms and to work comfortably in this regard with parents and teenagers alike. Hands on in supporting, guiding and leading the adolescent by every member of the adult community at school will guarantee improved results in the adolescents' behaviour and mind set. Provision and administering of HIV/AIDS support, care and medical attention to the adolescent scholar should be backed up by a HIV/AIDS policy at each school accompanied by a register detailing every HIV related case/incident identified and required attention given excluding the name of the candidate.

What is expected from the community-based health services? Due to the mistrust in health workers because of the lack of confidentiality, the majority of the respondents indicated their unwillingness to seek treatment and advice from the local clinic, and voiced that they are not happy with the counseling service in Valhalla Park. In their anxiety and embarrassment about sex, young people need to be encouraged to present themselves for medical attention when they experience sexually - related problems and coming for testing. Literature on care-giving on the other hand, shows and recognizes that stigma and fear of contagion and fear of death have clear negative effects on health care workers' attitudes towards treatment (Gerbert et al., 1991; Kelly et al., 1987; Weinberger et al., 1992). A code of conduct, that include the vision and mission of the institution, a confidentiality clause and a detailed professional service delivery endorsement, should be drafted by various stakeholders within the community and local health department. This must be displayed within the public's naked eyes (the code of conduct was not on display when the researcher visited the site during the research intervention period). Policy and practice should go hand in hand. It is equally important that the clinic should compile a house policy that addresses effective and efficient service delivery, work ethics, levels of job descriptions, management, staff and community related issues and training.

What is expected from the community? It seems as if the HIV/AIDS tide has put more 'dope' than 'hope' in people's minds. HIV infection should not be taken as a death sentence. The epidemic should be seen as a wake-up call for ordinary people to do extraordinary things. Curbing the spread of the epidemic should be a collective community-based and individual-level approach. Although 16 of the respondents marked under the HIV Knowledge and Perceptions Questions (HIVK-PQ:-1-13) part of the questionnaire their parents as HIV information source, this study recommends

that parents/adults must take their parental role more seriously and should open the communication channels between themselves and their children. Parents have to show an open interest in what, where, why and how their children are doing. HIV related topics e.g., sexual abstinence; voluntary counseling and testing (VCT); sexual risk behavior and it's dangers; alcohol abuse, condom use and intercourse; STI's; biological changes and urges; peer and relationship pressure; identity crisis; teenage pregnancy, health seeking advice and HIV infection should be naturally encouraged at home with teenagers. Defiant sexual behaviour amongst adolescents should be discouraged at all cost and adults have to set an example by refraining from such behaviours themselves. Advice or counseling services should be approached to overcome domestic barriers straining family relationships.

In Valhalla Park, as in the wider Western Cape, there is a need for church leaders to play an active, spontaneous, tolerant, leading and open role in assisting HIV infected adolescents that experienced the inability to cope psychologically and physically. They should be trained to provide continues and effective spiritual counseling for those adolescents who are infected and affected.

6.7 Conclusion

This chapter provided a brief overview of the study's main findings obtained in relation to theory and literature that paralleled the research's objectives. It also addressed the question of the findings' validity, by providing a comparative analysis of the current study's data to that of a local and international KAB-study. Furthermore, the chapter also illustrated and confirmed the validity of the data as it not only supports and advances the study's literature review but is also in consensus with it.

The research clearly demonstrated that the group of scholars have the correct knowledge on HIV transmission, with most of them showing adequate knowledge on items such as the signs and symptoms of AIDS, but exhibited an inconsistent knowledge regarding a cure and treatment for AIDS. The data also shows that there is a significant percentage that does not have knowledge on how to prevent HIV infection as less than half of the group attended any HIV awareness sessions at school. These factors, therefore, translated into high-risk sexual behavior. Although a great

proportion of the respondents said that they would rather use a condom when being intimate to curb infections, evidence from this study's data of high-risk sexual behaviour includes multiple sexual partners, sexual and relationship cohesion, substance abuse, unequal power relationships, deceitful partners and penetrative sex. This behaviour is further perpetuated by factors such as cross-generational 'trauma and pain', single parenthood and low parental monitoring, social construction and prescription, socio-economic circumstances, poverty and deprivation, lack of knowledge on prevention of HIV infection, biological urges, peer pressure, fear of losing a partner, own and social identity, low self-esteem, silence, denial, stigma and blaming. These reasons can however pose barriers to safe sex as it was found that the adolescents are aware of the effectiveness of condoms, but have negative attitudes towards using them.

The majority of the participants are experiencing emotional and psychological harm as they have to deal with feelings of severe unhappiness, worries, lost and hopelessness when having to face the reality of living in the HIV/AIDS era of which they are in total denial. The present study also found that perceptions and beliefs amongst the scholars support the idea that adolescents living in Valhalla Park, are in general, still in denial of their own vulnerability to HIV/AIDS by judging prostitutes, gays, lesbians, foreigners and PLA's, believing that the disease is among others not belonging to 'their' group and must be discriminated against and looked down upon as 'others' by their own and treated as such. Stigmatization of others, personal attitudes and beliefs however, affect these adolescents' access to HIV prevention, testing, disclosure, healthcare and support efforts.

As the outcome of this study's findings is a matter of serious concern, the primary recommendation is that government and non-government organizations must conduct future studies on a significant scale that includes quantitative and qualitative methodologies to explore HIV/AIDS related knowledge, perceptions, beliefs, attitudes and behaviour amongst adolescents in the Western Cape to enable the results to be generalizable and use to inform intervention and prevention programmes that target the adolescent sector of the community. The study's intended recommendation for future life skills curriculums at schools is that it should be tailored to incorporate HIV/AIDS knowledge on transmission and infections as an element of other learning areas and focus on sexual abstinence should be emphasized. The study's findings and

recommendations are meaningful and can be implemented in a variety of service settings attending to vulnerable populations.

In conclusion, this study recognized that the adolescents in townships on the Cape Flats, given their context as a group, are at greater risk of contracting HIV. Given the fact that the AIDS era enforced a renouncement of perceptions, beliefs, attitudes and behavior that embedded Aids-related stigma, silence, denial, fear and blame, persistence of sexual risk behaviour will continue to be a way of life for most adolescents that are trapped within these socio-economic deprived societies. Serious life changes apposing the existing way of life, without the required spiritual, emotional and psychological support, will bring about insecurities, uncertainties and inconsistencies. Adolescent should live and grow-up in a secure environment, free from fear and anxiety, where stability and order prevail. For them, living a sheltered life will certainly translate into low-risk behavior. Hopefully, this study will serve as a reminder, that as "a society and as individuals we face major challenges and opportunities in providing a better future for our adolescents" (Nightingale and Fischhoff, 2001:11).

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Appendix 1: The Questionnaire

Adolescents' Knowledge, Attitudes and Behaviour Regarding HIV/AIDS in Valhalla Park: An Exploratory Study.

Conrad Henry Isaacs
(Ph: 021-9349318)

A Mini-Thesis submitted in partial fulfillment of the requirements for the degree of Masters in Development Studies in the Faculty of Arts, Institute for Social Development, University of the Western Cape

Supervisor: Ms Ina Conradie
(Ph: 021-9593845)

Name of Institution.....

Date ____/_____/_____

Please do not write your name on this questionnaire

STATEMENT OF CONFIDENTIALITY

This research project is in partial fulfillment of the requirements for Masters of Arts: Development Studies at the University of the Western Cape.
Here are some questions that I would like you to answer honestly and truthfully. Some of them deal with personal and sensitive subjects, so I want to remind you that nobody here will see your answers. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent. Also: Your name will not be attached to your responses or used in any way.

Instructions:

1. Please try to answer every question, unless you are asked to skip questions that do not apply to you or your situation.
2. If any part of the questionnaire doesn't make sense to you, please ask the researcher for clarification, but don't show your answers to anyone.
3. Please feel free to write notes about things you feel are important. Use the left margins and blank spaces for this purpose.
4. Please note that you can tick more than one box if options are provided or indicated.
5. After you have answered all the questions, please hand over the questionnaire to the researcher. The findings of this study will hopefully contribute to the fight against HIV/Aids, and we thank you for your role in this regard.
   Note: After a while, you feel that you do not want to proceed with the questionnaire, please discuss it with the researcher, and do not feel forced to continue. If you can complete the questionnaire, however, your answers will help us in a great way to understand the problems surrounding STI's.

THANK YOU FOR YOUR TIME AND COOPERATION

Section I.

i) Sex: Male: ____

Female: ____

ii) Age at last birth day: ____ years

iii) Level of Grade at which you are studying: _____

iv) Number of years in this school: _____

v) What is your religion?

1. Christian: ____
2. Moslem: ____
3. No religion: ____
4. Other (Specify): _____

vi) Do you have children? No: ___ Yes: ____ Number:_____

vii) What type of housing do you live in?

1. Own House (Brick): _____

2. Council House: _____

3. Rented House: _____

4. Informal Shelter (Shack or Wendy House): _____

5. Rented Room: _____

viii) How many people live with you in the house? _____

iv) Who looks after you where you are staying? 1. Both Parents: ____ 2. Mother: ___

2. Father: _____ 4. Other (Specify):_____

Section II. (Please circle either YES or NO)

1. Which of the following statements describe HIV?

1.1 AIDS is caused by HIV — the human immunodeficiency virus. Yes / No

1.2 HIV is transmitted through blood, semen, vaginal fluids, and breast milk. Yes / No

1.3 HIV cannot be spread by having unprotected sexual intercourse with someone infected with the HIV virus. Yes / No

1.4 HIV is not commonly spread by sharing needles or syringes with someone who has the virus. Yes / No

1.5 HIV is commonly spread by getting HIV-infected blood, semen, or vaginal secretions into open wounds. Yes / No

1.6 HIV can not be passed from infected pregnant woman to her unborn baby during pregnancy, birth and breastfeeding Yes / No

1.7 HIV is transmitted by simple casual contact such as kissing,

sharing water glasses, cutlery or hugging. Yes / No

1.8 Eating food prepared by a HIV+ person. Yes/No

2. Which of the following statements describe AIDS?

2.1 AIDS is short for Acquired Immune Deficiency Syndrome. Yes / No

2.2 It is the most advanced stage of HIV infection. Yes / No

3. What are the symptoms of HIV/AIDS?

3.1 Rapid gaining of weight. Yes / No

3.2 Long-lasting diarrhea. Yes / No

3.3 Recurring fevers and/or night sweats. Yes / No

3.4 Recurring or unusual skin rashes. Yes / No

3.5 Development of muscular strength. Yes / No

4. Have you ever needed information on STI's (Sexual Transmitted Infections) for yourself?

1. Yes: ____ 2. No: ____

5. Can you name a few STI's ? 1. Yes: ____ 2. No: ____

6. If Yes, please name them:

_____

_____

7. Which of the following sources provide you with information about HIV/AIDS?

a. Television - Yes / No

b. Parents - Yes / No

c. Magazines - Yes / No

d. Friends - Yes / No

e. Relatives - Yes / No

f. Teachers - Yes / No

g. Doctor - Yes / No

h. Clinic - Yes / No

8. What can a person do to avoid getting the virus that causes AIDS? (Tick appropriate answer/s)

i. Avoid sharing razor blades _____

ii. Avoid blood transfusions _____

iii. Limit sex to one partner _____

iv. Having sex with prostitutes (commercial sex workers) _____

v. Avoid sex with person with many partners _____

vi. Avoid sex with persons of same sex _____

vii. Avoid sex with person who inject drugs _____

viii. Use condoms _____

ix. Avoid injections _____

x. Avoid kissing _____

xi. Avoid mosquito bites _____

xii. Seek protection from traditional healers _____

xiii. Abstain from sex or unprotected sex _____

xiv. Avoid doctors who help HIV positive people _____

Please CIRCLE your response.

9.1. Most people who have the HIV/AIDS virus show signs immediately.

1. True 2. False 3. Unsure

9.2. There is a cure for HIV/AIDS.

1. True 2. False 3. Unsure

9.3. Traditional healers can cure HIV/AIDS.

1. True 2. False 3. Unsure

9.4. Sex with a virgin can cure HIV/AIDS.

1. True 2. False 3. Unsure

9.5. It is possible for a person to get a STI (Sexual Transmitted Infection) from having sexual intercourse once without a condom.

1. True 2. False 3. Unsure

10. Do you know where to get treatment for a STI?

1. Yes 2. No

11. Have you ever attended any HIV awareness sessions at school?

1. Yes 2. No

12. If no, what was the reason for you not attending?

_____

13. I. Do you believe that ART (Anti-retroviral Therapy) delays HIV from developing and progressing in the body? 1. Yes 2. No

13. II. Why? _____

Section III. (Remember that you can tick off MORE than one response)

14. When you are alone with your partner, what would you usually do?

i. Talking and kissing: ____ ii. Talking, kissing and touching one-another: ____

iii. Talking, kissing and being intimate: ____

15. If you ever were to have sex, would you:

i. Do it because you really want to experience it? Yes ____ No ____

ii. Have penetrative sex? Yes ____ No ____

iii. Use a condom? Yes ____ No ____

iv. Do it for money or other gifts in return? Yes ____ No ____

v. Do it because your partner insists on having sex? Yes ____ No ____

vi. Do it with anyone that appeal physical (looks beautiful/attractive) to you? Yes ____ No _____

vii. Do it because your friends/peers are having sex? Yes ____ No _____

viii. Do it for fear of losing your partner? Yes ____ No ____

ix. Do it for fun and enjoyment? Yes ____No _____

x. Do it with more than one partner? Yes ____ No _____

16. When you are intimate with someone, do you use drugs? (Alcohol, ecstasy, Tik, ect.)

1. Always: ____ 2. Sometimes: ____ 3. Once or twice: _____
4. Never: ____ 5. Am not intimate: ____

17. When you are intimate with someone, does your partner use drugs? (Alcohol, ecstasy, Tik, ect.)

1. Always: _____ 2. Sometimes: ____ 3. Once or twice: _____
4. Never: _____ 5. Am not intimate: ____

18. Do you think your partner(s) is/are intimate with others? 1. Yes: ____ 2. No: ____
3. Do not know: _____ 4. Do not have a partner: ____

19. Do you think that you stand a chance of getting HIV that leads to AIDS ?

1. Yes: ___ 2. No: ___
3. Why do you say Yes/No? _____

Section IV. (Remember that you can tick off MORE than one response)

20. If you were to have a sexually transmitted infection, what would you do?

i. Seek advice from a health worker in a clinic or hospital .____
ii. Seek advice or medicine from a traditional healer. ____
iii. Continue to being intimate with others ____
iv. Seek advice or buy medicines in a shop or pharmacy? ____
v. Ask for advice from friends or relatives? ____
vi. Stop being intimate with others ____
vii. Use a condom when being intimate with others ____

21. Are you happy with the counseling service people receive in your community?

1. Yes: _____ 2. No: _____

22. If No, why? _____

23. What do you think are the reasons to get a HIV test?

i. Marriage _____
ii. Family planning _____
iii. Being intimate without a condom _____
iv. Protect partner _____
v. Protect child _____
vi. If I'm feeling sick _____
vii. Know my status _____
viii. Other (Specify): _____

24. What would be reasons not to go for a HIV test?

i. Lose partner ____
ii. Fear of knowing ____
iii. Stigma (Afraid of what others would say or do) ____
iv. Other (Specify): _____

25. Who would you talk to before having a HIV test?

i. Parents ____
ii. Partner ____

iii. Peers/ Friends ____
iv. Nobody ____
v.Teacher ____
vi. Priest ____
vii. Family (grandma, cousin, ect.) ____
viii. Other (specify) _____

26. Who would you tell the results of an HIV test?

i. Parents ____
ii. Partner ____
iii. Peers/ Friends ____
iv. Nobody ____
v.Teacher ____
vi. Priest ____
vii. Family (grandma, cousin, ect.) __ __
ix. Other (specify) _____

27. Why? _____
_____
_____

28. Have you ever been tested for HIV? 1. Yes ____ 2. No_____

Section V.

29. Who do you think is to blame for the spread of HIV/AIDS?
(You can choose more than one)

1. Prostitutes: _____
2. White People: _____
3. Black People: _____
4. Gay Men: _____
5. Foreigners: _____
6. Animals: _____
7. Lesbians: _____
8.Other (Specify): _____

30. Why do you blame them? _____
_____

31. Do you know someone who is HIV positive? 1. Yes: ____ 2. No: _____

32. Do you think it is people's own fault if they have HIV/AIDS?
1. Yes: ____ 2. No: ____

33. Why do you say Yes/No? _____

Section VI. (You can choose more than ONE answer)

34. How do you as an adolescent feel to live in this HIV/AIDS era?

1. Fear: ____ 2. Fearless (Without Fear): ____ 3. Worried: ____
4. Not Worried: ____ 5. Loss: ____ 6. Happy: ____
7. Unhappy: ____

35. Why do you feel so? _____

_____

Is there anything that you are concern about or that you still want to say?

_____
_____

Thank you very much for your cooperation and honesty

Appendix II: Afrikaans Vraelys

VRAELYS

Naam van Instansie: .....

Datum: ____/_____/_____

Moet asseblief nie jou naam op die vraelys aanbring nie.

VERKLARING VAN GEHEIMHOUDING

Hierdie studie-projek is in gedeeltelike voltooiing vir die vereistes van my Meestersgraad studies by die Instituut vir Sosiale Ontwikkeling aan die Universiteit van Weskaap. Hier volg ‘n paar vrae wat ek graag wil hè moet EERLIK beantwoord word.
Aangesien sommige van die vrae van ‘n persoonlike en sensitiewe aard is, sal NIEMAND wie hier teenwoordig is, jou antwoorde sien nie.
Die informasie wat verkry word sal uitsluitlik vir die doeleindes van die studie aangewend word.
BELANGRIK: **Jou naam sal nerêns aangewend of gebruik word nie.**

Instruksies:

1. Beantwoord alle vrae sover as moontlik. Daar is geen REGTE of VERKEERDE antwoord nie.
2. Indien jy onseker is oor enige gedeelte van die vraelys, vra asseblief die fasilliteerder om te verduidelik. Moet nie jou antwoorde aan klasmaats toon nie.
3. Staan vry om notas te maak in die kantlyn of oop spasies, oor dit wat jy beskou is belangrik of wat jou pla.
4. Let wel: By die vrae waar dit verlang word kan meer as een opsie afgemerk word.
5. Na voltooiing van al jou antwoorde, handig asseblief die vraelys by die fasilliteerder in. Die resultate van die studie sal hopelik ‘n groot bydrae lewer in die geveg teen VIGS, en ek wil daarom die waardering uitspreek vir jou aandeel in die verband.

Let wel: Indien jy voel om nie die vraelys te voltooi nie, bespreek dit met die fasilliteerder, maar moet nie verplig voel nie. Indien jy dit wel voltooi, sal jou antwoorde van groot hulp wees om die probleme rondom Seksuele Oordraagbare Infeksies te verstaan.

BAIE DANKIE VIR JOU TYD EN SAMEWERKING

Afdeling I.

i) Geslag: Manlik: ____

Vroulik : ____

ii) Ouderdom by laaste verjaarsdag: ____ jaar oud

iii) Graad waarin jy tans is: ____

iv) Aantal jare by skool: ____

v) Wat is jou geloof?

1. Christen ____
2. Moslem ____
3. Geen geloof ____
4. Ander (Spesifiseer): _____

vi) Het jy kinders? 1. Nee: ___ 2. Ja : ____ 3. Getal:_____

vii) Watter soort huis bewoon jy?

1. Ouers/eie (Steen) _____
2. Munisipale Huis _____
3. Huur Huis _____
4. Informele Opslaan Huis (Pandok of "Wendy" Hout Huis) _____
5. Huur Kamer _____

viii) Hoeveel mense bly saam met jou in die huis/kamer? _____

ix) Wie kyk na jou en by wie woon jy? 1. Albei Ouers :_____ 2. Moeder: _____

3. Vader: _____ 4. Andere (Spesifiseer): _____

Afdeling II. (Trek 'n sirkel om OF JA OF NEE)

1. Watter stelling/s beskryf MI-virus (Menslike Immuniteitsgebrek virus of HIV in Engels).

1.1. VIGS word veroorsaak deur die MI-virus JA/NEE

1.2. Die MI-virus is oordraagbaar deur bloed, saad (spermselle), vaginale vloeistowwe en borsvoeding. JA/NEE

1.3. Deur sonder `n kondoom seksueel met 'n Vigslyer te verkeer kan die MI-virus nie oorgedra word nie. JA/NEE

1.4. Deur naalde en spuitnaalde te gebruik wat deur vigslyers ook gebruik word is nie 'n manier hoe die MI-virus versprei word nie. JA/NEE

1.5. Die MI-virus word oor die algemeen versprei deur besmettte bloed, semen/spermselle, of vaginale afskeidings in oop wonde te laat gaan. JA/NEE

1.6. Die MI-virus kan nie oorgedra word van besmette verwagtende ma tot baba gedurende swangerskap, geboorte en borsvoeding nie. JA/NEE

1.7. Die MI-virus is oordraagbaar deur algemene kontak soos soen, deel van drinkglasse of eetgery, en omhelsing. JA/NEE

1.8. Die MI-virus is oordraagbaar deur kos te eet wat deur 'n vigslyer voorberei was.

JA/NEE

2.Watter van die volgende stellings beskryf VIGS (Verworwe Immuniteitsgebrek Sindroom of AIDS in Engels)?

2.1. VIGS staan vir Verworwe Immuniteitsgebrek Sindroom. JA/NEE

2.2. VIGS is die mees gevorderde stadium van MI infeksie. JA/NEE

3. Wat is die simptone vir VIGS ?

3.1. Vinnige gewig aansit. JA/NEE

3.2. Aanhoudende diarree (Diarrhoea). JA/NEE

3.3. Aanhoudende koorsigheid en/of nagsweet. JA/NEE

3.4. Aanhoudende of abnormale veluitslag. JA/NEE

3.5. Ontwikkeling van spierkrag. JA/NEE

4. Het jy al ooit informasie gehad oor SOI's (Seksuele Oordraagbare Infeksies of STI'S in Engels) vir jouself? 1. JA: ____ 2. NEE: _____

5. Ken jy 'n paar SOI's ? 1. JA: ____ 2. NEE: _____

6. Indien JA, dui voorbeelde aan: _____

_____

7. Watter van die volgende bronne verkry jy jou informasie oor VIGS?

a. Televisie - JA/NEE

b. Ouers - JA/NEE

c. Tydskrifte/Nuusblaaie - JA/NEE

d. Vriende - JA/NEE

e. Familie - JA/NEE

f. Onderwysers - JA/NEE

g. Geneesheer - JA/NEE

h. Kliniek / Daghospitaal - JA/NEE

8. Wat kan jy doen om te voorkom dat jy die MIV-virus (HIV) kry? (Tik af die korrekte antwoord/e)

i. Voorkom die deling en gebruik van skeermeslemmetjies _____

ii. Voorkom bloedoortappings _____

iii. Beperk seksuele omgang tot een persoon _____

iv. Om seksueel te verkeer met prostitute (Sekswerker) _____

v. Voorkom seksuele omgang met `n persoon wie baie bedmaats het _____

vi. Voorkom seksuele omgang met iemand van dieselfde geslag _____

vii. Voorkom seksuele omgang met iemand wat dwelms gebruik _____

viii. Gebruik kondome _____

ix. Verhoed inspuitings _____

x. Verhoed soenery _____

xi. Verhoed muskietbyte _____

xii. Verkry beskerming van tradisionele genesers (traditional healers) _____

xiii. Onthou van of voorkom onbeskermde seksuele omgang _____

xiv. Vermy dokters wie met VIGS pasiente werk _____

Trek ‘n sirkel om jou antwoord.

9.1. Meeste VIGS-lyers toon tekens van die siekte onmiddelik.

1. Waar 2. Onwaar 3. Onseker

9.2. Daar is gelukkig genesing vir VIGS.

1. Waar 2. Onwaar 3. Onseker

9.3. Tradisionele genesers (Traditional healers) kan VIGS genees.

1. Waar 2. Onwaar 3. Onseker

9.4. Seks met ‘n maagd (virgin) kan VIGS genees.

1. Waar 2. Onwaar 3. Onseker

9.5. Dit is moontlik vir ‘n persoon om ‘n SOI (Seksuele Oordraagbare Infeksies) te kry deur net eenkeer seksueel sonder ‘n kondoom te verkeer.

1. Waar 2. Onwaar 3. Onseker

10. Weet jy waar om mediese behandeling vir SOI te verkry? 1. JA 2. NEE

11. Het jy al enige VIGS bewusmaking sessie bygewoon? 1. JA 2. NEE

12.Indien NEE, waarom nie? _____

13. I. Glo jy dat ARB (Anti-retrovirale behandeling) vertraag die ontwikkeling en groei van VIGS in jou liggaam?

1. JA 2. NEE 3. Onseker

13. II. Waarom sê jy JA/NEE? _____

Afdeling III. (Onthou dat jy MEER as een keuse kan afmerk)

14. Wat doen jy gewoontlik wanneer jy en jou maat (boy/girlfriend) alleen is?

i. Gesels en soen: ____ ii. Gesels, soen en raak/streel mekaar: ____

iii. Gesels, soen en verkeer intiem: ____

15. Indien jy ooit seksueel sou verkeer, sal jy:

i. Dit doen vir die ondervinding? 1. JA:____ 2. NEE: ____

ii. Penetreerde (penetrative) seks het? 1. JA:____ 2. NEE: ____

iii. ‘n Kondoom gebruik? 1. JA:____ 2. NEE: ____

iv. Dit doen vir geld of geskenke? 1. JA:____ 2. NEE: ____

v. Dit doen omdat jou vriend (boy/girlfriend) daarop aandring? 1. JA: ____ 2. NEE:____

vi. Dit doen met iemand wat uiterlik mooi vir jou voorkom? 1. JA: ____ 2. NEE: ____

vii. Dit doen omdat jou vriende ook seksueel verkeer? 1. JA:_____ 2. NEE: ____

viii. Dit doen omdat jy vrees dat jy jou vriend (boy/girlfriend) gaan verloor?

1. JA: ____ 2. NEE: ____

ix. Dit doen vir die lekkerte en plesier? 1. JA: ____ 2. NEE: ____

x. Dit doen met meer as een persoon? 1. JA: ____ 2. NEE: ____

16. Wanneer jy intiem met iemand verkeer, gebruik jy dwelmiddels? (Wyn, Ekstase tablette (ecstacy), Tik, ens.)

1. Altyd: ____ 2. Somtyds: ____ 3. Een-of tweekeer: _____
4. Nooit: ____ 5. Verkeer nie intiem: ____

17. Wanneer jy intiem met iemand verkeer, gebruik jou vriend dwelmiddels? (Wyn, Ekstase tablette (ecstacy), Tik, ens.)

1. Altyd: ____ 2. Somtyds: ____ 3. Een-of tweekeer: _____
4. Nooit: ____ 5. Verkeer nie intiem: ____

18. Dink jy dat jou vriend/in met andere intiem verkeer?
1. JA: ____ 2. NEE: _____ 3. Onseker: _____ 4. Het nie 'n vriend/in: ____

19. Dink jy dat jy ooit die Vigs-virus sal kry? 1. JA: ___ 2. NEE: ___
3. Waarom sê jy JA/NEE? _____

Afdeling IV. (Onthou dat jy MEER as een keuse kan afmerk)

20. Indien jy 'n SOI (seksueel oordraagbare infeksie) sou opdoen, wat sal jy doen?

i. Advies van 'n geneeskundige by 'n kliniek of hospital kry ____
ii. Advies en medisyne by 'n tradisionele geneser te kry. ____
iii. Voort te gaan om intiem met ander te verkeer ____
iv. Soek advies of koop medisyne in 'n winkel of apteek? ____
v. Soek advies by 'n vriend of familie? ____
vi. Nie meer intiem te verkeer nie ____
vii. Om 'n kondoom te gebruik tydens intieme verkeer met andere ____

21. Is jy gelukkig met die Vigs voorligtingsdiens in die gemeenskap? 1. JA:___2. NEE: ____

22. Indien NEE, waarom nie? _____ _____

23. Waarom dink jy is dit nodig vir 'n VIGS-toets?

i. Wanneer jy wil trou _____
ii. Familie beplanning _____
iii. Intiem sonder 'n kondoom verkeer het _____
iv. Vriend/in te beskerm _____
v. Jou kind/ers te beskerm _____
vi. Wanneer jy siek begin voel _____
vii. Om my status te weet _____
viii. Ander Rede: _____

24. Waarom dink jy is dit NIE nodig vir 'n VIGS-toets nie?

i. Vrees dat jy jou vriend sal verloor _____
ii. Vrees vir die waarheid _____
iii. Stigma (Vrees wat ander sal dink of sê) _____
iv. Ander Rede: _____

25. Met wie sal jy praat en in jou vertroue neem voor `n VIGS-toets?

i. Ouer/s _____
ii. Vriend/in (Partner) _____
iii. Vriende _____
iv. Niemand _____
v. Onderwyser _____
vi. Pastoor/Priester _____
vii. Familielid (Ouma,niggie, ens.) _____
viii. Ander Persoon/sone (Spesifiseer): _____

26. Aan wie sal jy die uitslag van jou VIGS-toets vertel?

i. Ouer/s _____
ii. Vriend/in (Partner) _____
iii. Vriende _____
iv. Niemand _____
v. Onderwyser _____
vi. Pastoor/Priester _____
vii. Familielid (Ouma,niggie, ens.) _____
viii. Ander Persoon/sone (Spesifiseer): _____

27. Waarom aan diè persoon?

_____

28. Het jy al 'n VIGS-toets laat doen? 1. JA: ____ 2. NEE: _____

Afdeling V.

29. Wie dink jy is skuldig vir die verspreiding van die Vigs-virus?
(Jy kan MEER as een antwoord kies)

1. Prostitute (Sekswerkers) ____
2. Wit Mense ____
3. Swart Mense ___
4. Homoseksuele Mans ___
5. Buitelanders(Foreigners) ____
6. Diere ___
7. Lesbiese Vrouens ____
8. Andere (Spesifiseer): _____

30. Waarom is dit hul (le) skuld? _____

31. Weet jy van iemand wat die VIGS-virus het? 1. JA: ____ 2. NEE: ____

32. Dink jy dit is iemand se eie skuld indien die persoon VIGS onder lede het?
1. JA: ___ 2. NEE: ____

33. Waarom sê jy JA/NEE? _____
_____

Afdeling VI. (Onthou dat jy MEER as een keuse kan afmerk)

34. Hoe voel jy as `n jeugdige om in hierdie VIGS era te lewe?

1. Vrees(Beangs): ____ 2. Geen Vrees: ____ 3. Bekommerd: ____
4. Geen Bekommernis: ____ 5. Verlore: ____ 6. Gelukkig: ____
7. Ongelukkig: ____

35. Waarom voel jy so? _____

_____

Baie dankie vir jou Eerlikheid en Samewerking

Is daar iets wat jou pla of wat jy graag wil sê:

Appendix III

Student Information and Consent Letter

Dear Student

About The Study:
This research project is in partial fulfillment of the requirements for Masters of Arts: Development Studies at the University of the Western Cape. This project aims to gain a deeper insight into the issues surrounding STI's, and the results could assist in developing better strategies in combating the dreaded HIV/AIDS epidemic and also in empowering the youth.

What Will Happen?
With all the above in mind, I request your consent to participate in this study by:
The answering of a questionnaire as accurately and honestly as possible.

Will Anyone Know That I Participated In The Study?
No. Your name will not appear on the questionnaire. Your participation and answers on the questionnaire are strictly confidential and anonymous. No one other than the researcher and his supervisor at the university will see the answers that you give on the questionnaire. The findings of the research will be compiled into a report with all the students' data combined; therefore your information will not be identifiable.

Are There Any Risks?
No. There are no risks to you for taking part in the study. No information will be given about any individual student's involvement. The results of the study will form a part of a M.A. mini-thesis. The mini-thesis along with the research findings will be submitted for examination.

Do I Have To Participate In The Study?
No. Taking part in this study is completely voluntary. You may stop participating in the questionnaire or choose not to answer some questions on the questionnaire.

Who Can I Ask If I Have Questions About The Study?
If you have any questions at a later time you can call: Conrad Isaacs – Ph: 021-9593858
University of the Western Cape
Private Bag X 17 Bellville, 7535
If you have any complaints or worries about the research, please contact: Ms Ina Conradie
Ph 021- 9593845
University of the Western Cape
Private Bag X 17 Bellville, 7535

By signing this document, you agree to participate in this study. Your participation is highly appreciated.

Student's signature

Appendix IV: Research's Application Letter

Ph: 021 9349318 (H)
021 9593858 (ISD)

15 Wessel Circle
Montana

Mobile: 0840624045 7490

4 December 2007

The Principal
Beauvallon Secondary School
Agness Crescent
Valhalla Park
7490

Dear Sir

Re: Proposed research project: School-based. Course: Masters of Arts Department: Institute for Social Development. University of the Western Cape
Title: Adolescents' knowledge, attitudes and behaviour regarding HIV/AIDS in Valhalla Park: An exploratory study.

Firstly, I would like to express my sincere gratitude for approving the conducting of above study at your school in principle.

.

To realize the objectives of this investigation, a series of mixed methodology will be applied. This implies that:

i) One group consisting of 10 boys and 10 girls is required. The pupils should be 15 and 18 years of age and ideally be in grades 10 to 12.
ii) Participation by the learners should be ideally on a voluntary basis with parental and teachers' permission.
iii) One session of 60 minutes will be required to obtain maximum research insights.
iv) The participants are expected to complete a questionnaire (Please refer to inclusive proposal).

If it is to your convenience, I would like to conduct this session between 15 and 28 February 2008. If however, this arrangement is unsuitable for the school, please be so kind as to advise me thereof. I will also convene an appointment with you before this time.

Attached, for your perusal, be so kind as to find the prescribed proposal for this mini-dissertation.

Thanking you and kind regards.

Yours in education.

Conrad H. Isaacs