THE IMPACT OF CULTURE ON THE PREVENTION AND TREATMENT OF HIV/AIDS AMONGST PEOPLE IN LOW-RESOURCED AREAS: A SOCIAL WORK PERSPECTIVE

BY

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THIS DISSERTATION WAS SUBMITTED IN FULFILMENT OF THE REQUIREMENT FOR THE MA (SOCIAL WORK) DEGREE COURSE IN THE FACULTY OF HUMANITIES (SCHOOL OF SOCIAL SCIENCES) AT THE UNIVERSITY OF THE NORTH

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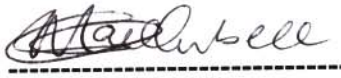
DECLARATION

I Jabulani Calvin Makhubele hereby declare that this document is my own work and that all the sources I have used and quoted have been acknowledged by means of complete references.



JABULANI CALVIN MAKHUBELE

DATE

DEDICATION

This dissertation is dedicated to my late father - Tshameleni Daniel Makhubele, my late brother - Magezi Phineas Makhubele, my beloved mother – Mphephu N'wa-Mikhayisi Makhubele and my wife – Charlotte Makhubele

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ABSTRACT

The aim of this study was to explore the impact of culture on the prevention and treatment of HIV/AIDS amongst people in low-resourced areas like Malamulele. The study focused on the lifestyles, beliefs, attitudes and perceptions around cultural elements and practices, which might impact negatively on the prevention and treatment of the HIV/AIDS epidemic. There were three groups of research respondents namely: learners from three high schools in Malamulele, some parents of the learners and the traditional/cultural leaders. The researcher collected both qualitative and quantitative data. The data was gathered through the use of an interview schedule (questionnaire), focus group discussions and round-table discussion sessions. The data was presented, analysed and interpreted by means of tables and charts.

It was found that people in low-resourced (rural) areas have little knowledge about HIV/AIDS, causes, symptoms and how the disease is transmitted. Despite the fact that awareness and educational campaigns and programmes are being rendered, people in low-resourced (rural) areas have little knowledge and needed skills about prevention and treatment of the pandemic. Polygamy and extra-marital relations by men is still highly valued and viewed at high esteem. Religious structures seem to be detached to the issue of HIV/AIDS as they mentioned that talking about HIV/AIDS is immoral and against their principles. The study also tried to explore the extent to which people in low-resourced areas view and use condoms as a protective means.

CHAPTER ONE

GENERAL ORIENTATION OF THE STUDY

1.1 INTRODUCTION

It is currently two decades since the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) have been discovered. Morison (2001:7) states that around the world 36.1 million people are living with HIV/AIDS. By the year 2002, HIV reportedly, had infected over 69 million people worldwide of which 29 million people were already dead from AIDS (World Bank: on line). The Sub-Saharan region has been devastated by this HIV/AIDS epidemic. Since South Africa is part of the Sub-Saharan Africa, it is not excluded from being ruined by this epidemic and as such HIV/AIDS is described as South Africa's most killing disease (Beeld, 11 August 1999 quoted by Strydom 2000:195 and United Nations 1998:167). South Africa's situation compared to other countries world-wide does not show an inclination towards positive change or reduction of the epidemic. There are currently between 159 000 and 163 000 people estimated to be living with HIV/AIDS in the country (MRC: on line). Researchers blame the lack of change on the apparent reluctance of the government to freely provide the most life-saving drugs, which are anti-retroviral drugs (Nevirapine) to the most needy people.

The HIV/AIDS pandemic is often explained as being due to the failure of the medical community to provide an answer to the disease. The failure has placed an unprecedented emphasis on the social sciences to address what is currently the most studied disease in history. No single profession on its own can successfully deal with the HIV/AIDS pandemic. There is need for a multi-disciplinary approach which would involve bio-medical and psychosocial scientists/professionals working together towards prevention, research and treatment of HIV/AIDS. Each profession should cooperate and collaborate with others, instead of working in isolation.

Professions should complement one another and not compete and/or push each other aside. Social scientists have to strive for the prevention of the HIV/AIDS alongside and in complementarity of medical scientists. While the biological scientists and the medical professionals use the bio-medical model in the primary prevention and treatment of HIV/AIDS, social scientists using the bio-psychosocial model which focuses on understanding and modifying behaviour must complement them. The complementarity of bio-medical and bio-psychosocial scientists is essential as human beings are bio-psychosocial beings who are affected by their immediate environment as well as their past and present experiences and also their future aspirations. The current study is based on the biopsychosocial model only. The important role of social scientists in the primary prevention of HIV/AIDS has been confirmed by numerous researchers such as Webb (1997:xi); Bonell and Imrie (2001:155) and Huszti, Parsons, Cotton, Mendoza, Harlow, Rich, Parish, Nuss, and Riske (1998:508).

The biopsychosocial approach alludes to social and cultural factors with regard to behaviour change and the transmission of the virus. Researchers have observed that the HIV pandemic does not discriminate against people on the basis of gender, sexual orientation, socio-economic status, ethnicity or skin pigmentation (Bandura 1997:25; Boulton 1994:1; Rushing 1995;xi; DiClemente and Wingood in Umeh 1997:62,and Bharat 2000:43). Different ethnic groups and cultures recognise different illnesses, symptoms, and causes. People have different perceptions towards different diseases. The lifestyles of people are determined by the norms of the community that is, the culture of people (Kottak 1997:414 and Keesing and Strathern 1998:47). Culture therefore, determines and/or influences the prevention and treatment of the HIV/AIDS epidemic. The role of the social work profession is to explore the cultural elements, which work against the prevention and treatment of the HIV/AIDS pandemic and subsequently to suggest intervention strategies. Thomas (1997:558) comments that it is essential that people's perceptions on various issues that are related to HIV/AIDS be assessed before preventative and treatment strategies, which are culturally sensitive among ethnic minorities may be introduced. In order that innovative means towards the HIV/AIDS pandemic might be developed, the culture of a target group should be explored in detail so that cultural barriers which may hinder a positive response to a primary prevention programme may be understood.

According to Sheafor, Horesji and Horesji (1997:60) the fundamental purpose of the social work practitioner is to help clients to change dysfunctional behaviour and to learn effective patterns of social interaction. In this regard, the role of the social worker as a teacher would be to focus on the primary prevention of HIV/AIDS. Barker (1999:376) defines primary prevention as: actions taken to keep conditions known to result in disease or social problems from occurring. The current study was geared towards an exploration of the impact of culture on the prevention and treatment of HIV/AIDS amongst people in low-resourced areas. The researcher particularly targeted the Malamulele District in the Limpopo Province. The purpose of this study was to provide knowledge and needed skills to people around Malamulele so as to prevent problems or to enhance the social functioning of the participating clientele.

In this chapter, a general orientation to the study has been presented. The researcher has alluded to his motivation for undertaking the study, the statement of the study as well as the aim and objectives of the study. He has provided assumptions and research questions which guided and directed him in the study. The researcher has further outlined the research design, research methodology as well as profile of the area of the study. Towards the end of this chapter, the researcher discussed the significance of the study, limitations of the study as well as the definition of the concepts.

1.2 MOTIVATION FOR UNDERTAKING THE STUDY

In the RSA, as well as in the other countries in Africa many people fall prey to HIV/AIDS patients who harbour myths about ways in which the disease can be cured. Among others, the prevailing myth that HIV/AIDS can be cured when patients indulge in sexual intercourse with virgins (Uwakwe in Umeh 1997:41) has resulted in the spate of babies, infants, and young girls being raped as is regularly reported in the mass media. Another myth that prevails is the belief that when young men indulge in sex with elderly women, then no friction occurs and there is no danger of being infected with HIV/AIDS (Phahlamohlaka 2000:34). The latter myth has resulted in the prevalence of rape of elderly women by young men. These myths cannot be eradicated merely with the punishment of perpetrators. There is a need for the exposure of the majority of people to primary prevention programmes which will help

them not only to gain insight about the disease, but also to be cautious of the need for behaviour modification, as well as being aware of practices that may be dangerous. The researcher in this study has been motivated by the negative effects of the prevailing myths in the rural areas as well as the denial that prevails with regard to the existence of HIV/AIDS. In the grossly under-resourced (rural) areas in the RSA, many people explain the symptoms of HIV/AIDS and death that results subsequently to witchcraft. As a social worker, the researcher in the current study is sure that he can make a contribution in the primary prevention of HIV/AIDS, particularly in the Malamulele District in the Limpopo Province, by using the Design and Development (D & D) model which is currently being referred to as the intervention research model (Rothman and Thomas 1994:28 and De Vos 1998:384). The rationale for this study was to fill the gap between social work practice and research. Intervention research serves as the elusive bridge between practice and research and is conducted with the purpose of getting an insight, developing and establishing the feasibility, efficacy and effectiveness of interventions that can be generated across other settings and population groups (Schilling 1997:173).

There is a general belief amongst young people, that HIV/AIDS is just a government ploy aimed at misleading them. Youth are in denial, as they believe that HIV/AIDS is prevalent only among certain groups and that it is not common among Black Africans (Reddy, Enews at 07h00, 2001, December, 03 and City Press, 25 November, 2001:18). Thomas and Quinn (as cited by Klonoff and Landrine 1997:56) assert that black people reject health information in favour of the view that HIV/AIDS is a man-made virus that is employed in a genocidal conspiracy.

The researcher in this study has been further influenced by his awareness of the fact that some religious leaders are less concerned about HIV/AIDS, as they tend to be judgemental about it. These religious leaders maintain that provision of information on sexual issues to congregants is against their culture and their religion. They further assert that in no way can they talk about sexual matters openly in their churches. Such leaders even prohibit their congregants from consulting either medical practitioners or inyangas (traditional healers) when they are ill. They prefer that the congregants should pray to God and be prayed for to cure their illnesses (Patta, Enews, 2002, January, 23).

1.3 STATEMENT OF THE PROBLEM

Records on HIV/AIDS reveal that the incidence of the disease is higher in the Republic of South Africa (RSA) as compared to other countries in the world (Morison 2001:13). The Medical Research Council in its report for the year (2002) indicated that 1500 people in the RSA, get infected with HIV/AIDS on a daily basis. This dreadful disease reportedly claims many lives daily. There are many hazards, which hinder the decrease or even the extermination of this disease in the RSA. Amongst others are poverty, cultural practices and even political haggling over the distribution of the anti-retroviral drugs (nevirapine) to the potential victims of HIV/AIDS. It is however, unfortunate that when the debate on nevirapine ends, it is mostly the urban dwellers who will benefit since rural health centres are to a large extent inadequate and not easily accessible to the majority of the poor who live in the developing provinces such as the Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo.

One major factor which is prominent in the spread of HIV/AIDS, is the use and abuse of alcohol and drugs as these lead to risk-taking behaviour which occurs because of impaired judgement (Strunin and Hingson in Sherr 1993:126). Some of the risks taken by people under the influence of alcohol and/or drugs entail the practice of needle sharing and unsafe sexual behaviour, which makes them vulnerable to infection. Youth, particularly adolescents are most prone to infection as they are inclined to experiment with and to take risks with alcohol, drugs and sexual intercourse. Strunin and Hingson in Sherr (1993:126) assert that the rate of unprotected sexual behaviour is high among the adolescents.

The social dimensions of HIV/AIDS are far too serious and complicated. Each situation, which requires prevention and/or treatment, is unique. This implies that both prevention and treatment strategies require an understanding of the cultural context in which both strategies have to take place. A review of both strategies at the micro-level (individuals, families, and communities) and also at the macro-level (poverty, urbanisation, and gender relations) reveals that programs on prevention and treatment must not overlook beliefs, attitudes and culture of the victims as well as potential victims of the pandemic (Bharat 2000:45).

Cyr-Delpe in Reid (1995:67) points out that culture is at the core of the struggle against HIV around the world and the hope for the future is anchored on the changing attitudes and sexual behaviour which is inclusive of personal, religious, and social beliefs. Other researchers too, have observed that there is a tendency amongst black people, to underestimate the personal risk to HIV infection (Kalichman as quoted by Klonoff and Landrine 1997:51). It is therefore essential that a multi-disciplinary approach which amongst other disciplines, includes social work, should be used in the prevention and treatment of HIV/AIDS. Social work is described by Sheafor, Horesji and Horesji (1997:4) as the "professional activity of helping individuals, families, groups, or communities to enhance or restore their capacity for social functioning and for creating societal conditions favourable to this goal". The role of the social worker in the prevention and treatment of HIV/AIDS is that of educator – to teach and provide patients and prospective victims with information necessary for their social functioning. Social work intervention does not only confine itself to the patients (victims), but it focuses on a broad spectrum which also involves significant others (family, friends, contacts and the entire community) in the therapy process. In this study, the impact of culture on the prevention and treatment of HIV/AIDS amongst people in low-resourced areas: a social work perspective, the lifestyles of people in the Malamulele District will be assessed with the ultimate goal of using social work intervention to help to minimise the problem. The following observations with regard to condom use have been made:

- Condom use and non-condom use among married couples

Women are forced to rely on their partners' willingness to use a condom. The final decision during sexual intercourse, for the use of a condom, rests with the male partner (Fontanet, Soba, Chandelying, Sakondhavat, Bhilaleus, Rujpao, Chongsomchai, Kiriwat, Tovanabutra, Dally, Lange and Rojanapithayakorn 1998:1852 and Hankins in Sherr 1993:31).

- Condom use and non-condom use among adolescents

Strunin and Hingson in Sherr (1993:130) found that adolescents believe that condoms reduce sexual pleasure. Young people have negative attitudes towards condoms and

as such they are unlikely to use them. Studies conducted by Peersman and Levy (1998:191); Buzi, Weinman and Smith (1998:314) and Piery, Foutes and Bordean as cited by Phahlamohlaka (2000: 21 – 22) indicate that young people are reluctant to use condoms during sexual intercourse. As long as the youth uphold this myth about condoms minimizing sexual pleasure, the incidence of HIV/AIDS cannot be reduced.

1.4 AIM AND OBJECTIVES OF THE STUDY

1.4.1 Aim

The current research is a baseline study that will provide information on the lifestyle, beliefs, and attitudes of the people in Malamulele with regard to HIV/AIDS. The study will also provide the respondents with information in order to help them change their negative lifestyle, beliefs, and attitudes towards the pandemic. The main aim of this study is to explore and assess the cultural elements, which deter HIV/AIDS prevention and treatment methods. The researcher has explored ways of removing prevailing myths around HIV/AIDS. The researcher has also made an attempt to empower people with skills towards conscientising them and encouraging them to adopt a lifestyle that will alleviate the epidemic.

1.4.2 Objectives

- To assess the perceptions and interpretations of people on HIV/AIDS within a specific cultural environment (Malamulele Central Circuit)

- To explore the beliefs of young people, parents and cultural [traditional] leaders in Malamulele on the causes of HIV/AIDS

- To explore the knowledge around the means of HIV/AIDS prevention (Malamulele Central District)

- To investigate the level of knowledge related to the transmission of HIV/AIDS

- To add to the knowledge base of the caring professions such as Social work, Nursing, and Clinical Psychology on the impact of culture on the prevention and treatment of HIV/AIDS

1.5 ASSUMPTIONS

As this is an exploratory study, only assumptions may be provided to guide the study. According to (Fouché and De Vos in De Vos 1998:57) an exploratory study generates hypotheses. Such hypotheses can be used as a point of departure for future research studies. For the purpose of this study, the following assumptions were made: that

- Unequal power relations between men and women with regard to sexual matters, have an impact on the increasing rate of the HIV/AIDS epidemic.
- Unemployment and poverty have a significant impact on the HIV/AIDS pandemic.
- Condom use amongst young people is low.
- Some practices used at initiation schools contribute to the spread of HIV/AIDS
- Traditional norms and conventions are still prevalent in Malamulele

1.5.1 Research questions

The researcher was curious about the cultural issues which may hinder the success of a primary prevention programme when delivered to the people of Malamulele. He designed an instrument (interview schedule) which hopefully, would unravel issues around negative responses to a primary prevention programme. Amongst others, the following questions were posed to the respondents.

- Can religious leaders play a role in changing the attitudes of people towards people living with HIV/AIDS?
- How can condom use be popularised among the young unmarried lovers?
- What renders HIV/AIDS awareness campaigns ineffective, and fruitless?
- How can parents be involved in the education of their children on HIV/AIDS?
- What makes the young people to be sexually active and not to take caution about safer sex?

- How does poverty contribute to the increase of HIV infection?
- What role can traditional women play in the prevention of the HIV/AIDS infection?
- How can conservative traditional men be helped to change their views on polygamy?
- How can the high rate of pregnancy and STD`s be reduced amongst adolescents in Malamulele?
- To what extent does substance abuse render AIDS intervention strategies ineffective?

1.6 RESEARCH METHODOLOGY

Rothman and Thomas`, Design and Development (D & D) model which is commonly known as intervention research has been used in this study. This model entails six phases which facilitate involvement of the subjects actively in the research, hence they learn or gain a broader insight on their problem and also contribute ideas towards minimising or solving the problem. The six phases of the intervention model as adopted from De Vos in De Vos (1998:385) entail the following:

- Problem analysis and project planning
- Information gathering and synthesis
- Design
- Early development and pilot testing
- Evaluation and advanced development; and
- Dissemination

Most researchers often avoid conducting studies in rural areas because of lack of infrastructure and the tedious protocol required by school head-masters (principals) and traditional leaders before permission is granted for a study to be conducted. Foreigners are viewed with suspicion and are seldom granted permission to conduct research. To overcome this problem, the researcher who is a resident of Malamulele followed protocol by first conducting preliminary discussions with school head-masters, traditional leaders and some parents. Other influential persons in the

community such as the chairpersons of the civic organizations, the youth and church leaders were also approached.

1.6.1 RESEARCH DESIGN

Research design refers to a plan that describes how, when and where data are to be collected and analysed (Parahoo 1997:42). In this study the researcher has used an exploratory research design. According to Fouché and De Vos in De Vos (1998:124) the purpose of an exploratory research design is to explore a relatively unknown research area with the aim of gaining new insights into the phenomenon. It is also to determine priorities for future research and to develop new hypotheses about an existing phenomenon. In this study, the researcher sought to be informed on how culture determines preventative and treatment methods. The Malamulele area was specifically chosen for this study since no research or study of this nature has ever been conducted there before.

1.6.1.1 Population

Zikmund (1994:444) describes the concept population as used in research, to refer to any complete group of entities that share some common set of characteristics. In support of this view, Wilson and Hutchinson (1996:240) describe a population as the total possible membership of the group to be studied. In this study, three types of populations have been used. These entailed the following:

- A population comprising of all grade 9 and 10 learners who attended at the three local high schools in the Malamulele Central Circuit. The learners were both males and females whose age ranged between 16 and 21 years. The selected learners were interviewed at their respective schools.
- All parents of respondents comprised the second type of population. These were interviewed at their homes. An interview schedule was used for gathering required information. This was subsequently followed by focus group discussions.
- All traditional leaders in Malamulele comprised the third type of population. Interviews were held at the chief's head kraal, and the interview schedule that was administered to the parents, was also administered to this group.

1.6.1.2 Sampling

A sample refers to a group of units selected from a larger population in some way so as to ensure that it is representative of the characteristics being investigated (Black 1998:43). In addition to that, Wilson and Hutchinson (1996:241) state that a sample refers to those elements of a population from whom data is collected and generalizations are made. In this study the researcher has used a non-probability sample design which refers to selecting respondents according to their being easily available and accessible. Non-probability sampling is also referred to as the convenience sample, as it uses available respondents. The research sample was heterogeneous in nature as it included learners of both sexes, whose ages ranged from early to late adolescence. The samples of parents and traditional leaders were neither age nor gender specific. With regard to the size of the sample from each population the researcher had initially set out to choose 100 learners from each school which would then result in a total of 300 respondents (learners only), 30 parents and 15 traditional (cultural) leaders to represent their respective populations.

1.6.2 METHODS OF DATA COLLECTION

Both qualitative and quantitative data has been collected from this study. The qualitative research method employs procedures, which are not strictly formalized. It also adopts a philosophical mode of operation. The quantitative research method employs procedures, which are highly formalized, and are explicitly controlled (De Vos, Schurink and Strydom in De Vos 1998:15). Leedy as quoted by De Vos, Schurink and Strydom in De Vos (1998:15) identified the qualitative research methodologies as dealing with data that are principally verbal while the quantitative research methodologies deal with data that are principally numerical. In support of this, Denzin and Lincoln (1998:8) state that the qualitative method emphasizes processes and meanings that are not rigorously examined or measured in terms of quantity, amount, intensity and frequency.

1.6.2.1 The quantitative data collection method

In this research, a structured interview schedule (questionnaire) has been used for collecting data. According to Hutchinson and Wilson as quoted by Notter and Hott (1994:104) a structured interview is similar to the questionnaire in that each interview follows a set pattern of questioning, with a wording and sequencing of questions being the same for all respondents. Both open-ended and close-ended questions were posed to the respondents. The data collected is both qualitative and quantitative in nature. Quantitative data was obtained mostly from close-ended questions and the demographic factors of the respondents.

1.6.2.2 The qualitative data collection method

To obtain qualitative data in this study, procedures, which were used entailed brainstorming, focus group and round-table discussion sessions, as well as asking open-ended questions in the structured interview. The researcher held brainstorming sessions with young learners and also with the traditional leaders, around issues of culture on HIV/AIDS. Round table discussions too were conducted and these entailed informal discussions with young learners whose ages ranged between 16-21 years. The purpose of such discussions was to explore respondents` perceptions around issues of sexuality, gender inequality, commercial sex work, homosexuality and HIV/AIDS.

1.6.3 METHODS OF DATA ANALYSIS AND INTERPRETATION

Data analysis refers to the description of procedures, which were used to analyse data which had been collected for the study. It involves the breaking down of data into constituent parts in order to find answers to the research questions. The raw data has been analysed, interpreted and presented in the form of tables and charts. This means that the data has been explained accordingly. The main purpose has been to reduce data to a clear and understandable form so that its relation to assumptions might be studied and that hypotheses may be generated for future studies once conclusions have been drawn (Fouché and De Vos in De Vos 1998:100 & 203). Data that was collected in the current study has been analysed both qualitatively and quantitatively.

The research findings have been presented in the form of tables, pie charts, bar graphs, line graphs and histograms and finally these were interpreted and recommendations have been made.

1.7 PROFILE OF THE AREA OF STUDY

1.7.1 Environmental/Geographical boundaries

This study was conducted at Malamulele among the following communities: Mapapila, Matsakali, and Gidja-Mhandzeni. These are rural communities. Malamulele is in the Vembe region which is serviced by the Thulamela Municipality within the Limpopo Province. The language spoken by the people in the area is Xitsonga/Shangaan though some people are proficient in other languages too. Other languages which are spoken in this area, are TshiVenda, Sepedi, Isindebele, IsiZulu, Afrikaans and English. With regard to religion, the most popular and freely practised types are, Christianity, ancestral worship and a combination of both.

1.7.2 Traditional practices which have an impact on HIV/AIDS

Traditional practices which have an impact on the lifestyle and treatment of HIV/AIDS in Malamulele are the following:

- **Male circumcision/initiation**

The traditional way of circumcision which is practised in Malamulele entails admission of initiates at institutions which are set up occasionally for this purpose. Such institutions are commonly known as initiation schools. Initiation schools are conducted in winter, once over a period of 5 years. Traditional leaders permit traditional surgeons to conduct initiation ceremonies in the various villages. There is however, no control of the age group of people who may participate hence, sometimes, even young children who have not reached puberty (for instance, even those who are only 8 years old) are admitted in the initiation schools, as long as their parents are willing to pay the fee. Community members have high regard for the traditional way of initiation and they tend to ridicule those who have not been to the initiation schools. The tradition of

conducting initiation schools only once every five years often results in desperation in some families who then send in children who are still too young. Some children themselves elope from their homes under the influence of friends and peers and enrol themselves for initiation without parental consent. The procedure of circumcision exposes the initiates to infection of various diseases such as HIV. Some casualties die at the schools while others hold life time scars. External intervention even from health authorities is not allowed in these schools which are still held in high esteem by the villagers. The sole purpose of these schools is to train boys into men. Young boys automatically become men after circumcision and they may also indulge in manly pleasures such as alcohol and sex.

- **Female circumcision/initiation**

In Malamulele, females too, undergo initiation. Female initiation schools are conducted annually and sometimes more schools are conducted within a year during school vacations such as Easter, winter, spring and summer. The duration of female initiation schools is shorter than that of male initiation schools. These last over a period of one week. The criterion used for selecting female initiates is puberty. Only girls who have started to menstruate regardless of their age are admitted. In Malamulele, the female initiates are not subjected to any form of physical harm, hence there are no known death nor healing period. Just as male initiation schools, female initiation schools too are, for training girls into women and to prepare them for child birth and marriage. Unwittingly, female initiation results in loss of childhood and subsequently early indulgence in adult pleasures such as sex and the resultant early pregnancy and/or STD infection including HIV/AIDS. In Malamulele, before a girl starts indulging in sexual activities, convention demands that she must first attend an initiation school. Information on female initiation schools was obtained from the headman's councillors and the traditional leaders during brainstorming sessions. Information on male initiation was based on the researcher's own personal experiences. As a Malamulele resident, he too had been compelled to attend an initiation school. All members of his family too have had to follow tradition – both males and females.

- **Polygamy**

Polygamy entails multiple sex partners for males who practise it. It is commonly practised in many countries of Africa in particular. Researchers state that men are more likely to have two or more concurrent sexual partners and are therefore at great risk of both contracting the virus and passing it on. However, women are socialised to be submissive with regard to sexual matters (Foreman 1999:ix, and Bunch, Carrillo and Shore in Stromquist 1998:5). Safer sex practices like use of condoms are shunned by many people. Research findings by Wood and Foster (1995:14) noted that there are negative attitudes towards condoms hence the low use of them. Condom use is unlikely in situations where sex is forced upon subordinates (Garcia-Moreno and Watts 2000:257). Primary prevention efforts towards the fight against the scourge of HIV/AIDS should target change of attitudes and beliefs with regard to sexuality.

Polygamy is prevalent and acceptable in Malamulele. It is regarded as a status symbol for some men irrespective of whether one can afford to feed his family or not. Male indulgence in multiple sexual partners within and outside wedlock is revered as a symbol of maturity, royalty and being macho. No one speaks against this practice and those who indulge in it have social approval and even admiration. Discussions on sexually transmitted diseases are taboo hence discussions on HIV/AIDS too are limited and are actually not popular. Denial of the existence of HIV/AIDS is discernable here and even where there are obvious symptoms of the virus and disease, community members still regard the subject as taboo and would rather displace their anger, disappointment and frustration on those who are branded as witches. Prevention and treatment of HIV/AIDS is hindered by the perception of polygamy and the denial of the existence of the disease by a substantially significant number of people in Malamulele.

- **Substance use, misuse and abuse**

Adult pleasures to which children are introduced too at initiation schools in Malamulele schools, are to a large extent limited to sexual intercourse and use of substances. Rights of the individual, over and above his/her obligations are seen to be emphasised at initiation schools; hence the young initiates often behave irresponsibly and tend to

go overboard. In Malamulele, substance use and abuse by both males and females among the young and old is a common form of recreation. Indulgence in substances is a popular week-end and holiday time form of recreation which to a large extent is provided in the form of celebrations, confirmation, baptism and even funerals. During the week only those who are not employed indulge freely, while those who are employed indulge only after hours. Like in many other rural areas in the RSA, in Malamulele the socio-economic lifestyle of many people may be rated as below the poverty datum line since the majority of people are unemployed. Unemployment, poverty, illiteracy and lack of recreation prevail in Malamulele. In seeking for purpose , some people overindulge in substances. The most easily available drugs are alcohol and dagga. The most common means of earning an income, is by selling home-brewed alcohol and dagga.

- **Educational level in Malamulele**

A very low premium is placed on education, hence the majority of people are not literate. School drop out is largely due to the fact that once learners have been initiated into adulthood, they usually drop out of school. Reasons advanced for the high drop out rate is disillusionment, as youth are aware and mention the fact of unemployment which affects even those who have educational qualifications. The low level of illiteracy which exists in Malamulele affects the effectiveness of the HIV/AIDS prevention programmes negatively.

1.8 SIGNIFICANCE OF THE STUDY

Findings of the current research study will help the service providers for HIV/AIDS patients and their significant others in Malamulele to be culturally sensitive in their service delivery. Moreover, the research findings will help to modify the perceptions around HIV/AIDS with regard to how HIV is spread and how it is not spread in the area of study. The research findings will also add to the knowledge base of the caring professions such as Social Work, Nursing and Clinical Psychology in the prevention and treatment of HIV/AIDS in Malamulele as well as in many other rural areas in the RSA where traditional practises and socio-economic factors may be similar to those that prevail in Malamulele.

The issue of sexual activity among sexual partners with regard to HIV infection has not been given adequate attention by social and behavioural researchers in Sub- Saharan Africa (Painter 2001:1397). The fact that HIV/AIDS raises cultural sensitive issues of sexuality, gender inequalities, commercial sex, homosexuality and intravenous drug use (IDU) has often led to the denial of the disease and the reluctance to address it. This then obviously exacerbates the disease (Morison 2001:1). This study explored these issues in Malamulele and therefore contributed by providing more information on them. While the researcher was exploring cultural issues, respondents got educated and were challenged to review their circumstances and to think of possible solutions.

1.9 LIMITATIONS OF THE STUDY

The researcher was aware and mindful of the following limitations to the current study:

- There is a dearth of literature regarding the impact of culture on the prevention and treatment of HIV/AIDS specifically on the Vembe region of the Limpopo Province as well as on many low-resourced (rural) areas in the RSA.

- Cultural factors such as lack of trust of strangers, secrecy around the issue of circumcision and unwillingness of some traditional leaders and influential persons in the communities to respond to the researcher would serve to limit the size of samples to be drawn from the various populations that were under surveillance.

- The traditional leaders` inclination to be defensive and highly secretive as they astutely guard and conserve cultural practices and defy development which is a natural process and is also bound to occur as the country grows and the young people are influenced by mass media, education and technology. Securing information from traditional leaders would entail numerous appointments and visits to the villages before a breakthrough could be made. This however would serve to test the patience of the researcher and indeed turn the study into a costly exercise.

Illiteracy of the majority of respondents who comprised the second and third types of samples, as well as the tendency of cultural secrecy around issues of sexuality in Malamulele were anticipated to serve as a problem, which would and indeed did

prolong interviews. The researcher would first have to establish rapport with respondents, before data could be gathered. The reception of the researcher and the length of period required to establish rapport would be a time-consuming exercise. Additional problems occurred because of the following factors.

- **Acquiescence bias** – This is a category of response bias that results because some individuals tend to agree with all questions or concur with a particular position (Zikmund 1994:217-218). This kind of response is common among respondents who are not literate. There is need to ask each question several times to ensure that one ultimately gets an honest response.

- **Extremity bias** – This refers to a bias that results because the responding style varies from person to person, some individuals tend to use extremes when responding to questions (Zikmund 1994:218).

- **Interviewer bias** – Zikmund (1994:218) describes this as a response bias that occurs because of the presence of the interviewer. His presence influences the answers of the respondents.

- **Interviewer's error** – This, according to Zikmund (1994:220) refers to the mistakes, which are made by the interviewer when performing his tasks. To eliminate this problem the researcher followed the intervention research methodology, which facilitated him to involve a substantial number of community members in the first three phases of the study and also to conduct a pilot study in order to iron out the biases.

To avert bias, in Malamulele, workshops on sexuality, condom use, homosexuality, substance use/abuse, gender inequalities, and societal attitudes towards HIV/AIDS had to be conducted as part of the intervention research on the primary prevention and treatment of HIV/AIDS. Other activities aimed at averting anticipated limitations to the study entailed preliminary negotiations with traditional leaders. These were begun six months before the study was conducted in order to ensure cooperation and collaboration of the leaders in this study.

1.10 DEFINITION OF CONCEPTS

The following concepts have been operationalised for the purpose of this study:

1.10.1 Culture

In simple terms, culture refers to the people's way of living. Barker (1999:114) defines culture as the customs, habits, skills, technology, arts, values, ideology, science, and religious and political behaviour of a group of people in a specific time period. Harris (1997:88) states that culture refers to the learned socially acquired traditions of thought and behaviour found in human societies. For the purpose of this study the researcher used the concept, culture to refer to the lifestyle of the people in Malamulele (Mapapila, Matsakali, and Gidja-Mhandzeni villages). This concept was further limited to practices and tendencies that were associated with the prevention and treatment of HIV/AIDS.

1.10.2 Prevention

According to Barker (1999:374) prevention refers to action taken by social workers and other social service professionals in order to minimize and eliminate those social, psychological, or other conditions known to cause or contribute to physical and emotional illness and sometimes socio-economic problems. The researcher in this regard refers to all activities, which can be carried out by social workers to deter the continuous spread of HIV/AIDS as they play significant roles such as enabler, information disseminator and educator in the primary prevention of the HIV/AIDS epidemic. The prevention effort of a social worker occurs within a team. In this study, the researcher has focussed only on the role of the social worker within the multi-disciplinary team.

1.10.3 Treatment

It refers to correcting or alleviating a disorder, disease or problem (Barker 1999:493). In this study while the researcher was aware of all intervention procedures aimed at alleviating and reducing the spread of HIV/AIDS, the concept of treatment has been

limited only to the role of the social worker. This concept was used interchangeably with others such as therapy and/or intervention with regard to HIV/AIDS.

1.10.4 Sexuality

Barker (1999:439) defines sexuality as characteristics of an individual that essentially pertain to the reproductive function, including anatomy and physiology, primary and secondary sexual traits, sex role patterns, and behavioural characteristics. In this study, the researcher has adopted the same meaning of sexuality as has been described by Barker.

1.10.5 Sexually transmitted diseases

Sexually transmitted diseases are venereal diseases, which are infectious since they are passed from one person to another through coitus or other intimate contact. Sexually transmitted diseases include gonorrhoea, chlamydia, genital herpes, syphilis and HIV/AIDS (Barker 1999:439). For the purpose of this study the researcher has adhered to the above-defined meaning of sexually transmitted diseases. However, he has concentrated only on HIV/AIDS, as a sexually transmitted disease.

1.10.6 Condom use

Barker (1999:97) defines a condom as a thin sheath of rubber, latex, polyurethane, or similar material that fits tightly over the penis and is used for contraception and the prevention of sexually transmitted diseases such as AIDS, syphilis, gonorrhoea and genital herpes. The researcher focussed on condoms only as protective measures against sexually transmitted diseases particularly HIV/AIDS.

1.10.7 Homosexuality

Barker (1999:220) explains homosexuality as a form of sexual behaviour that is practiced by gays and lesbians. It refers to the sexual act or erotic orientation by some men and women for members of their same sex.

1.10.8 Promiscuity/Prostitution

According to Barker (1999:382) promiscuity refers to casual, frequent, and indiscriminate sexual encounters while the latter refers to the illegal act of offering oneself for sexual contact with another in exchange for money or other benefits. The researcher in this study has used these concepts interchangeably when referring to commercial sex workers or prostitutes as promiscuous persons. The concept of promiscuity has also been used to refer to any man who has more than one sexual partner at a time whether within or outside marriage.

1.10.9 Socio-economic class

This refers to social status as well as the economic positions of people in the society. Barker (1999:458) defines this concept as categorization of groups of people according to specified demographic variables, such as level of income or education, location of residence, and value orientation.

1.10.10 Substance abuse

This refers to maladaptive patterns of using certain drugs, alcohol, medications, and toxins despite their adverse consequences (Barker 1999:470).

1.10.11 Epidemic/Pandemic

Barker (1999:156 & 345) defines epidemic and/or pandemic as the occurrence of a disease, disorder, or social problem that spreads rapidly and affects many people in a community within a relatively short period. The latter, is a term applied to social problems, diseases, or mental disorder that appear on a broad scale throughout a specific large area (such as a city, a nation, a continent, or the entire world). The researcher in this study has interchangeably used these concepts similarly.

1.11 CONCLUSION

In this chapter an overview of the study has been presented. The researcher has alluded to his motivation for undertaking the study, the problem statement, aim and objectives of the study, assumptions, research design, research methodology, profile of the area of the study, significance of the study, limitations and definition of concepts. He has indicated the importance of teamwork and the multi-disciplinary approach which entails forging a link between the bio-medical and the psychosocial models in the prevention and treatment of the HIV/AIDS epidemic. He has further alluded to cultural practices and the socio-economic factors that prevail in the Malamulele district and has indicated the influence of these on the prevention and treatment of HIVAIDS in Malamulele. The intervention research model which has been used in this study, has been explained as a social work research model which links research and practice and also offers respondents an opportunity to participate in the study not just as subjects but also as beneficiaries.

CHAPTER TWO: LITERATURE REVIEW

CULTURAL ELEMENTS THAT IMPACT ON THE PREVENTION AND TREATMENT OF HIV/AIDS

2.1 INTRODUCTION

The majority of people in the Limpopo Province reside in rural areas which are as yet under-researched, under-developed and low-resourced. A variety of problems among which HIV/AIDS is but one, assail rural dwellers. Each problem cannot be studied in isolation as it is either the cause or effect of the others too. However, each study must have parameters to facilitate focus and relevance of research. In the current chapter the researcher has focussed on sexuality and gender diversity issues as these are cultural elements that impact on the prevention and treatment of HIV/AIDS. The views and findings of other researchers have been presented in this chapter, as a basis upon which the researcher may observe, explore and compare the cultural elements that impact on the prevention and treatment of HIV/AIDS among people in the low-resourced areas of Malamulele with what happens elsewhere. HIV/AIDS has reached pandemic levels and seems to be accelerating at a much faster pace in the developing countries which are also low-resourced. While the developed countries seem much closer to having conquered the HIV/AIDS pandemic, developing countries are as yet nowhere nearer to controlling this scourge.

Many researchers have alluded to cultural issues, which deter control of HIV/AIDS. Many communities adhere to a patriarchal system which endows males with limitless power over females. Men wield and enjoy power which at times is self-destructive yet the majority cling to power and are reluctant to relinquish it as they view loss of power as synonymous to emasculation. To a large extent services of the prevention and treatment of HIV/AIDS programmes should target males firstly [as they are the powerful ones] and secondly females as they are the subordinate yet important partners in all relations. The power of men is bestowed upon them by cultural norms. It is viewed by many as an unchanging aspect of culture yet some cultural factors such as polygamy, extra-marital affairs and religious beliefs and practices have an effect on

HIV/AIDS. Socio-economic factors too, have been found to have an influence on the spread of HIV/AIDS. The epidemic is high in the disadvantaged and marginalized areas such as Malamulele communities, since the majority of people live below the bread line and are therefore vulnerable to infection as they strive to meet their primary day-to-day needs. The means used by poor people to earn a living, amongst others, include commercial sex work. In Malamulele, myths abound around an effective cure and/or prevention of HIV/AIDS just as in many other parts in Africa. The effects of substance use/abuse on the spread of HIV/AIDS have also been alluded to in this chapter.

2.2 SEXUALITY AND GENDER DIVERSITY

Heterosexual relationships account for the high rate of the HIV/AIDS prevalence between men and women in Sub-Saharan Africa (Morison 2001:12). In a study conducted by (Blair, Ojakoa, Ochola and Gogi in Umeh 1997:51) in Kenya respondents advanced the following reasons, on the reluctance of African men on refraining from multiple sexual partners and promiscuity:

- "God gave Adam a partner and for that reason, sex is natural "
- "The sexual urge is strong-at times uncontrollable"
- "The sexual urge is natural and incessant in man: It is like a thief going to steal in the place where another thief was killed."
- "The sexual appetite is insatiable."
- "Human beings are human beings who forget easily and go back straight into the ditch"
- "One cannot resist the sexual urge acquired from the Garden of Eden."
- "Even God's people (priests) have women friends too.

While the above statements were made to researchers in Kenya, they have been echoed throughout many communities in Africa. In studies that were conducted by social work students in their fourth year of study, at the University of the North, the above statements were repeated, as well as African idioms that justify promiscuity among men e.g. " monna ke thaka wa naba or monna ke selepe u lala a adimilwe" meaning a man can be shared among several women or a man is allowed to have

extra-marital affairs. Gender relations and sexual relationships in a specific cultural environment are crucial in understanding HIV transmission and to develop effective preventative and treatment programmes (Schoepf, Payanzo, Rukarangira and Walu as quoted by Schoepf 1993:87 and Campbell 1999:84). In many communities, males are viewed as superiors to females. Women are socialised to accept this viewpoint and not to question it. While urban dwellers are gradually questioning men's domination over women, rural women are very passive and accept the status quo as a cultural determinant. Many rural women do not make an effort to strive for gender equality but rather docilely accept a position of inferiority and dependence on men.

As the majority of the societies around the world are male-dominated, men therefore pose a threat to public health because women have less power to protect themselves from the disease. Males tend to be aggressive and violent towards the females in the issues of sexual matters (Mann quoted by Kottak 1997:417 and Harris 1997:337). Men are endowed with more power than women. Women are regarded as subordinates while men have all the power to make decisions as well as to dominate every sphere of human life in the exclusion of women. Men are regarded as representatives of God on earth. They are empowered to order women about, and to use them as their sex tools in their own time without being questioned, disturbed or deterred. The status of superiority that is bestowed on men is based on an intricate belief system. Women are powerless and subservient to their men. They are not in the position to negotiate safer sex due to cultural norms (Wood and Foster 1995:25). The degradation of women in most societies renders them vulnerable to any sort of illness including HIV/AIDS. The vast majority of women with HIV infection world wide are from the most disadvantaged, poorest sectors of society and are therefore often least able to advocate for themselves (Hankins in Sherr 1993:29). Conversely, women are regarded as inferior, weak and passive (Mashishi 2000:82-83, Sewpaul and Rollins 1999:260 and Anthias 2001:373).

Since men determine when and how to have sex and they even choose their sexual partners, to a large extent, they are often the carriers of the virus and it is them who infect women with the HIV. Many men do not take precautions in the prevention of the sexually transmitted diseases including HIV as they actually prefer what is commonly known as flesh-to-flesh sex with whoever they have sexual intercourse with

(Sagrestano, Heavy and Christensen 1999:67, Somlai, Kelly, Wagstaff and Whitson 1998:9; MacPhail and Campbell 2001:1624, Barnett, Whiteside, Khodakevich, Kruglov and Steshenko 2000:1397 and Ickovics and Yoshikawa 1998:196).

Findings by Mayaud and McCormick (2001:141) and Deaux (1995:13-16) reveal that women are forced to indulge in unprotected sex as a result of unequal power relations between them and males. Unprotected sexual intercourse with multiple sexual partners is a co-factor for HIV infection (Schoepf 1993:87). Many researchers point out that men are more energetic and competent than women and that they harass women sexually.

South Africa is a patriarchal society. In the patriarchal system men are regarded as natural leaders and are preferred over women to hold positions of power. Women are regarded as subordinates and they therefore have to support men's roles and status. Women are expected to be followers and not leaders. In other countries as well, for example in Morocco, women are regarded as subordinate to men. Women's space and interaction with men is limited and sanctioned by Islamic traditions. Certain cultural factors that are rooted in traditional religious beliefs and practices hinder women's participation in development projects (Sadie and Van Aard 1998:88; Lagarde, Enel, Seck, Gueye-Ndiaye, Piau, Pison, Delaunay, Ndoye, and Mboup 2000:78; Hamel 1999:74; and Phiri 1997:68).

2.2.1 Power relations and sexual matters

With regard to sexual relations between males and females, Garcia-Moreno and Watts (2000:254) aptly commented that men usually use power, which is culturally sanctioned over females, while women are expected to assume a position of subordination. Unequal power relations are culturally approved and perpetuated by the way people are socialised in relation to gender diversity, roles, status and need fulfilment, especially around sexual matters. Men are socialised to be the dominant partners and decision makers hence they often force themselves on their sexual partners and sometimes even over very young females without giving them any choice. This unbecoming behaviour is visible everywhere, both in developed and in developing countries. It may be that in many settings, girls are socialised to expect

violence and forced sex as part of a relationship. Young girls are coerced to sexual matters without their consent. Physical abuse coexists frequently with sexual abuse, as well as the subsequent effects – injury and a variety of sexually transmitted diseases, including HIV/AIDS.

Frazier, Cochran, and Olson (1995:23) indicate that women are socialised to be humble and to obey their husbands. This provides men with direct authority over their sexual partners. More often, men use money to lure women for sexual favours. With special reference to Africans, these researchers point out that young women usually indulge in sexual relations with older men who are likely to be HIV-positive. Some researchers have also pointed out that women's infection is very high at an early age when compared with young men (IAFRICA: on line). African culture forbids women to initiate sexual activities. This is regarded as a male prerogative hence some impose their power on women. In particular, men at the family level exercise power even on issues, which require women's consent. Conventionally; men and women who are married should accord each other conjugal rights, yet in reality this does not happen; instead men coerce women for sex and men tend to blame sex workers for spreading HIV/AIDS, whereas it is their clients who demand sex without condoms.

Generally, manhood and sexual gratification are viewed as synonymous. Men's virility is often gauged through their promiscuity – which is socially acceptable and viewed as ability to satisfy numerous sexual partners. In actual fact, society expects men to prove their sexual prowess. Men are likely to have sporadic relationship and to have several sexual partners during their adolescence and young adulthood stages. Yet women are commonly expected to be sexually inexperienced when they get married (Sigh, Wulf, Samara and Cuca 2000:21 & 27). It is commonly believed and accepted that men's sexual needs are beyond their control and that if men are denied sex they might suffer mentally and physically. While promiscuity and extra-marital affairs are frowned upon for women, such practices however are condoned and actually encouraged among men. Promiscuity among women is not socially acceptable whereas it is socially acceptable for a married man to have mistresses and concubines. Men's extra-marital relations are generally taken for granted and are socially accepted as normal behaviour for men. In most African states, polygyny is prevalent and sex outside marriage largely by men is frequent. This places many

women in danger of being infected with HIV. Schoepf (1993:91) and Little, Obbo, Larson and Caldwell et al as quoted by Rushing (1995; 65). Gysels, Pool, and Nnalusiba (2002:182) comment that: Males are naturally promiscuous and that it is culturally appropriate for them to have extra-marital affairs. A woman however, is expected to be faithful to her husband and to tolerate his infidelities. Because of this bias, men are not limited to one sexual partner each, hence they are prone to catching and spreading HIV as they are culturally sanctioned to have as many sexual partners as they like without being labelled. However, such behaviour is not condoned among women. Women who indulge freely in sex work are labelled as prostitutes. Commercial sex workers are inclined to have sex with as many partners as they choose, as this is a means of livelihood; however, society despises sex workers while they condone the practice of men who use them.

2.2.2 The impact of polygamy and extra-marital affairs on the spread of HIV/AIDS among the married couples

Marriage is the oldest institution universally. It is within it that sexual intercourse is sanctioned; yet quite substantial sexual activities are to a large extent often performed outside marriage. Problems around sex occur both within and outside marriage. Marriage does not protect women from sexual harassment. It is within the family that females are at the bottom of the hierarchy while males are at the top. Men have power and authority over females and as a result they are more competent and more status worthy than women. Due to the fact that men view themselves as much more important than women, extra-marital relationships are regarded as the norm hence multiple sexual partners are associated with the rapid spread of HIV and other sexually transmitted diseases. Besides their wives, some men still have additional sexual partners thus placing themselves and their wives in danger of infection with HIV. Similarly, women see themselves as being powerless. They are often reluctant to discuss issues pertaining to their health with specific reference to HIV/AIDS. The reason advanced for promiscuity among African males is based on the idea that "ngwana o tsebja ke mmage/ n`wana u tiviwa hi mana wa yena" meaning that a man is seldom sure that he is the father of a child. To ensure their chances of fathering, some men resort to having several sexual partners to increase their chances, as hopefully, at least one of the sexual partners might conceive a legitimate child and make the

father proud (Schwarzwald and Koslowsky 1999:26; Carli 1999:92; Ridgeway 2001:648; Lagarde, Auvert, Carael, Laourou, Ferry, Akam, Sukwa, Morison, Maury, Chege, N`doye, and Buve` 2001: 878; Garcia-Moreno and Watts 2000:257-258; MacPhail and Campbell 2001:1623; Cecil, Pinkerton and Bogart 1999:166; and Manhart, Dialmy, Ryan, and Mahjour 2000:1375).

Unequal relationships between husband and wife are rooted in the dynamics within the family as the consequences of socio-economic and macro-class structure (Foreman 1999:17; Svenkerud and Singhal 1998:17; Shirahase 2001:406 and Mill and Anarfi 2002:326). Males therefore, are usually in need of sex, either within or outside the formal institution of marriage – hence they resort to multiple sexual partners. The social norm, which gives men authority and power over women, still exists universally. This high-risk behaviour amongst men seems to facilitate the HIV and other sexually transmitted diseases to spread easily (PANOS: on line).

2.3 RELIGION

Religion is a cultural aspect that is based on the values and beliefs of people. Culture encompasses all spheres of human life including religious beliefs. Every individual, ethnic group, tribe or nation has a belief system, which determines and shapes the lives and everyday activities of members. Attitudes and the belief system have an impact on people's viewpoints and behaviour including their sexual relationships. As HIV/AIDS affects all people within the society, the attention of the religious leaders has also been drawn to this pandemic, which is a scourge of society especially, that there is no known cure for it as yet. According to Di Lima and Schust (1997:149); Raditapole in Reid (1995:61); Svenkerud and Singhal (1998:99); Woods and Ironson (1999:396) and Pattillo-McCoy (1998:768) some religions view HIV/AIDS as a punishment and/or a curse from God for immorality. Since religion is regarded as an integral part of culture, illnesses such as HIV/AIDS are truly seen as a curse from God for sins committed by the sufferers. For those who believe in ancestral worship, HIV/AIDS is blamed on witchcraft or as a curse from the gods due to some moral transgression (Lathan as quoted by Umeh 1997:xvi).

Schoffeleers (1999:413-414) found that in Malawi, people regard HIV/AIDS as a curse from their ancestral spirits hence communities meted out punishment to people who experienced disconformities to society's mores and values, which forbid promiscuity and pre-marital relations. Malawians still practice what is known as MCHAPE - some medicine and power to resist poisons of all kinds. Accordingly, instead of keeping people from promiscuity, MCHAPE actually promotes it; since people who use it often claim that they are immune from HIV/AIDS and they further believe that they have power to immunise others by having sexual intercourse with them. In this way, the religious system practiced in Malawi, has the consequences of spreading HIV/AIDS instead of preventing it. In actual fact, fatalism leads people to believe that the HIV infection is predetermined by supernatural forces rather than failure to adhere to safer sex practices. In several African communities, traditionalists practise some religion known as Black Christianity. This is a combination of traditional and Christian beliefs. It entails a constitutive dimension of all human action. Believers in Black Christianity have to conform to cultural norms because failure results in punishment. People who uphold such beliefs also regard HIV/AIDS as a curse from God. This then reinforces reluctance to use safer sex methods, as believers in Black Christianity believe that they can evade HIV/AIDS by simply conducting certain rituals in order to avert God's` punishment . Unfortunately such rituals do not incorporate safer sex practices.

Various religions including Christianity, Traditional ancestral worship and Islam all place the man as head of the family and as a superior to the females. It is therefore the male who determines the values and beliefs upheld by members of his family and he seldom seeks their opinions but unopposedly dictates the lifestyle to be followed in his family. All subordinates live in awe of the head of the family and may not oppose him. Polygamy is thus determined by the man and sometimes the only privilege given to the wife, may be to help him choose the women who may be her husband's additional wives; but this privilege is rarely bestowed.

2.3.1 Religion and gender diversity

The existing status quo of unequal power relations in most societies is deeply rooted in religious beliefs and values. Categorically, in South Africa, Christianity is the dominant religion and the church and various Christian denominations are inclined to

emphasise man's superiority and the maintenance of gender stereotypes. Religion is not only an aspect of culture, but it is also on its own, a lifestyle which exerts immeasurable pressure on women. Lauver (2000:78) asserts that hierarchical and dualist beliefs in religion have had negative implications for women. God is seen as superlative to man, and man as superlative to women and animals. Women are often accorded the same status as animals because they have physical functions such as menses, birth and breastfeeding that are shared with other female mammals. The physical functions have lesser value, and therefore if women are associated with physical functions, then women are presumed to be inferior to men. Women are regarded as subjects who are under the control of both men and God. Religion gives men protection as superiors while women are forced to be subservient hence they lack control over their personal risk of HIV infection.

Njoroge (1997:81) observed that Christian women are in a helpless state as they are trapped between the Gospel message (which emphasises their subordinate state to that of men) and the dictates of some cultural practices such as female circumcision which subjects women to mutilation, which sometimes result in life-long physical and/or emotional health problems. Amongst other cultural practices which relegate women to a helpless and inferior position, Njoroge (1997:81) cites the levirate system (wife inheritance) which she views as a source that might create possibilities for sexually transmitted diseases, especially HIV/AIDS. She further observed that women are generally concerned that men jealously support the maintenance of cultural norms and that "uncritical cultural retrieval and glorification of African religion and culture will continue to erode women's dignity and wholeness."

2.3.2 The positive impact of religion towards the prevention of HIV infection

Numerous researchers have observed that in Africa, women are oppressed both on religious and cultural basis. Men are the custodians of both religious and cultural norms. They oversee strict adherence to cultural norms which serve as a machinery to monitor appropriate and desired behaviour of all members, while religious norms sanction socially accepted behaviour and simultaneously reprimand anti-social behaviour. Men in their roles as community and church leaders could play a significant role in changing attitudes. The church is a powerful institution and should therefore

play a prominent role in HIV/AIDS prevention and treatment. The church can influence modification of sexual behaviour of its members and in this way may help to reduce the incidence of HIV/AIDS within the society. Raditapole in Reid (1995:61); Garner (1998:159); Phiri (1997:72); Lekganyane (1999:8); Lekganyane (2000a: 5 & 8); Lekganyane (2000b: 5); Lekganyane (2001a: 5-6 &8); Lekganyane (2001b: 5,8,12 &14); Makhubele (2000a: 10-12); Makhubele (2000b: 13) and Makhubele (2001:26)

This however, does not mean that women should be passive partners who have to wait until men relinquish their power and superior status. Women and young people too, have the responsibility of protecting themselves from abuse by acquiring empowering knowledge about their sexuality through mobilisation within their various churches. The young people should adhere to moral values as determined by each individual church because HIV/AIDS is not a joke but a reality which paralyses the economy and depletes health services. Church leaders should be vocal enough about the dangers of HIV/AIDS and each person should know that he/she is at risk. Barriers in communication must be broken down to facilitate discussions on how HIV/AIDS is spread as well as how it can be prevented (Mugemana in Reid 1995:77-78 and Lekganyane 2000a: 5 & 8).

2.4 SOCIO-ECONOMIC FACTORS

In the current text, socio-economic factors have been analysed from the following two aspects namely socio-political and socio-cultural factors. As subsistence farming is on the decline in Africa, income is commonly earned by males as heads of families. A common system of income generation is through the migrant labour system which entails that a large percentage of men sell their labour to employers who live far from the labourers' homes. Husbands migrate to cities and industrial sites where they can sell their labour while their wives are left behind as homemakers and nurturers of children. While wives are not free to take up jobs away from their homes, single women are free to sell their labour wherever they like. The separation of husband and wife often leads to promiscuity as migrant labourers (husbands) often settle with new families nearer to their employment sites – while wives too may be tempted to find means for providing for their children by finding temporary sex partners in the form of contract workers or long-distance truck drivers. The high poverty and unemployment

rates apparently dispose people to high-risk behaviour, hence the belief that poverty causes AIDS. Raditapole in Reid (1995:61) contends that it is necessary to address the socio-economic factors and political conditions that enable the spread of the HIV/AIDS epidemic.

2.4.1 Socio-Political factors

Developing countries are assailed by unemployment, poverty as well as many other problems such as the HIV/AIDS pandemic. These tend to hinder major change and development. Lack of attention to socio-economic and cultural issues may contribute to the spread of HIV. The spread of HIV is to some extent determined by socio-economic processes, which are set in motion by political and economic relations between African states and the developed countries (Miller and Rockwell as quoted by Schoepf 1993:88). Unemployment is rife in developing countries hence poverty occurs as a result. The high unemployment rates lead both men and women into high-risk behaviour, which amongst others include: plying the sex trade, indulging in unsafe sexual intercourse, multiple sexual partners and substance abuse. All these high-risk behaviours put the lives of poor people, at a high risk of HIV infection (Foreman 1999:23 and Wingood and DiClemente in Umeh 1997:121 and Masa, July, 2002:5).

South Africa is neither a developed, nor a developing country. It is a country in transition. Women's social and economic status is still low, hence the high rate of the pandemic in the country. Women are more vulnerable to HIV/AIDS because they lack social and economic status and also have limited decision-making power on issues that affect their welfare and their families (Mhloyi in Reid 1995:18). It has been observed that women are most affected by unemployment and poverty much more than their male counterparts. Chimere-Dan (1996:7) indicates that in South Africa economic and political policies have transformed rural areas into reserves of cheap labour for the services of the mines, industries and commercial agriculture. The wives of the workers in the mines, industries, and commercial agricultural sectors are not permitted to stay in their husband's place of employment. The separation of husbands and wives by the migratory system makes them vulnerable to seeking for sexual partners outside marriage thus becoming targets for HIV infection.

2.4.2 Socio-cultural factors

A number of researchers have focussed their attention on the socio-economic factors that influence the lifestyle of people particularly women. In countries like Nigeria and Vietnam, the socio-economic status of women is very low and that predisposes them to HIV/AIDS (Thuy et al 1998:431; Uwakwe in Umeh 1997:40; and McDowell and Pringle 1992:4). In support of this view Mwadi in Reid (1995:135) asserts that women's financial dependence on men, poverty and socio-cultural factors facilitate and/or expose them to infection and the transmission of HIV. Due to economic dependence, many women have declared that they cannot change their situations because they depend entirely on their husbands. These researchers further found that young women are often dependent on older men and employed partners for financial support. Young females indulge in sex with older men, not just for instant financial gains, but also for long-term economic support in case they fall pregnant. Older men have been found to provide care more reliably, than younger men who tend to freak out when faced with paternity suits. In prioritising primary needs, researchers have also found that people place food and housing higher than the need to exist (fear of dying from HIV/AIDS). Women are more vulnerable to HIV heterosexual transmission because of their financial dependency on their partners. Financial dependency often limits the subordinate's power to negotiate safer sex and condom use (Laga, Schwärtlander, Pisani, Sow and Caraël 2001:933; Feldman, O`Hara, Babbo, Chitalu, and Lu 1997:462; Svenkerud and Singhal 1998:212 and Jackson, Hobfoll, Jackson, and Lavin 2001:3).

The high rate of unemployment and the increased number of people living in poor conditions has relegated women to the lower positions. Low incomes often predispose women to promiscuity, which is a high risk factor for HIV infection. Women's low socio-economic status correlates with the high prevalence of HIV infection amongst them (Young, Martin, Young, and Ting 2001:302; Melkote and Goswami 2000:102; Cecil et al 1999:166 and Janssen, De Wit, Stroebe, and Van Griensven 2000:488). In the Republic of South Africa, politicians have demonstrated their concern for the powerlessness of women. The Deputy President –Dr Jacob Zuma commented that: " The majority of women are dependent on men in various facets of social and economic activity, which makes it difficult for women to negotiate safe sex" (Sowetan,

14 February 2002 :16). Many women regardless of their age and socio-economic status are not in the position to say "NO" to sex. In actual fact, they are not assertive (Schoepf 1993:90).

It has been found that there is a strong link between poverty and the transmission of HIV and that poverty has an impact on the HIV epidemiology. In a South African context, blacks are the people mostly affected by poverty. The poor living conditions of black people in the RSA have particularly been created by the apartheid policy. In their plight for seeking income as well as lack of privacy in their homes, they became vulnerable to high-risk behaviour, which exposes them to HIV/AIDS. Watney (1994:27) asserts that local and national policies, create and also maintain the poor living conditions of people. These policies need to be challenged if the primary preventative programmes are to be effective. Other researchers too, have observed that poverty contributes to the escalation of the HIV/AIDS epidemic (Webb 1997:31; Gilks 2001:171-173 and Mill and Anarfi 2002:326). While researchers confirm that men are the most likely victims of HIV/AIDS, women and children from the underdeveloped communities have been observed to be the fastest growing segment of the population developing HIV/AIDS (Stein, Nyamathi and Kington 1997:520 and Des Jarlais and Caraël 1999:235).

Socio-economic factors may also be linked to certain sexual patterns such as commercial sex work and homosexuality, which are practiced within communities.

2.4.3 Associating commercial sex work with spreading of HIV/AIDS

Commercial sex work constitutes high-risk behaviour. People who indulge in commercial sex work are vulnerable and/or at high risk of HIV infection as well as its transmission. Cyr-Delpe in Reid (1995:66) asserts that intensified economic hardships lead to an increase in both male and female sex workers as unemployment is sure to result in poverty and subsequently high risk behaviour. While initially, sex work was regarded as a job carried out by women, the increasing rate of homosexuality in Africa has now opened up channels for sex work among young men who ply their trade among much older and wealthier clients.

A number of researchers have found that girls often trade sex in exchange of money for their living. Children, who have been abused and/or neglected, or those who live in the streets (homeless children) are often involved in commercial sex or informal sex work. Sometimes they even barter sex for drugs, money or favours. Poverty and homelessness eventually force children to have sex with HIV infected persons; yet in spite of such danger, women still engage in commercial sex for economic benefits. Women in most cases enter into commercial sex work because of poverty. With regard to those women who are working, some may indulge in the sex trade in order to augment their income. In such cases sex workers are unlikely to use condoms or influence their male partners to use condoms for fear that their clients might consider them dirty or infected with HIV when they insist on using condoms (Duncan, Tibaux, Kloos, Pelzer, Mehari, Perine, Peutherer, Young, Jamil, Deirougar, Lind, Reimann, Piot, and Roggen 1997:444; Peersman and Levy 1998:192; Rushing 1995:63; DeoCampo and Fleras in Reid 1995:52 and PANOS: on line).

Economic stress such as unemployment and low income sometimes predisposes parents and particularly women to offer their children for sex in order to ensure the survival of the rest of the family. Due to that, women are often left with no option except to allow their children and/or even themselves to trade sex for a living. Of late, journalists too have demonstrated their concern about the HIV epidemic by writing and broadcasting about it on a regular basis. The following extract by Bhengu illustrates this concern: "Lack of jobs has led many destitute people like Zanele to indulge in commercial sex work for survival". Bhengu quotes Zanele who stated that "I really want to make a fresh start but I do not know where to start without a job. Life is not easy for me as a destitute woman with HIV. I have to engage in prostitution to survive" (Sowetan, 21 February, 2002:6). Due to economic pressures within the communities exacerbated by socio-political and socio-cultural factors the high risk of being infected with HIV is underrated (Jackson et al 2001:10, Siegel, Karus, Raveis and Hagen 1998:449 and Garcia-Moreno and Watts 2000:254).

- Condom use and non-condom use among the commercial sex workers

While condom use is one of the means of safer sex practices, it has been reported that there is a low use of condoms among commercial sex workers and their clients

(Morisky and Coan 1998:189). The major reason advanced by commercial sex workers for not opting for condom use during sexual intercourse, is fear that their clients might consider them as diseased or dirty (Deocampo and Fleras in Reid 1995:52). However, Plant in Sherr (1993:230) contends that condom use to a large extent is determined by negotiating power of both male and female prostitutes. He observed that commercial sex workers who are working in organized establishments such as brothels, saunas or massage parlours are able to enforce the use of condoms than those who are working in isolation and privately.

Commercial sex work which is further aggravated by the low status of women accorded them in patriarchal communities makes them vulnerable to sexually transmitted diseases including HIV/AIDS. It has been observed that men prefer sex workers to satisfy their sexual fantasies and that they are even prepared to pay highly for this hence women who seek income indulge in commercial sex work, which is a high risk for HIV infection and transmission. Commercial sex workers often infect their customers who in turn infect their wives and girlfriends (Campbell 1999:74). While sex work in the Republic of South Africa has not yet been legalised, a large number of women and young men, however, earn their income by plying the sex trade. The commercial sex workers take the risk of being arrested, scandalised, mugged, assaulted, killed and even infected with sexually transmitted diseases including HIV/AIDS.

2.4.4 Associating homosexuality with spreading of HIV/AIDS

Of late, the issue of homosexuals and the spread of HIV/AIDS are gaining momentum. Same sex contacts reportedly account for a high rate of HIV infection. Homosexuals might be males and/or females. Males who engage in sexual contacts with other males are referred to as gays, while females who indulge in homosexuality are referred to as lesbians.

- **Gay men**

Homosexuals believe that sex with the same sex person is safer than sex with a person of the opposite sex. They regard sex between males as less risky than sex

between a male and a female. The practice of men having sex with other men [MSM] has however been described by Campbell (1999:14; and Tawil, O`Reilly, Coulibaly, Tiémélé, Himmich, Boushaba, Pradeep and Carael 1999:242) as a high risk factor which is one of the surest means of transmitting HIV/AIDS.

Studies that have been conducted indicate that there is a low inclination to use safer sex amongst people who indulge in unprotected anal intercourse (UAI) (Mansergh, Marks, Miller, Appleby and Murphy 2000:1845-1846). Davidovich, De Wit and Stroebe (2000:704) indicate that unprotected anal intercourse poses a real threat of HIV transmission. There is inconsistent use of condoms amongst gay people and some have indicated that they do not use condoms at all (Peterson in Herek and Greene (1995:88)

Many studies reveal that many gay couples practise anal intercourse. Quite a substantial number of men reported having had anal sexual intercourse with men and this is a high-risk behaviour for HIV infection. Sexual activity between males is the primary risk factor for HIV infection and transmission (Koblin, Torian, Guilin, Ren, Mackellar and Valleroy 2000:1796; Waldo, Stall and Coates 2000:10 and Prins, Sabin, Lee, Devereux and Coutinho 2000:1832). These researchers indicated that 1 in 5 men are sexually violated during their lifetime. Male sexual assault remains vastly under-reported. Men who have been violated and abused sexually often advance reasons such as fear of not being believed when reporting the case and fear of what friends and/or family might think and/or say about them (AEST: on line).

Adolescence marks the period when young people start being sexually active. Young people mostly want to experiment with almost everything including sex. It has been found that the majority of adolescents who are infected are gays (Rotheram-Borus, Hunter and Rosario in Herek and Greene 1995:156 and Watney 1994:129). However, gays are marginalized and stigmatised as they are generally regarded as HIV/AIDS transmitters. The social security and safety of the homosexuals (gays) is vulnerable because their identity to people is synonymous to HIV carriers. As a consequence of being rejected by society because of their sexual identity, gays might become socially isolated and as a result of that they may engage in unsafe sexual practices (Sandfort in Herek and Greene 1995:33).

- **Lesbians**

Lesbianism has been observed to be on the increase and that there is a misunderstanding and misconception about HIV/AIDS amongst them. They believe that HIV/AIDS is God's way of getting rid of disobedient people who do not conform to His rules. They cite gays and intravenous drug users as the defaulters that God targets with HIV/AIDS. They believe that they are God's chosen people and that they can never get infected with HIV (Gómez in Herek and Greene 1995:20). Yet, findings from a study that was conducted in San Francisco by San Francisco Department of Public Health and Weiss as quoted by Gómez in Herek and Greene (1995:21) reveal that lesbians are at higher risk for HIV infection than exclusively heterosexual women. There are also some unpublished reports on lesbians who are HIV positive and have also reported that they had not been involved in heterosexual relations and that no other form of transmission except female to female contact could be the cause of their malady (Davidson and Foster as quoted by Gómez in Herek and Greene 1995:22).

The various ways in which HIV might be transmitted through female-to-female sexual contacts have been listed below:

- HIV transmission between women can occur from insertion of fingers from vagina to vagina (Johnson, Smith and Guenther as quoted by Gómez in Herek and Greene 1995:22).
- Exchange of vaginal secretions and menstrual blood between women having sex with women through the use of toys (Gómez in Herek and Greene 1995:22 and Campbell 1999:23).
- Women who use their own vaginal secretions to lubricate their hands and/or fingers prior to inserting them into their female partner's vagina and/or anus (Gómez in Herek and Greene 1995:22).
- Oral and vaginal mucous membranes when exposed to infected vaginal secretions and/or menstrual blood could lead to HIV transmission (Spitzer and Weiner and Wofsy as quoted by Gómez in Herek and Greene 1995:22-23 and Campbell 1999:23). Oral-genital sex is mostly common and favoured by lesbian sexual partners.

- Needle sharing with an infected partner during drug injecting use or sex with an infected man (Gómez in Herek and Greene 1995:23 and Campbell 1999:23).
- Women having anal sex with men (Gómez in Herek and Greene 1995:25 and Campbell 1999:23).

2.5 ASSOCIATION OF SUBSTANCE ABUSE AND HIV/AIDS

HIV/AIDS has been strongly associated with moral denigration and lifestyles involving deviant and perverse sex, intravenous drug use (IDU) and promiscuity. The drug usage behaviour, which is associated with HIV/AIDS, is judged to be more than just a weakness. It is indulgence, delinquency, addiction to chemicals that are illegal and perverse sex (Sontag in Bharat 2000:45 and Stevens-Smith, 1998:16). Drug use is often associated with loss of control and mind distortion (De Miranda 1996:5) and subsequently high-risk behaviour, which among others include unsafe sex. The spread of HIV/AIDS between sexual partners is associated with the use and abuse of substances, which is a high-risk behaviour for HIV infection (Kesby 2000:1728). The discussion has been focused on intravenous drug use, alcohol, crack and the environmental factors which might have a major contribution on the spread of HIV/AIDS.

2.5.1 Intravenous drug use

In their research, Stein, Nyamathi and Kington (1997:520) found that there were some female intravenous drug users who traded sex for drugs and money and these people were more likely to be HIV positive than those who do not trade sex. Leggett (1999:162) further made an observation that intravenous drug use in the RSA has been found to be more common than ever before. Respondents which comprised both men and women in the studies that have been mentioned above, were found to be using illicit intravenous drugs. The introduction of new drugs in the RSA market has implications for the spread of HIV/AIDS. Quite a substantial number of intravenous drug users have tested HIV positive. The patterns of injecting drug use and sex work are conducive to the spread of HIV/AIDS. Intravenous drug users (IDU's) reportedly have a high rate of HIV infection (Friedman, Des Jarlais, Ward, Jose, Neaigus and

Goldstein in Sherr 1993:42-48). Women who abuse substances are the potential victims of rape due to the fact that drugs alter their moods and judgement and that places them at high risk of being infected with HIV (Nataraj in Reid 1995:42; Webb 1997:6; Hata in Reid 1995:169 and Morison 2001:7). Female intravenous drug users are more likely than male intravenous drug users to have a drug-using partner and to share injection equipments with that partner (Brown and Weissman as quoted by Campbell 1999:61). Female intravenous drug users who trade sex for drugs and money are more likely to be HIV positive than those who do not trade in sex because they indulge in unprotected sexual intercourse (Garcia-Moreno and Watts 2000:257; Moore and Halford 1999:157; Ickovics and Yoshikawa 1998:192; Gross and Billingham 1998:81 and Peersman and Levy, 1998:192).

According to Laurichesse, Mortimer, Evans, and Farrington (1998:656) and Siegel et al (1998:449) the use of contaminated equipments for injecting drugs and the tendency of sharing needles among intravenous drug users continues to expose them to HIV infection. Drug abuse has immeasurable effects on the transmission of HIV/AIDS (Buzi et al 1998:316). Somlai et al (1998:9) asserts that the use of both injecting drug use and non-injecting drug use like crack and cocaine has been associated with the increased vulnerability to HIV infection. The excessive use of drugs regardless of the mechanisms employed has the link with a spread of HIV/AIDS.

Campbell (1999:17-18) further alludes to the fact that: " Women have a greater risk of coming into contact with an infected partner. There is a larger pool of infected men. Most IDUs and hemophiliacs are men, and, in addition, some men who acquired the HIV disease from sexual contact with men also have sex with women. Women are more likely than men to have sex partners who are IDUs or who themselves have multiple partners".

2.5.2 Alcohol

One of the most and easily accessible drugs in the RSA particularly in the rural areas is alcohol. It can easily be brewed at homes and be used for a variety of reasons such as entertainment or ritual purposes. When drunk, people have no inhibitions and they

throw caution to the wind and do not mind indulging in unsafe sex which might expose them to HIV/AIDS infection.

The use of alcohol and other psychoactive drugs, notably cocaine, fosters the unprotected sexual activity which is a high-risk behaviour leading to HIV infection. Alcohol damages the immune system and leaves the body vulnerable to HIV infection. It also depresses the immune system. It increases susceptibility to other AIDS-related diseases like tuberculosis (TB) (Plant in Sherr 1993:223-226). Shor-Posner and Miguez (2001:88) indicate that alcohol use may contribute to the impairment of the immune system and affect neurocognition. Alcohol use may increase replication of the HIV in the body and chronic alcohol users have higher viral load levels than non-drinkers who are infected with HIV. Because of the fact that alcohol affects the behaviour of the person, alcohol use affects adherence to treatment, and patients are not compliant with the medication and therefore, alcohol complicates treatment. Besides alcohol, crack is one of the major substances available in the rural and semi-rural areas of the Republic of South Africa.

2.5.3 Crack

Another substance which has a major contribution on the spread of HIV is crack. It has been found that it initiates some form of sex trade and women addicted to crack exchange sex for it. It activates the sexual drive and it prolongs sexual activity. While men under the influence of crack have been found to have difficulties in ejaculating, women who use crack experience dryness of the vagina, which often results in vaginal and penile bleeding during sex. This condition is conducive to the transmission of HIV (Campbell 1999:60). Nevertheless, open sores on the lips and tongues of crack users, which are the result of burns from hot crack pipes, are common and these facilitate the transmission of HIV/AIDS (Inciardi, Lockwood and Pottieger as quoted by Campbell 1999:60).

Amongst other factors which exacerbate substance abuse and high transmission of HIV/AIDS are the environmental factors which include high risk environments and urbanisation

2.5.4 Environmental factors in association with substance abuse and HIV/AIDS

There is a high level of substance abuse in rural areas. However, studies in the rural areas have not yet been well documented in the RSA. More research has been conducted in the urban areas because of its cost-effectiveness. High-risk environments such as urban areas and places where drug trafficking is prevalent have an effect on the usage of drugs and subsequently the HIV infection. In the urban areas, due to a high inflow of people including foreigners drug trafficking has become easy. (Rhodes, Stimson, Crofts, Ball, Dehne, and Khodakevich 1999:260-261; and Van den Hoek, Yuliang, Dukers, Zhiheng, Jiangting, Lina and Xiuxing (2001:756).

2.6 CONDOM USE AND THE SPREAD OF HIV/AIDS

Researchers reveal that in many countries, condom use is still low hence Witte, Cameron, Lapinski and Nzyuko (1998:350) indicated that more people need more information verifying the effectiveness of condoms. Researchers further noted that people often express greater religious and moral hesitation towards the use of condoms (Cecil et al 1999:169). A condom is a thin shield that is worn on the penis and the vagina. There are male and female condoms available for use during sexual intercourse. Condoms help to prevent sexually transmitted diseases including HIV/AIDS. Condoms trap the semen expelled from the penis during intercourse, preventing sperm from entering the vagina. There are many types of condoms such as latex, polyurethane and animal skin. Condoms can be lubricated, ribbed or treated with spermicides (EPIGEE: on line). However, people have different views towards condoms. The different views determine their use and non-use thereof.

One of the ways in which sexually transmitted infections including HIV/AIDS are transmitted is through sexual intercourse. Condoms are used as a means of safer sex. Wood and Foster (1995:14) assert that condom use is intimately linked to social construction of sexuality and gender as well as power relations operating between individuals. However, carrying condoms and condom use is perceived as a sign of promiscuity and infidelity among sexual partners (PANOS: on line); hence there is no consistency in condom use especially among people who use substances as well. Many researchers have revealed that there is low use of condoms in sexual relations

(Fusilier, Manning, Villar and Rodriguez 1998:208; Bentley, Spratt, Shepherd, Gangakhedkar, Thilikavathi, Bollinger and Mehendale 1998:1876 and Schwarzer and Fuchs 1997:261). Regardless of that Jacob Zuma, The Deputy President of the Republic of South Africa has contended that: "Apart from abstaining from sex, there is no better method to prevent a sexually transmitted infection than a condom (Sowetan 14 February 2002:16)". This is an indication that the invention of condoms has not only brought about negative views, it has also been viewed positively as well.

2.6.1 Condom use among married couples

According to Foreman (1999:ix); Mill and Anarfi (2002:326); Gysels, Pool and Nnalusiba (2002:180,182 and 190) and McDowell and Pringle (1992:3 &4) men are naturally promiscuous. In Africa as well as in other countries, generally, men are more likely to have two or more concurrent sexual partners. They are therefore, at great risk both of contracting HIV/AIDS and/or passing it on to their wives and other sexual partners. Although extra-marital affairs are socially sanctioned and commonly condoned for men in Africa, it is disapproved for women to have extra-marital partners. In many communities, there is approval for men to have as many sexual partners as they want whereas women are expected to observe high morals and to stick to only one partner. Men are essentially the heads of families while women are regarded as subordinates and dependents for their basic daily needs. Men are thus the decision makers and if they refuse to use a condom, women are in no position to argue or to deny them sex. Many men abhor condoms and women inevitably have little control over the use of condoms (Barnett and Blaikie 1994:3). In the African language only women may be labelled as adulterous and even be punished for it. The concept "adultery" is never applied to men and no man may be accused nor punished for extra-marital activity. Those who may be accused for extra-marital activities often get sympathy from the rest of the community. The only charge that may be laid against promiscuous men is responsibility for the maintenance of children who may be born to women other than their wives.

In an established relationship, the partners, in particular men are reluctant to use a condom. Married people delude themselves that they do not need condoms due to the fact that they have established fidelity and trust. As women are usually financially

dependent on men and are also subordinate to them, it is expected of them that they should surrender their lives by indulging in sexual intercourse without due consensus between the two partners. Laga et al (2001:932-933) contend that HIV is transmitted more easily from men to women than from women to men. Consistent condom use is the most effective way to reduce the likelihood of HIV being transmitted during sex between an infected and an uninfected person. Schoepf (1993:88 & 90) refers to results of a study which was conducted in Zaire (Democratic Republic of Congo) as he points out that African men often reject using condoms and state that condoms are an unnatural way of indulging in sex and also that they are inappropriate for use in regularly constituted relationships. On the other hand, women, regardless of their age and socio-economic statuses are unable to negotiate for the use of condoms during sexual intercourse, as they too believe that condom use symbolises lack of trust and infidelity.

2.6.2 Condom use among commercial sex workers

In the case of commercial sex workers, condom use is reportedly very low, as they fear that the paying partner might regard the sex worker as somehow untrustworthy or perhaps infected with HIV. Somlai et al (1998:16) and Cecil et al (1999:166) indicate that generally the response is to label any woman who may attempt to initiate condom use. Such women are often regarded as prostitutes. Condom use is viewed by some people as immoral in a relationship. It is associated with extra-marital sex and sex with prostitutes. (Auvert, Ballard, Campbell, Caraël, Carton, Fehler, Gouws, MacPhail, Taljaard, Van Dam and Williams 2001:889; Mill and Anarfi 2002:332; Sewpaul and Rollings 1999:260; Manhart et al 2000:1366 and Barnett et al 2000:1398). It has also been indicated that social norms are less favourable towards condom use (Janssen et al 2000:487). Some researchers have observed that condom use is a male controlled issue. The condom can only be used provided the male partner requests for one otherwise it is often a "flesh-to-flesh" exercise without any device for protection against sexually transmitted diseases. Researchers however, suggest that women should not just accept their fate but, they must use tact in negotiating condom use with their sexual partners.

2.6.3 Condom use among adolescents

Since many adolescents are sexually active, some researchers have taken a step further to find out about the consistency of condom use among young people. Their studies have revealed that there is a low use of condoms among adolescents generally. Even among those who do not have a steady sexual partner, condom use has been found to be inconsistent and low. Young people often prefer having numerous sexual partners disregarding the risks of being infected with HIV and even death (Buzi et al 1998:317; Colón, Wiatrek and Evans 2000:560; Vogel´s, Brugman, and Van Zessen 1999:376; Hubbs-Tait and Garmon 1995:558 and Melkote and Goswami 2000:95). Campbell (1999:31) remarked that first sexual intercourse occurs mostly at an early age and adolescents are inconsistent in their use of condoms.

2.6.4 Reasons advanced for not using condoms

People have different reasons for not using condoms. Several researchers have observed that respondents all over the globe advance similar reasons for not using condoms. Respondents in varying researches have described condoms as mere contraceptives rather than a means to prevent sexually transmitted diseases such as HIV/AIDS. Another finding by different researchers is that condoms are not regarded as 100% reliable, as a protective means, as they sometimes leak and some people may get infected with HIV while using them. Other people indicated that they do not use condoms as they fear that condoms might burst and cause injury, whereas others are concerned about the quality of available condoms in the market. Still others indicated that putting on a condom wastes time and that condoms make sex less enjoyable, and that they are offensive to sexual partners. A commonly advanced reason is that condom use is in conflict with some peoples` cultural values (Temin, Okonofua, Omorodion, Renne, Coplan, Heggenhougen and Kaufman 1999:188; Esu-Williams in Reid 1995:95; DeoCampo in Reid 1995:52; Nicholas 1998:893; Darrow 2001:268; Cecil et al 1999:169 and Manhart et al 2000:1376). In support of these findings Moore and Halford have mentioned the feelings that were expressed by respondents in their study as follows: "The idea of using condoms is like 'having a shower' in a raincoat. Condom use is difficult and it has a potential loss of sensation.

They are perceived as unromantic, their use imply promiscuity or lack of trust and/or commitment in the relationship".

The findings by Ross-Frankson in Reid (1995:88); Esu-Williams in Reid (1995:95); Nataraj in Reid (1995:36) and Moore and Halford (1999:161) indicated that some men pay an extra fee to a commercial sex partner if the condom is not used, as this device is regarded as alien. Women in particular however regard the condom as a useful contraceptive device which can only be used as long as one is not ready to fall pregnant. It is then discarded by those who need to fall pregnant as they regard it as a menace that may jeopardise their men's` pleasure. Black people regard condoms as 'white-men's-balloons' and therefore they are reluctant to use them. The inconsistent condom use is in relation to factors such as the person's behaviour, cultural background, socio-economic and educational status (Thuy et al 1998:431). Mayaud and McCormick (2001:141) have also stated that condoms are the best protective means against HIV infection however; there is low use of them.

Whereas condoms were invented as devices that could be effective in reducing the spread of sexually transmitted diseases and prevention of pregnancy, lack of interest in their use has resulted in the high birth rate as well as infection by sexually transmitted diseases including HIV/AIDS. All brands of condoms have been known to break during use. Breakage can happen even if the person does everything right. The only safer sex is abstinence or mutual faithfulness to an uninfected partner. Condoms reduce chances of infection, however, 1 in 3 AIDS victims will contract the disease from an infected partner despite 100% use of condoms (EPIGEE: on line). Wearing a condom will not protect one against contraction of the disease if exposed skin comes in contact with an infected person and/or object (B-FREE CONDOMS: on line).

With special reference to latex condoms, in the laboratory they have been found to be effective at blocking transmission of HIV because the pores in the latex condoms are too small to allow the virus to pass through. However, outside of the laboratory condoms are less effective because people do not always use them properly (AVERT: on line). Natural skin condoms are expensive and do not protect one against the infection (EPIGEE: on line). Polyurethane condoms are non-latex condoms. They are mostly used by those who are allergic to latex condoms (ABC CONDOMS: on line).

In an attempt to reduce sexually transmitted diseases including HIV/AIDS, the Health Department in the RSA has made condoms easily and freely available to all sectors of the community. Condoms are accessible for free even at the most remote rural areas. Those who prefer to buy may do so without restrictions. Nevertheless, information about the type, quality and risks embedded in using condoms should be made available to the community. The public should be well educated about condoms in order to avert the high transmission of the epidemic. Criticisms with regard to the lack of information on condoms and their setbacks have been brought forward by Dr Larsen who asserted that: " the truth about condoms should be made known, so people can make an informed decision before risking their lives by using them - they should have warnings printed on them, similar to those on cigarette packs" (Sowetan Sunday World, 21 July, 2002:24). Even the best made sheaths can have tiny pin holes, which is all it takes for one little sperm to get out or one little germ to get in. Condoms provide little protection against HIV/AIDS because they contain standard holes or voids of about five microns in size. HIV is 0.1 microns in size, or about 50 times smaller than the standard holes in latex rubber (BE-FREE CONDOMS: on line and Sowetan Sunday World 21, July, 2002:24).

Teaching about correct condom use is quite necessary. This requires extensive, well-designed instructions by professionals rather than cursory instruction [such as reading a pamphlet]. Condom use is a skill and it requires knowledge and actual practice (THE BODY: on line). However, the answer to South Africa's epidemic of HIV/AIDS is not continuing promiscuity with condoms, but a return to traditional standards of chastity and faithfulness in marriage. More money should be spent promoting "A for abstinence", "B for be faithful to your partner" and "C for change your behaviour instead of condomise" (Sowetan Sunday World, 21 July, 2002:24).

2.7 PROBLEMS WHICH HINDER PREVENTION AND TREATMENT OF HIV/AIDS IN AFRICA

There are many problems which hinder the efforts of the HIV/AIDS prevention and treatment programmes which are being run throughout the continent. These include dispelling myths harboured on HIV/AIDS in Africa, and changing attitudes towards HIV/AIDS patients

2.7.1 Myths harboured on HIV/AIDS cure in Africa

In Africa, many people believe that HIV/AIDS is curable. Several researchers have indicated queer myths. Procedures for the prevention and/or cure of HIV/AIDS are described. Some of these have resulted in a high spate of women and child abuse based on the reason that perpetrators want to prevent or be cured from the HIV/AIDS epidemic. Child and infant rape is associated with a high risk for HIV transmission especially where there is injury inflicted on the victim (MRC: on line).

In Uganda, a myth abounds that healthy women cannot be HIV positive. Ugandan men believe that female beauty is a protection against HIV infection and also that pregnant women cannot be infected with HIV hence the men are on the lookout for young girls and pregnant women as they believe that they will not be infected with HIV (Barnett and Blaikie 1994:45). In Mozambique, it is generally believed that a sick person can be cured by passing the disease to another. This belief has subsequently resulted in a high spate of rape of young females by men who have been infected with sexually transmitted diseases including HIV/AIDS. Gender power relations place girls at greater risk than boys for child sexual abuse and many children are subjected to or even forced into sex involuntarily (Campbell 1999:85). Children are at great risk of being infected with HIV (Masa, 01 March, 1999:3 and Janssen et al 2000:488).

In Ghana and in the RSA, some men are on the lookout for virgin girls and babies as they believe that young girls and babies are less likely to be infected with HIV/AIDS. In December 2001, a case of a five-month-old baby who was raped was brought for trial before a magistrate in Johannesburg. The perpetrator explained that he was HIV positive and believed that safer sex for him could be achieved by indulging in sex with a baby. Soon afterwards another report was published on another infant who had joined the harrowing list of abused babies - when a two-month-old baby was repeatedly raped in KwaZulu-Natal (Sunday Sun, 10 March, 2002:10). This myth needs to be discouraged as it is dangerous to both the children and men themselves (Mill and Anarfi 2002:327; San Reddy, Enews at 07h00, 3 December, 2001 and Shell and Zeithin 2000:148). Subsequently, other cases involving rape of babies have been reported in various newspapers, the radio and the television in the RSA. All these cases evolve around the myth of preventing or curing HIV/AIDS.

In South Africa, incidences of women and child abuse have been based on a variety of factors and myths. Galloway in (MRC :on line) asserts that " violence against women and children is a result of the much more basic problems of a society ' extremely brutalised by the political violence in the country's past', disruption of families, poverty, gender inequalities, a culture of male sexual entitlement and the lack of severe enough punishment and societal condemnation of rape"

Another myth which compounds the prevention and treatment of HIV/AIDS in the RSA, is based on the belief that HIV/AIDS is a disease which has been invented by whites in order to eliminate the black race. This then places prevention and treatment programmes at risk of not being successful in their mission as patients adopt a fatalistic attitude and are often reluctant to take treatment. The controversial issue is whether HIV causes AIDS and it is detrimental to HIV/AIDS primary prevention (DiClemente and Wingood in Umeh 1997:63 and City Press, 03 February, 2002:9). The misperception and misinformation about AIDS are the consequences about the way HIV/AIDS prevention messages are delivered (Klonoff and Landrine 1997:51).

2.7.2 ATTITUDES TOWARDS HIV/AIDS PATIENTS

People living with HIV/AIDS are often stigmatised and rejected hence they are unwilling to disclose their HIV (health) status and to seek assistance. Manhart, Dialmy, Ryan and Mahjour (2000:1378) observed that people who are suffering from HIV/AIDS (PWA) are stigmatised, isolated, rejected, and marginalized. Due to negative labelling against them. PWA tend not to disclose their HIV status and they harbour negative feelings, which make them prone to chronic stress. Such people are usually not well cared for. They are not treated humanely and are discriminated against due to their health status (Bor in Sherr 1993:141-144 and Lee, Campbell, and Mulford 1999:301). The culture of silence and fear of rejection and isolation that has developed around the disease causes infected people to refrain from disclosing their HIV status (Strydom 2000:196). Mayisa from Ga-Sekororo in the Limpopo Province has called on the public to break the stigma attached to HIV/AIDS and its patients and that people should disclose their HIV-positive status to the community. Malatjie cites Mayisa who said: "Breaking the stigma is the only way to conquer the HIV pandemic, which is decimating our population" (Capricorn Voice, 31 October-02 November, 2001:07).

The attitudes of society towards people with HIV/AIDS are negative and hostile. Cultural mores and values play an important role in preventing people from disclosing their HIV status because they fear being mocked, laughed at and/or reprimanded (O`Hare, Williams and Ezoviski 1996:51; Siegel et al 1998:450 and Wood in Bloor and Wood 1998:125). People living with HIV/AIDS are afraid to divulge their HIV status to their family members as they anticipate a violent reaction from them, They prefer to be silent about their HIV positive status in order to abate violence from significant others and the community at large. Many HIV victims have reported being ill-treated. They are beaten up, thrown out of their houses, abandoned, and sometimes killed because they are suffering from HIV/AIDS. Some women got stoned to death when they disclosed their HIV status and some who were employed were forced to resign when it was noticed that they were HIV infected. A woman was rejected by the father of her five-year-old son and her own family when she disclosed her HIV status (Sowetan, 21 February, 2002:6 and Campbell 1999:38).

These reactions from the significant others pressurise people living with AIDS (PWA) to keep their health status secret (Garcia-Moreno and Watts 2000:259; Erwin and Peters 1999:1523; Mill and Anarfi 2002:328 and Webb 1997:158-165). The victims of HIV/AIDS are regarded as people who are dirty. People believe that holding hands, using the same toilet seats and eating food prepared by a person who is infected with the virus and even sharing eating utensils with them can transmit the virus. The stigma is both attached to the people who are infected with HIV/AIDS and also the disease. People do not feel free to talk about it since they associate it with a curse from either God and/or gods. This prevents people who are infected to access and receive appropriate services available to them such as social support from their significant others (SAHR: on line). It is not only individuals who keep secrets about their HIV statuses but, even families too, keep secrets of their members who might be infected with HIV. Families keep the secrets from fear that the entire community might mock, isolate and eventually stigmatise them [Campbell 1999:160].

People living with AIDS are stigmatised, marginalized and isolated. They are also referred to as people who are immoral, promiscuous and non-religious (Jakobsen and Rice 1997:62; Woods and Ironsen 1999:408 and Lee, Campbell and Mulford 1999:301). Confidentiality and non-disclosure of HIV status occurs because of fear,

stigma and the taboo associated with HIV/AIDS. It is not pleasant for any person to be gossiped about nor to be singled out by other people because he/she is HIV positive (Antle, Wells, Goldie, DeMatteo and King 2001:162; Dubois-Arber and Haour-Knipe 2001:1535; Windal in Umeh 1997:16 and Foster and Williamson 2000:282).

2.8 CONCLUSION

The cultural elements that impact on the prevention and treatment of HIV/AIDS have been highlighted in this chapter. The researcher reviewed literature which indicates numerous elements which if not attended to might pose impediments in the primary prevention and treatment of HIV/AIDS. Socio-political and socio-cultural issues which have a bearing on HIV/AIDS have been alluded to as well as the myths that abound around prevention and treatment of HIV/AIDS and the attitudes of the society towards the HIV/AIDS victims. The succeeding chapter will focus on the analysis of socio-political, and socio-cultural elements that compound in the prevention and treatment of HIV/AIDS in the RSA, from a social work perspective.

CHAPTER THREE

AN ANALYSIS OF SOCIO-POLITICAL AND SOCIO-CULTURAL ELEMENTS THAT COMPOUND IN THE PREVENTION AND TREATMENT OF HIV/AIDS IN THE RSA: A SOCIAL WORK PERSPECTIVE.

3.1. INTRODUCTION

Aspirations of every community are to develop and become healthy and wealthy. Health behaviour is rooted within the society. The different communities vary according to their level of development, ethnicity, culture and their perceptions and attitudes of different illnesses, symptoms and causes thereof. Each community attempts to develop a health care system and prevention strategies that will help it to survive; hence there are different health systems and different strategies that are used in the different communities. HIV/AIDS prevention and treatment strategies should therefore recognise the culture of people they aim to service. In a sub-regional workshop of United Nations Educational, Scientific and Cultural Organisation held in Uganda (Kampala) participants realised the need to conceptualise the HIV/AIDS prevention/care programs into the cultural environment where people themselves are the key actors and beneficiaries. A cultural approach would enhance understanding of those aspects of culture that facilitate the transmission of HIV/AIDS, and design a culturally appropriate intervention programme to deter their effects (UNESCO :on line).

Generally people are fearful about HIV infection yet many are adamant to accept that it is their sexual behaviour that could lead them to being infected with HIV and could even cause them to die (Gomez in Herek and Greene 1995:20). There is a need for the multi-disciplinary approach in dealing with the scourge of HIV/AIDS. Social work intervention is appropriate in dealing with HIV/AIDS as it combines treatment with research and also serves as a link between a wide variety of therapists, clientele and resources (Bywaters and McLeod 1996:63).

The most obvious and inevitable benefit of effective preventative programmes, of course, is that the programmes reduce the number of people who die of AIDS and also stop the further spread of the virus (Bailey in Herek and Greene 1995:212 and Sandfort in Herek and Greene 1995:46). There are factors, which work against the prevention and treatment programmes, which are: poverty, migration, unemployment, socio-economic status of women, cultural, racial and environmental factors (SAHR: on line). The main constraint, which has been identified which works against the prevention and treatment programmes is the lack of cooperation from other professionals besides health professionals (SAHR: on line).

In this chapter, the political response to HIV/AIDS, the traditional medical system, HIV/AIDS awareness campaigns, and the role of the social work profession have been analysed in order to determine the impact of culture on the prevention and treatment of HIV/AIDS in rural areas.

3.2. POLITICAL WILL AND COMMITMENT AS ESSENTIAL FOR THE PREVENTION AND TREATMENT OF HIV/AIDS IN THE RSA

Presently, South Africa is the country with the highest number of people living with AIDS in the world (Piot 2001:3; Morison 2001:13; Sowetan, 28 December, 2001:8; and Financial Times, 18 July, 2002:6). It is noteworthy to understand that HIV/AIDS is as much a political, psychosocial, economic and cultural phenomenon as it is a biological one (Brown 2000:235; Mill and Anarfi 2002:326 and DiClemente and Wingood 1997:62). South Africa will continue to experience a high rate of HIV/AIDS prevalence as already seen in some other African states if politicians do not show political will and commitment to deal with the epidemic (Doyle, Mühr, Steinberg and Broomberg in Whiteside 1998:60).

In 1996, Uganda became the first African state to report a substantial decline in national HIV rates. In Sub-Saharan Africa, the majority of the states are still in denial over the existence of HIV/AIDS. Of all the countries in the Southern African Development Region (SADEC), the response of the South African government to the HIV/AIDS epidemic has been the one mostly characterised by denial, ministerial wrangling and lack of necessary resources. It has been muffled throughout by those

forces either resisting or pushing for political transformation. There are many public figures in South Africa who have HIV/AIDS and who do not feel safe talking about it or even acknowledging it. The fact that they do not acknowledge it often means they do not fight it properly (FHI: on line and Webb 1997:71).

There is need that the government should enlist and support the assistance of civil society and religious sectors in addressing the HIV/AIDS pandemic focusing on moral lifestyles (Masa, July, 2002:5). Because South Africa for many years has not responded positively to the HIV/AIDS epidemic, particularly from the political system, hence the high rate of the epidemic, researchers have to speak the language of the politicians if their results are to inform actions. Politicians and decision makers should be involved in the planning of research from the beginning till the end and also in the research itself (Pisani in Whiteside 1998:120).

The acknowledgement of the existence of HIV/AIDS by politicians will have a positive impact on the prevention and treatment of the disease. Some African heads of states have failed to acknowledge the presence of HIV/AIDS. Political will and commitment are the 'key ingredients' to fighting the disease successfully in Africa. By speaking out, leaders will demystify the disease and can permanently alter the 'norms, values and traditions that are fuelling the epidemic. Changing such behaviour is especially important in Africa because of its limited resources for medical interventions (Jogunosimi 2001:1). Leading politicians both in their personal and political portfolios have to recognise and accept that the disease exists. The most important action is to be aware of the epidemic and how it affects the society (IAFRICA: on line). Their involvement will help to mobilise the resources and fast-track implementation of preventative and treatment programmes.

However, it is clear that without top-level political commitment and mobilisation of resources, HIV prevalence will not decline. Political will is a necessary condition for the reduction and amelioration of the high incidence and prevalence of HIV/AIDS. Regardless of how good and effective preventative and treatment programmes might be, without political commitment, such good intentions and programmes of action remain mainly rhetoric and merely ideas, rather than deeds. Political leaders should swallow their pride and also put aside their (un) scientific theories regarding HIVAIDS.

They should wear the red ribbon as a sign of commitment (City Press, 25 November, 2001:18). Political will and commitment therefore, are the fundamental prerequisites for setting up either a national, provincial and local preventative and treatment response strategies to HIV/AIDS (Thomas and Howard in Whiteside 1998:107).

In the RSA, political will towards HIV/AIDS treatment has been shown by the Western Cape Premier, Mr Peter Marais who recommitted the province to wide scale use of anti-retroviral drugs and called for unity in the fight against AIDS (City Press, 17 February, 2002:10). It has been reported that politicians should go to war on HIV/AIDS. This must begin with an unequivocal acknowledgement that HIV causes AIDS (Sowetan, 07 February, 2002:7). The politicisation of the HIV/AIDS epidemic has severely hampered prevention efforts. There are billions of rands budgeted for HIV/AIDS prevention and treatment programmes but still, the country remains the hardest-hit by the disease world-wide (Webb 1997:112).

3.3. AN ANALYSIS OF INDIGENOUS TREATMENT PROCEDURES FOR HIV/AIDS IN AFRICA

Every individual's behaviour to a large extent is determined by the norms of a community (Kottak 1997:414, and Malama in Kasonde and Martin 1994:47). In Africa, traditional healing is still adhered to for many ailments and to a large extent some people believe that traditional healers can cure all ailments including HIV/AIDS. In Africa, the use of herbs for maintaining good health and treating diseases has been internalised, and has been used over a long period. Patients believe in the skills of the curer/healer whom they consult and compensate. There are many people who visit spiritual healers for HIV/AIDS treatment. Mjayezi (a medical practitioner) as quoted by Sesanti in (City Press, 03 March, 2002:18) commented that "Though it remains to be seen whether the spiritual healer's mixture can cure the disease or not, I am firm in the belief that the disease will be cured by a combination of African traditional herbs and western drugs".

The modern view emphasises western culture and its medical system while it negatively criticises the Traditional Medical System (TMS) in the third world. However, the World Health Organization (WHO) has recognised the need to incorporate the

traditional medical system in the health care system in order to accommodate the beliefs, traditions and culture of the various victims of HIV/AIDS. Good, as quoted by Schoepf (1993:93) indicates that the inclusion of African traditional healing into the health system could play a significant role in caring for persons living with AIDS. In different countries in Africa, traditional religious procedures have proven to be effective and helpful in providing solutions to presenting problems. In countries like Zambia, Zimbabwe, Botswana and Swaziland recently, people are being encouraged to integrate traditional healing into the formal health system. Indigenous cultural and traditional beliefs have been found to be more effective in dealing with the bio-psychosocial problems of indigenous people as compared to using only Westernised Medical Treatment (WMT).

The traditional medical system can, however, be positive or negative. Green et al in Joshi (2000:26) contends that traditional healers and their knowledge could be effectively utilised in developing empirical and culturally appropriate strategies for the prevention of sexually transmitted diseases including HIV/AIDS. Manhart et al (2000:1377) indicates that sometimes traditional prevention methods serve as a great barrier towards the HIV/AIDS prevention and treatment. These authors cite the following examples of traditional norms of preventing diseases:

- That people are taught to keep the genital tract warm and protect it from getting cold because it is believed that HIV/AIDS is caused by coldness
- People are forbidden to urinate in the streets and convention insists that people should take a bath after making love and stay covered
- Sharing of undergarments is also forbidden
- The spot where one has sat in the public bath must be cleaned
- Most importantly, people must always consult with the herbalists after making love

People engage in traditional religious practices such as sacrificing to ancestors, going on pilgrimage, prayer and appeasements of spirits to bring about healing within the confinements of their traditional beliefs. Religious leaders also intercede with the dead in the treatment of sick people. It is a universal belief that supernatural spirits punish individuals for unacceptable behaviour. (Kottak 1997:417; Joshi 2000:26; Rey 1997:176; Webb 1997:72; Muller and Steyn 1999:142; Erwin and Peters 1999:1526;

Feldman et al (1997:457); Woods and Ironson (1999:394; and Siegel et al 1998:450-451).

3.4. AN ANALYSIS OF THE EFFECTIVENESS OF HIV/AIDS AWARENESS CAMPAIGNS

There is a need for awareness campaigns on HIV/AIDS especially in the rural areas of the RSA. Research findings by Thuy, Nhung, Thuc, Lien and Khiem (1998:426) on the knowledge, attitudes, beliefs, and practices related to HIV/AIDS have revealed that there is a dearth of knowledge about the HIV/AIDS epidemic and high-risk behaviours in the developing countries. General knowledge about the causes of HIV infection is poor or totally lacking amongst people in the developing countries (Peltzer 2000:1065 and Sureender, Guruswamy and Verma (1997:604).

With regard to HIV/AIDS awareness campaigns, little has been done. The success of HIV/AIDS educational programmes depends upon how effectively the cultural norms of each ethnic group are incorporated into the programme designed for such people. There is a need for dramatic changes in sexual and reproductive behaviour in many less-developed countries in order to defeat the HIV/AIDS epidemic. Although awareness has been raised, it is poignantly evident that this knowledge has not yet been effectively transformed into sustained behaviour and attitudinal change hence the alarming escalation of HIV/AIDS (Mhloyi in Reid 1995:18 and Sowetan, 25 June, 2002:11). Arguments have been advanced in support of, as well as in opposition of HIV/AIDS awareness campaigns.

3.4.1. Arguments in support of HIV/AIDS awareness campaigns

HIV/AIDS awareness campaigns are used all over the country in an endeavour to alert people about the harmfulness of the disease. Other focal points are teaching people about how HIV is transmitted, protective measures on HIV/AIDS and how to treat already infected individuals. Some researchers have indicated that there is poor knowledge about sexually transmitted diseases including HIV/AIDS. There is also a misunderstanding about the personal risks of HIV infection (Peltzer 2000:1065 and Tawil et al 1999:243). In support of this view, Fusilier et al (1998:203) also contend

that there are insufficient prevention services and there is violation of human rights for people living with HIV/AIDS. Being insensitive when delivering preventative messages on HIV/AIDS often leads people to disregard educational programmes not to take them seriously because people might be fearful of being discriminated against by being ill-treated and stigmatised (Krause, Jones and Purdin 2000:186).

It is also equally important for HIV/AIDS awareness campaigns to help to modify the behaviour of those who have already acquired the virus to ensure that there is no further spread of the pandemic. HIV/AIDS awareness programmes should bear in mind that sexuality and health seeking behaviours are determined by social and cultural settings in which people live. Planned educational strategies to empower people to initiate change of behaviour must consider people's cultural background (Campbell and Hayes 1998:1; Huszti et al 1998:508). For HIV/AIDS awareness campaigns to be effective, they should be culturally sensitive. Promoting public awareness on HIV/AIDS and providing life skills training, are the focal points towards HIV/AIDS prevention. Such awareness programmes should be focussed on behaviour change and must be based on the premise that HIV causes AIDS (DOH: on line). There is therefore a need for regular campaigns and conscience raising among all sectors of people with regard to issues around HIV/AIDS.

3.4.2. Arguments against HIV/AIDS awareness campaigns

With no prospects of HIV/AIDS vaccine in the foreseeable future, HIV/AIDS prevention and treatment require sustained efforts of social mobilisation towards healthier and safer sexual behaviour (SAHR: on line). This is supported by Dr Jon Larsen (in the Sowetan Sunday World, 21 July, 2002:24). He also observed that campaigns for 'safe' sex might boost promiscuity. He indicated that programmes, which emphasise the use of condoms and explicit sex education to limit the spread of HIV, could be counterproductive. He argued that explicit sex education in its entire mission, with plastic penises having condoms rolled on them, is erotic for young people. Such type of programmes instead of delivering the desired behaviour with special reference to the young people, might influence them to experiment with sex and that is a high-risk behaviour for HIV infection. Moreover, research conducted by Livingstone (1998:781) indicates that awareness campaigns do not always have a positive effect. He

maintains that people generally take risks and that risky behaviours frequently continue despite such awareness campaigns. Even people with great knowledge sometimes engage in high-risk behaviours such as unprotected sex.

3.4.3. HIV/AIDS awareness campaigns targeting the youth

Adolescents are under tremendous pressure to have sex at an early age. South Africa has one of the highest levels of reported rape in the world, and violence against women is commonplace. In South Africa, 30 percent of young women indicated that their first sex was coerced. In Carltonville in South Africa, six out of 10 women, aged 20 – 25 years were found to be HIV infected. Male adolescents often tolerate or even condone sexual coercion. Young women too may view sexual violence or sex that is obtained through force, fear or intimidation as normal (Jogunosimi 2001:1; MacPhail, Williams and Campbell 2002:331; Rutenberg, Kaufman, Macintyre, Brown and Karim 2002: 8 – 9, United Nations 1998:173, Department of Social Development 2002:131 and UNFPA 2003: 21 & 25). Services of HIV/AIDS educational programmes should be rendered considering age differences among people and peer involvement could enhance the programmes efficacy (DiClemente and Wingood in Umeh 1997:68). With special reference to young people, HIV/AIDS awareness programmes are necessary provided they are augmented with sex education. Adolescents are at an increasing risk for HIV infection from heterosexual transmission and particularly those who are between 15-19 years old (Stine as quoted by Campbell 1999:10 & 17 and Masa, July, 2002:5).

Youth in Africa face fast growing rates of infection with HIV and other STD's. Countries like Botswana, Lesotho and South Africa have the highest incidence of HIV infection among the youth in Africa. Young people account for half of all new infections among the infected population - 6000 new infections every day. Sexual health attitudes and behaviours greatly affect adolescents' risks of infection. In Sub-Saharan Africa, as in other regions of the world, a culture of silence surrounds most reproductive health issues. Many people are uncomfortable to discuss about sexuality with the youth though others might be lacking accurate sexual health information. It was found that many Africans are unable to discuss sexuality across barriers of gender and age differences and as such they could not provide sexually active youth with condoms.

Youth in Africa have been socialised to believe that men are biologically programmed to need sexual intercourse with more than one woman. Polygamy is a central, social institution that reinforces this belief. Some youth have been sexually coerced at as early age as 10 years and awareness campaigns should be sensitive about such occurrences. It has been found that youth who had better education were far likely to experience casual sex and to use condoms for casual sex when compared to less educated youth. HIV/AIDS prevention services need to be prioritised for youth (Jogunosimi 2001:2 and Sowetan, 11 July, 2002: 8). Awareness campaigns should specifically target young women as they are disproportionately affected by HIV/AIDS. Half of all HIV infections worldwide occur in women in Africa. In Carltonville in South Africa, female youth in their 20's were found to be three times HIV infected higher than men. Kofi Annan-Secretary General of the United Nations, when addressing the African summit in Abuja in April 2001 said, " adolescent girls are six times more likely to be infected by boys" (Sowetan, 14 March, 2002:12 and Jogunosimi 2001:2). Every young person is curious about sex and there is always some kind of reaction to sexual issues. Young people want to experiment with sex as sex is tempting. It has been revealed that at Ga-Sekororo in the Limpopo Province, 20 people predominantly youth are buried every month because of HIV/AIDS (Capricorn Voice, 31 October-02 November, 2001:7).

Young people who are well informed, who know the consequences of indulging in sex prematurely are in the stronger position of not engaging in casual sex and are able to resist peer pressure (Margow 1999:83). Involvement of young people is a positive strategy towards the prevention of the epidemic. The focus should be on young people. Making investments in the well being of the youth and engaging them in the fight against HIV/AIDS has proven to be effective (UNICEF: on line).

3.5. SOCIAL WORK INTERVENTION IN THE PREVENTION AND TREATMENT OF HIV/AIDS

There is a dearth of information with regard to intervention methods with special reference to the HIV/AIDS pandemic (Fransen in Whiteside 1998:6). The social work profession has many roles to perform both in the prevention and treatment of the HIV/AIDS epidemic. Amongst other roles to be included are the following: The human service broker, the role of the teacher, and social change agent (Sheafor, Horejsi and

Horejsi 1994:17, 18 & 25). In fulfilling his/her roles, the social worker can serve to draw the attention of people to available services on HIV/AIDS (Broker), involve people in educational programmes on HIV/AIDS (Teacher) and mobilise government and private institutions in enacting of policies pertinent to HIV/AIDS prevention and treatment programmes (Social change agent). Social work practice generally has the potential to contribute to the promotion of good health, prevention and treatment of illness and to care for the people who are living with ill health (Bywaters and McLeod 1996:50).

The social worker in the realm of HIV/AIDS must help the victims to develop positive thinking and inner strength to facilitate and enhance their social functioning (Marcenko and Samost 1999:42). With special reference to cultural factors which work against prevention and treatment of HIV/AIDS, social workers are better able to intervene as their training encapsulates all facets of human beings. Yet the cultural values, beliefs and practices, which have been developed and shaped by socialisation, may pose a threat to the prevention and treatment programmes (Suarez and Siefert 1998:7 & 9). These authors further point out that social workers must use their full range of intervention skills, from individual client-centred interventions to programmes designed at the community level and finally at the broader social policy-focussed approaches. In this regard the social worker plays a role of a *social change agent* whereby the main purpose would be to identify individuals and communities who are assailed by the pandemic, and work together with the community members and policy makers using the intervention research approach towards the alleviation of the problem.

By familiarising themselves with cultural, economic, political, religious/spiritual and other barriers towards the prevention and treatment of the HIV/AIDS pandemic, social workers can assist to increase access of under-represented people such as women and children, the unemployed and also the poor within the society, to the prevention and treatment programmes. In this regard, social workers consider socio-cultural factors such as kinship ties, peer-support groups, gender and race. They also tap potential resources, which would be of help to HIV/AIDS people (Williams and Boykin 1999:37 & 45). Social workers assist the society in changing its negative behaviour towards people living with HIV/AIDS. They are in the forefront of educating people in order to eliminate and reduce the escalating spread of HIV infection. Furthermore, they play a role in providing supportive services by being sensitive, empathetic and

instilling hope in the lives of the victims. Social work services are also essential when it comes to counselling people before and after taking HIV tests (pre-test and post-test counselling) (McMahon 1996:74, Poindexter and Linsk 1999:57 and Heath and Rodway 1999:52). This task is not easy as resistance amongst people living with HIV/AIDS (PLWHIV and PLWAIDS) to disclose their health status. Social work services are very much important in assisting people living with HIV/AIDS as they grapple with issues of HIV/AIDS disclosure as they might think of ramifications of disclosure in coping with the reactions of others. HIV/AIDS disclosure can result in a loss of social support from significant others and the community at large. Social workers may assist with stigma management and controlling information disclosure by helping victims with regard to whom to tell; they also make support more accessible and relevant to the victims (Marcenko and Samost 1999:42 and Poindexter and Linsk 1999:56).

The social work profession considers human diversity in its practise and it is guided by professional values, principles and ethics. This implies that the social worker must understand the people's problems in their entirety as this includes the culture of people and its effects on the development and the functioning of the people specifically with the effects of social institutions on human behaviour. Understanding of human behaviour within a specific environment enables the social worker to respect people regardless of their places of origin, religious background, intellectual abilities, age differences, sexual orientations, and gender differences. The cardinal values are that social workers engage themselves in developing as well as utilising resources to the advantage of the clients. When helping clients, social workers respect the worth and dignity of clients. This implies respect of intrinsic worth irrespective of the person's past or present behaviour. Since people are different, social workers affirm their uniqueness and individuality in the helping process (Hepworth and Larsen 1993:53).

Social workers are trained to be empathetic with clients/patients. This helps to facilitate and bring some change in clients/patients lives. It makes a major difference for people with HIV/AIDS to have at least one confidant whom they can turn to and share their fears and concerns. Social workers provide encouragement, and a positive atmosphere, which help to improve the well being of patients (Remien and Rabkin in Herek and Greene 1995:178).

Prevention should focus on containment and enhancement of an individual's functioning, within interpersonal, social and physical environments with an aim of reducing significantly emotional, social, political, physical, and economic risk conditions (Lurie and Monahan 2001:71). Prevention programmes are most effective when they are based in the community; and also have the commitment of the community, use the language with which the community is comfortable with and understandable to them, come from and are offered by people who are trusted by and are representatives of the community (Miller, Turner, Moses and Valdiserri as quoted by Bailey in Herek and Greene 1995:214). Mechanic (1998:874) asserts that " health promotion and disease prevention depend on a population perspective that allows for the identification of risks and the mobilisation of protective and remedial interventions for both the individual and the community" It is against this background that social work intervention in the prevention and treatment of HIV/AIDS is needed. Social workers are in a position to help in the realm of HIV/AIDS since they are also able to operate in the multidisciplinary team.

People who are infected with HIV/AIDS are still capable of taking decisions pertinent to their health for change and growth. Professional social workers are not allowed to divulge information shared with clients except for professional purposes. The main function of the social worker is to mobilize the communities to address and speak out on the presenting disease (Johnson 1995:8 & 46 and Sheafor, Horejsi and Horejsi 1997:67-68). Social work therefore becomes one of the relevant professions in addressing HIV/AIDS issues as the intervention research model provides a service of both educating the people and also involving them in solving their own problems.

3.6. CONCLUSION

For effective and successful implementation of HIV/AIDS prevention and treatment strategies, a cultural approach to HIV/AIDS is essential. The cultural approach is inclusive of all spheres of human behaviour starting from political, economic, religious and socio-cultural aspects. Without professionals who are well conversant with a specific culture in a specific environment, prevention and treatment methods of HIV/AIDS will become a futile exercise.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The lifestyle, beliefs and attitudes of the people in Malamulele were subjected to scrutiny by the researcher. The Design and Development (D & D) model by Rothman and Thomas, which is commonly known as intervention (participatory) research has been used in this study. This model entails six phases, however, in the current study only the first two phases of this model were accomplished viz: Phase 1; Problem analysis and project planning and Phase 2; Information gathering and synthesis. In phase 1, the researcher together with the respondents through preliminary discussions have explored and identified the problem, which was the impact of cultural elements on the prevention and treatment of HIV/AIDS among the rural people. The researcher then began planning for the research project which entailed developing aim and objectives of the study, assumptions upon which the study would be based, research design and sampling methods. In phase 2, the researcher developed a research instrument for data collection and subsequent analysis and interpretation of the findings of the study. Respondents in this study provided information on their awareness of and beliefs about HIV/AIDS while they gained more information on the subject and their conscience was raised on many issues they took for granted.

Both qualitative and quantitative data was gathered, as a questionnaire was administered first and subsequently the respondents were subjected to focus group and round-table discussion sessions which enabled respondents to freely express themselves and to listen to each other's views about the impact of culture on the prevention and treatment of HIV/AIDS amongst the rural people. In this way respondents were exposed to some questions and information, which helped them to be aware of various issues about HIV/AIDS. Data was collected from three types of resources, which were as follows:

- The first sample comprised of youth (learners). A sample of 243 high school learners who were in grades 11 and 12 was randomly selected from 3 high schools in Malamulele. A questionnaire was administered to the learners and the researcher subsequently facilitated 19 focus group discussion sessions each with 12 – 13 learners. The questionnaire that was administered to learners included a section on the youths' sexual behaviour, and knowledge, attitudes and perceptions on HIV/AIDS.

- The second sample comprised of adults (parents of some learners). A sample of 23 adults whose age ranged from 31- 60 years responded to letters of invitation to participate in the study. The respondents demonstrated concern about the problems that assail their adolescent children and youth in general with regard to the HIV/AIDS pandemic. Two focus group discussion sessions were held with this group of respondents on the impact of cultural elements on the prevention and treatment of HIV/AIDS. The questionnaire administered to this group of respondents focused only on knowledge, attitudes and perceptions on HIV/AIDS.

- The third sample comprised of community and traditional leaders (cultural leaders). A sample of 11 cultural leaders was selected randomly on the basis of their willingness to participate in the study. Two informal group discussions were held with this group of respondents. The same questionnaire that was administered to the second sample (parents) was administered to the third sample too.

In this chapter, the data has been presented in the form of figures, tables and graphs. It has also been analysed descriptively and statistically in the sense that each table and figure is followed by some description, which indicates responses in statistical form, and the researcher's own interpretation of the data. The presentation comprises three sections, namely: section A – demographic factors of all respondents, section B – youth sexual behaviour, section C – knowledge about HIV/AIDS and section D – attitudes and perceptions about HIV/AIDS.

SECTION A

4.2 DEMOGRAPHIC FACTORS OF ALL RESPONDENTS

In this section, only data which pertains to demographic factors of learners, parents and traditional/cultural leaders has been analysed. Respondents were from three selected low-resourced (rural) communities which are: Mapapila, Matsakali and Gidja-Mhandzeni. Learners who participated in this research too, were selected from secondary schools within these communities in the Malamulele district.

4.2.1 Demographic factors of the learners

In this sub-section, factors which classify people in terms of strata have been presented, analysed and interpreted as a way of exploring the impact of culture on the prevention and treatment of HIV/AIDS among rural people in the Malamulele district. The rationale for concentrating more on youth in this study was to avoid confusion, which could arise due to different viewpoints held by younger and older people with regard to the impact of culture on the prevention and treatment of HIV/AIDS among people in low-resourced areas. Demographic factors, which were explored in this study, focused on age, gender, marital status, religious, educational and economic background of the respondents.

4.2.1.1 Age differences of learners

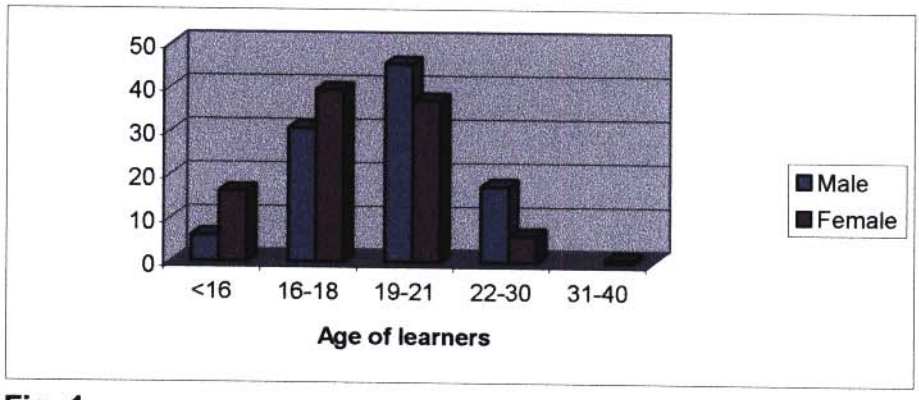

Fig. 1

Figure 1 above indicates that respondents whose age was less than 16 years, were 6.1% males and 16.3% females; while those between 16 and 18 years, were 30.7% males and 39.5% females. Respondents whose age was between 19 and 21 years were 45.6% males and 37.2% females; while those whose age was between 22 and 30 years were 17.5% males and 6.2% females. With regard to those respondents whose age was between 31 and 40 years, there were only females who comprised 0.8% of the sample. The majority of the respondents were below the age of 22 years (82.4% males and 93.0% females). This study shows that in low-resourced areas like Malamulele, there are still learners whose ages range between 22 and 35 years, who still attend at high schools. Most of the older participants were found to be married and the younger participants did not seem perturbed by the wide age difference of their fellow learners. An interesting observation that was made was that most of the female learners had children and some were staying with their spouses even among the younger and unmarried participants. Whereas the researcher had initially targeted a sample of 300 respondents of 16 – 20 year old learners, he however, accommodated all the grade 11 and 12 learners who were willing to participate in the study after being selected randomly from the three participating high schools. The final sample comprised 243 respondents (learners). The researcher being 27 years old then, was accepted by the learners as a peer educator, as he too spoke the same language with the respondents, came from the same area and had been in the same initiation school with at least some of them. "Young people respect wisdom, especially when it involves people like them who have been through or have learnt from others who have been through a difficult situation" (UNODC: 2003:12).

4.2.1.2 Gender differences of the learners

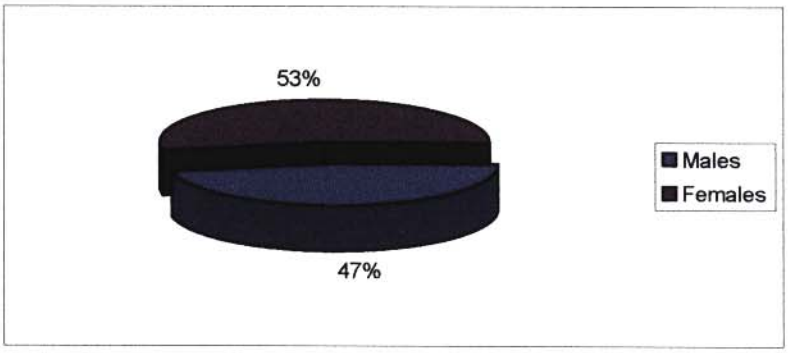

Fig. 2

The sample was heterogeneous in nature, as indicated in Figure 2 above. It comprised of both males and females. There were more females than males. Males constituted 47% of the sample while females constituted 53%. The high percentage of female participants is in keeping with the RSA statistics, which indicated that there were more females than males in the Limpopo province. Statistics from the 1996 census indicate that there were 2.6 million females and 2.2 million males (STATISTICS SOUTH AFRICA: on line).

4.2.1.3 Data on the marital status of learners

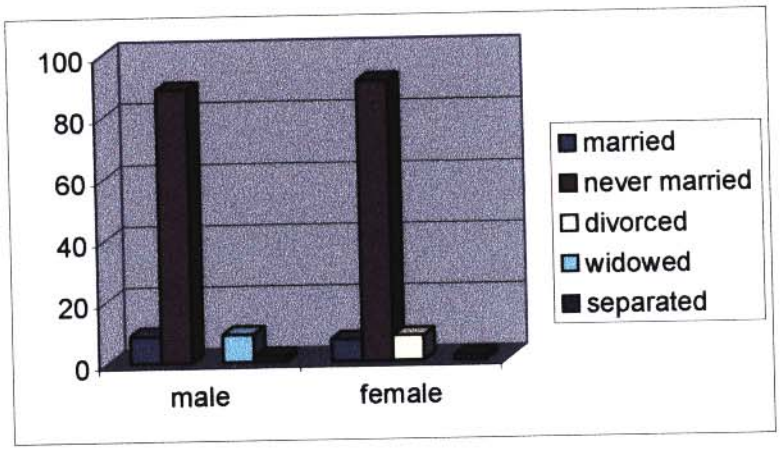

Fig. 3

As the respondents were high school learners, it was interesting to note that almost 16% were married. Of these, 8.8% of the males and 7.0% of the females in the sample were married and still living together with their spouses. Whereas 0.8% females were divorced, 1.8% were separated from their spouses. 0.9% males were widowers. It is important to note that 1.8% males and 1.6% females were separated from their spouses. The majority of the respondents (88.6%) males and (90.7%) females had never been married, yet during focus group discussions many indicated that they were living with some spouses (boyfriends/girlfriends) and that they had children. Indeed many of the high school learners in grades 11 and 12 were themselves parents. The majority of people in Malamulele are in cohabitation and this lifestyle seems acceptable and actually encouraged for young people. The youth describe themselves as "Vana va ximanjhemanjhe" meaning children of this era. Many learners leave their children in the

care of their parents, grandmothers or some caretakers while they go to school. Clearly modern youth want the pleasures of both the adult world (bearing children) and financial support from their parents (as children). "young people, no matter what their ethnic background, have a unique culture that is appropriate to their particular peer group in that particular time and space" (UNODC 2003:14).

4.2.1.4 Religious data of learners

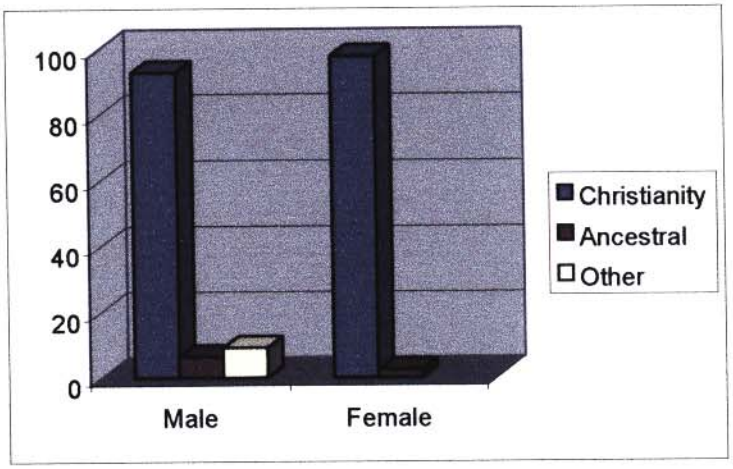

Fig. 4

The majority of the respondents indicated that they were Christians (92.9% males and 97.7% females) while 6.3% males and 2.3% females were traditionalists who believed in ancestral worship. Only 0.8% males indicated their religion as neither Christian nor ancestral. The latter group however, did not indicate their religious affiliation. Though Malamulele is a rural community, with regard to religion, Christianity for both male and female learners seems to dominate more than other religions due to the fact that if for instance a person venerates his/her ancestors, he/she would be viewed as uncivilised and demonic and none of the respondents wished to be associated with that. In the absence of recreational facilities, the role of the church seemingly is recreational. The church offers opportunities for "togetherness", music and testimonies hence a large number of youth who attend ignore the moral values that are emphasised by the church.

4.2.1.5 Christian affiliation of learners

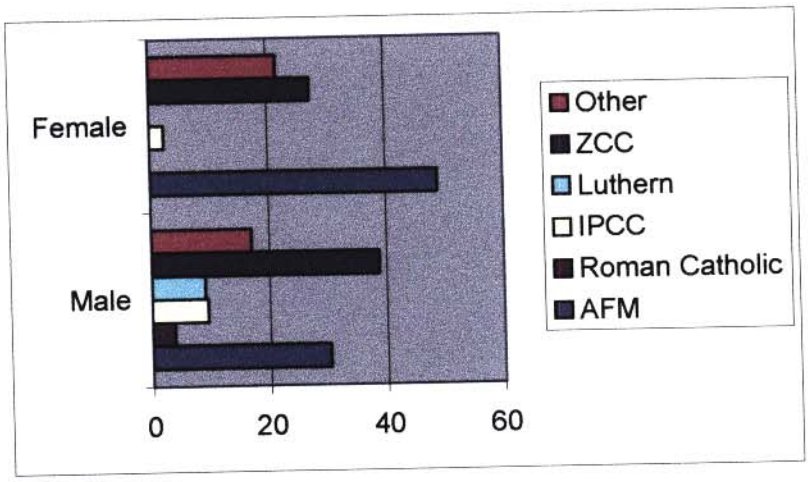

Fig. 5

As there are a variety of Christian denominations, respondents reported their denominational affiliation as indicated in Figure 5 above. It was interesting to note that only males attended the Roman Catholic Church (3.8%) and the Lutheran Church (9%) whereas the Apostolic Faith Mission (AFM) had members of both genders (30.2% males and 48.8% females). The Zion Christian Church too was reportedly attended by 38.7% males and 27.2% females; whereas the International Pentecostal Christian Church (IPCC) was attended by 9.4% males and 2.4% females while 17% males and 21.6% females did not indicate their church affiliation. In the past before other Christian denominations came into existence, the Apostolic Faith Mission was more visible and prevalent under the leadership of Pastor Bonke and that is the reason why more learners were members of this church. Whereas the ZCC, is one of the fast growing churches in South Africa and the Malamulele area is no exception hence the significantly large number of the ZCC members in this area.

4.2.1.6 Educational levels of learners

Table 1. Grade level of respondents

Grade	Number of Males	% For Males	Number of Females	% For Females	Total Number	Total %
11	80	70.2	102	79.1	182	74.9
12	34	29.8	27	20.9	61	25.1
Total		100		100		100

N= 243 (100%)

The majority of the respondents were in grade 11 (70.2%males and 79.1% females); while grade 12 learners comprised 29.8% males and 20.9% females. The researcher selected respondents from both grades 11 and 12 so that the data gathered would be representative of senior learners who were sexually active. It was interesting to note that a significant number of female respondents (girls) were gaining access to education, closing the gap with males. Female learners were often withdrawn from school and kept at home because they were seen to be vulnerable to premarital pregnancy which goes against social norms (UNFPA 2003:8-9).

4.2.1.7 Economic status of learners

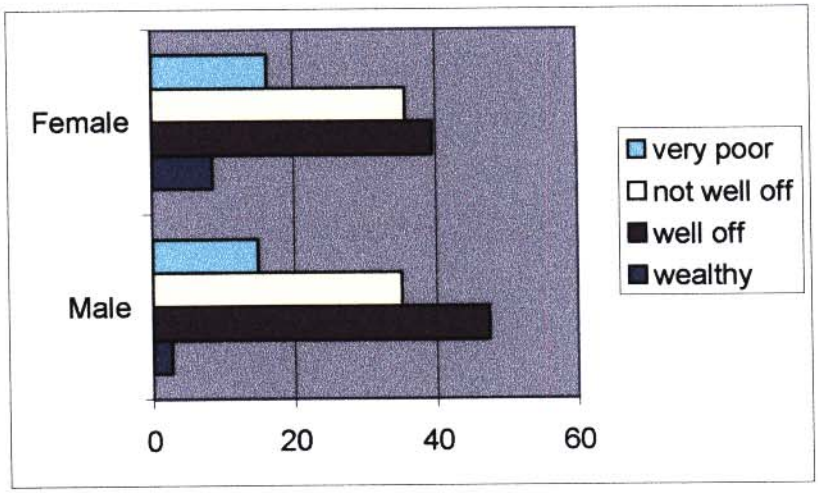

Fig.6

Respondents assessed their family economic status on a four-scale rating from very wealthy to very poor as indicated in figure 6 above. Whereas 8.5% females rated their families as very wealthy, only 2.6 males regarded their families as very wealthy. Nearly half of the male respondents (47.4%) and two-fifths (39.5%) of the females regarded their families as well off (middle class); while about one-third of both males and females (35.1% and 35.7% respectively) regarded their families as not well off. Quite a substantial number, (14.9% males and 16.3% females) rated their families as very poor. Clearly above half (50% males and 52% females) came from poor and very poor families, while the other half (50% males and 48% females) came from middle class to wealthy families. The Malamulele area is a rural setting with a high unemployment rate hence the majority of people live below the poverty datum line. Employment opportunities of parents have both direct and indirect effects on the quality of life of learners including sexual and reproductive health and rights (UNFPA 2003:8). The learners who mentioned that their parents were wealthy or well off, might be those learners whose parents were working in Gauteng or other provinces, as Limpopo is not an industrial province but an agrarian province hence the majority of people earn a living through subsistence farming. The understanding of the concept of "being wealthy" or "well off" to some learners might have been a status symbol which merely indicates having enough to eat and being satisfied

with what one could afford to wear. Under general no parents ever discuss their finances with their children in the Malamulele area.

4.2.1.8 Language proficiency of learners

Table 2. Indicating language proficiency of learners

Language	Number Of Males	% For Males	Number Of Females	% For Females	Total Number	Total Percentages
Xitsonga	114	100	129	100	243	100
TshiVenda	13	11.4	5	3.9	18	7.4
Sepedi	12	10.5	-	-	12	4.9
Afrikaans	19	16.7	14	10.9	33	13.6
English	31	27.2	25	19.4	56	23.0

N = 243 (100%)

All respondents were proficient in some other languages too, besides their mother tongue which is Xitsonga. Whereas all respondents indicated that they could read and write Xitsonga, 11.4% males and 3.9% females could read and write Tshivenda too and 10.5% males were proficient in Sepedi as well. Both males (27.2%) and females (19.4%) were proficient in English whereas 16.7% males and 10.9% females were proficient in Afrikaans. This is an indication that some learners could understand pamphlets, videos

and other educational material presented in languages other than Xitsonga. It was however, interesting to note that more than 75% high school learners within a system that teaches in the medium of English regarded themselves as not proficient in the language. This then probably means that learners would prefer to be provided with information in their mother tongue. There was a low percentage of learners who mentioned that they could communicate in other languages. The reason might be that in the family, the father and/or brother might have married a woman from a different ethnic group, as there are no longer laws prohibiting cross-cultural marriages.

4.2.2 Demographic factors of the parents

In this sub-section, the sample of adults (parents) who participated in this study has been analysed with regard to their age, gender, marital status, religious background, educational and economic background. These factors would enable the service providers in the field of HIV/AIDS when rendering preventative and treatment services to know for instance which age group and/or gender is resistant and/or what factors could influence or delay quick service rendering.

4.2.2.1 Age differences of parents

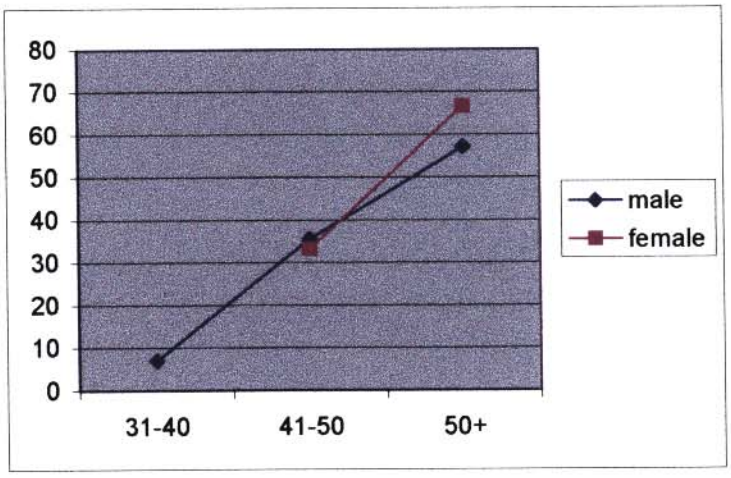

Fig. 7

The sample comprised 7.1% males only in the 31 – 40 years age group and 35.7% males and 33.3% females in the 41 – 50 years age group as well as 57.1% males and 66.7% females whose ages ranged from 50 years upward. The majority of the parents were in the middle to late adulthood phase, hence their concern about their adolescent children's problems and problems manifested by youth in general.

4.2.2.2 Gender of parents

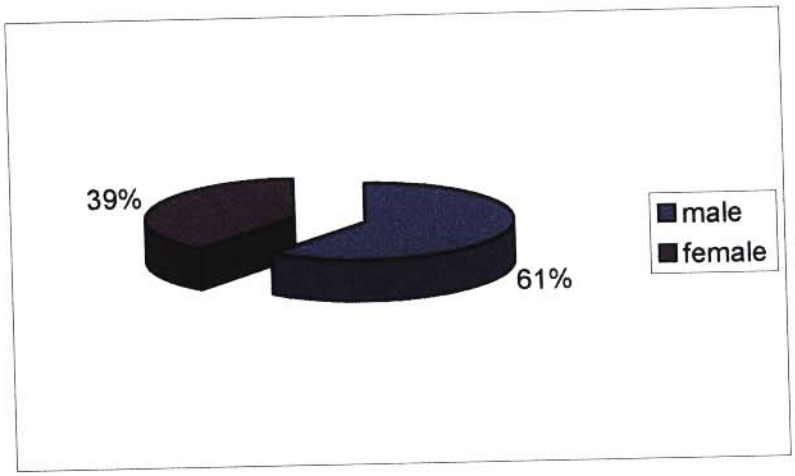

Fig. 8

The total number of the parents with whom the researcher had discussions on the impact of culture on the prevention and treatment of HIV/AIDS N =23(100%), of which 15(61%) were males and 8(39%) were females. As the researcher had sent letters inviting parents to participate in the study, more males responded than females. The reason being that the researcher is a male and for male parents it would be easier to communicate with him even about sexual matters whereas it would be difficult for females to discuss sexual issues with the researcher, hence a low number of female respondents. It is still common in Malamulele that discourse of any matter around sexual matters is abhorred between the elders and the young people.

4.2.2.3 Marital status of parents

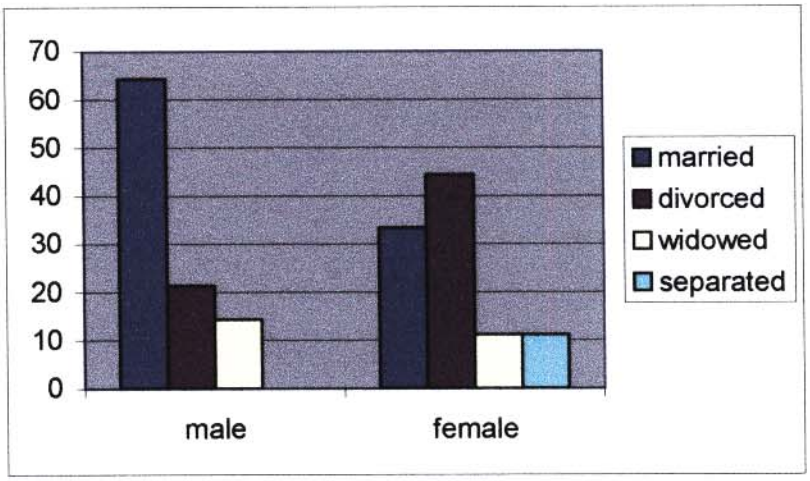

Fig. 9

Respondents who were married were 64.3% males and 33.3% females. Parents who were divorced were 21.4% males and 44.4% females while those who were widowed comprised of 14.3% males and 11.1% females whereas another 11.1% females were separated from their spouses. Clearly, about two thirds of the female respondents were single parents who had little control over their adolescent children. It is therefore not surprising that their children too, were going the same route of being single parents, as they themselves had children and some were in cohabitation with boy/girlfriends.

4.2.2.4 Religious data of parents

Table 3 indicating religious affiliation of adult respondents

Religion	Number Of Males	% For Males	Number Of Females	% For Females	Total Number Of Parents	Total % Of Parents
Christianity	8	57.1	5	55.6	13	56.5
Ancestral worship	6	42.9	3	33.3	9	31.9
Hinduism	-	-	1	11.1	1	4.3
Muslim	-	-		-	-	-
Total	14	100	9	100	23	100

N = 14 (100% males)

N = 9 (100% females)

N = 23 (100% both sexes)

Table 3 above indicates that Christian parents were in the majority, whereas there were no Muslims. There were 57.1% Christian males and 55.6% Christian females. Those who venerated their ancestors comprised 42.9% males and 33.3% females. Only 11.1% of the female parents indicated that they were Hindus. Since white people came to South Africa, people were indoctrinated into Christianity for benefits such as schooling, jobs and mobility. As Christians, who abhorred unbelievers commonly known as "heathens", dominated educational institutions and employment opportunities, many Africans adopted the Christian faith out of fear of prejudice in such institutions.

4.2.2.5 Data on the Christian affiliation of parents

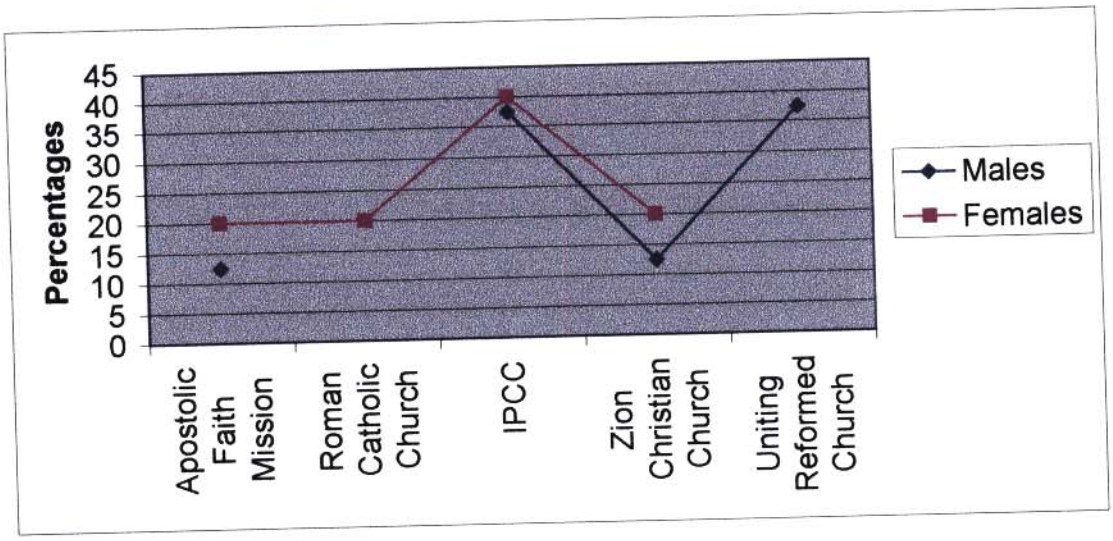

Fig. 10

Fig 10 above indicates that 12.5% males and 20% females belonged to the Apostolic Faith Mission; while 12.5% males and 20% females belonged to the Zion Christian Church (ZCC) and 37.5% males and 40% females were members of the International Pentecostal Christian Church (IPCC). Only 37.5% males indicated that they belonged to the Uniting Reformed Church (URC) while 20% females were members of the Roman Catholic Church (RCC). None of the parents indicated that they belonged to the Lutheran Church. Clearly many parents belonged to the ZCC and IPCC since these churches embrace African traditional practices such as polygamy. Most adult respondents indicated that it was difficult to absolutely abandon what they were used to for many years and had been practiced by their parents and fore-parents too.

4.2.2.6 Educational level of parents

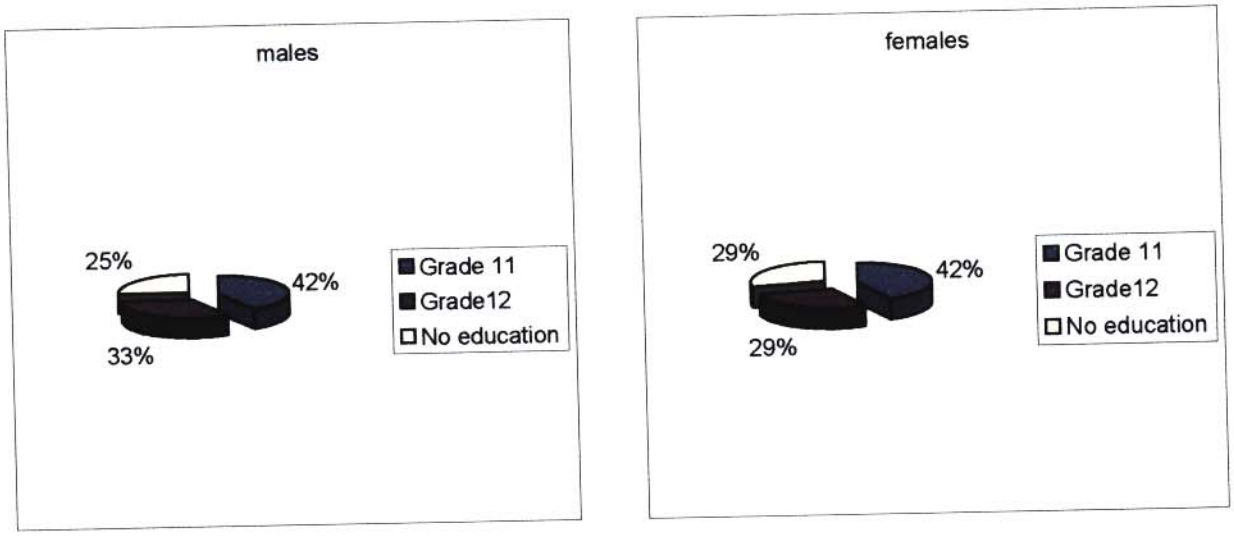

Fig. 11

It is interesting to note that an equal number of parents 42% males and 42% females had left school when they were at grade 11 whereas 33% males and 29% females had reached Grade 12. About one quarter 25% males and 29% females had never been to school. In the past, people who could attend school were only those who subscribed to Christian denominations that owned the schools. People who attended such schools were referred to as "majagani" meaning the civilised and educated while the schools were referred to as missionary schools. With regard to women, it was customarily believed that those who attended school would intermingle with men and that would eventually lead to unwanted pregnancy and children born out of wedlock.

4.2.2.7 Data on the economic level of parents

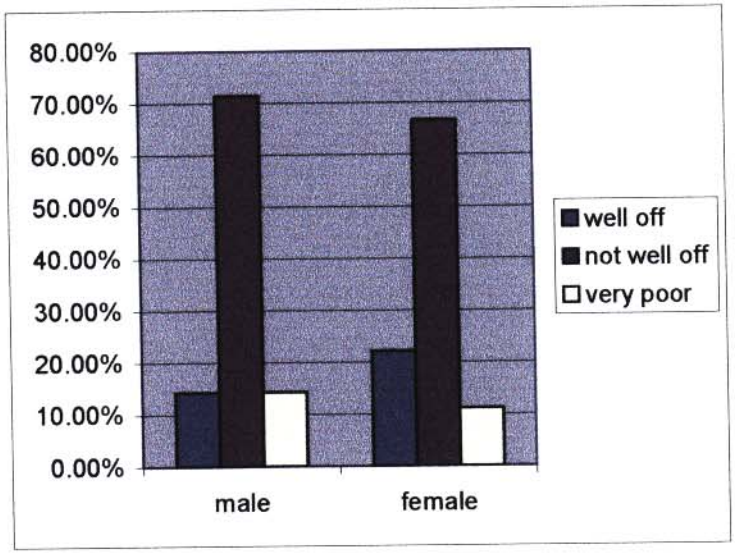

Fig. 12

Whereas the young learners (50%) had alleged that they came from middle class families, all parents however, indicated that none of them was wealthy; but, 14.3% males and 22.2% females reported that they were well off; whereas 71.4% males and 66.7% females indicated that they were not well off; while 14.3% males and 11.1% females declared that they were very poor. Many adults leave Malamulele to search for jobs in Gauteng and other provinces, thus leaving behind their children – hence the high rate of cohabitation among youth, as there would be no elderly person giving guidance, support and/or reprimand when the youth misbehave. The majority of people in Malamulele are subsistence farmers and are dependent upon rain for farming. In cases where the area experienced drought, people become dependent upon government poverty relief programmes for food supplies.

4.2.2.8 Language proficiency of parents

Table 4 indicating languages in which parents were proficient

Language	Number Of Males	% For Males	Number Of Females	% For Females	Total Number	Total %
Xitsonga	14	100	9	100	23	100
TshiVenda	9	64.3	4	44.4	13	56.5
Sepedi	7	50	4	44.4	11	47.8
Afrikaans	10	71.4	4	44.4	14	60.9
English	-	-	2	22.2	2	8.7

Parents too indicated their multilingual status. While all (100%) were proficient in Xitsonga, quite a substantial number - 64.3% males and 44.4% females were also proficient in TshiVenda, whereas 50% males and 44.4% females were proficient in Sepedi followed by 71.4% males and 44.4% females who were proficient in Afrikaans; and there were only 22.2% females who were proficient in English. Before 1967, there was a large number of Vha-Venda who lived in the Malamulele area and Vatsonga people who lived in Venda. However, due to the Group Areas Act, the two ethnic groups were separated and could no longer live together, but they live in adjacent areas, hence the large number of people who were proficient in TshiVenda. With regard to Sepedi, some respondents learnt

the language whilst they were working at farms which are within the localities of the Northern Sotho speaking people. With regard to Afrikaans, in the past it was compulsory for people to know and use this language as it was an official language which was used predominately above English.

4.2.3 Demographic factors of traditional/cultural leaders

Traditional/cultural leaders comprised the third sample of the research study. Herewith follows demographic factors of the traditional/cultural leaders. These depict the same details as those of the learners and their parents.

4.2.3.1 Age and gender of the traditional/cultural leaders

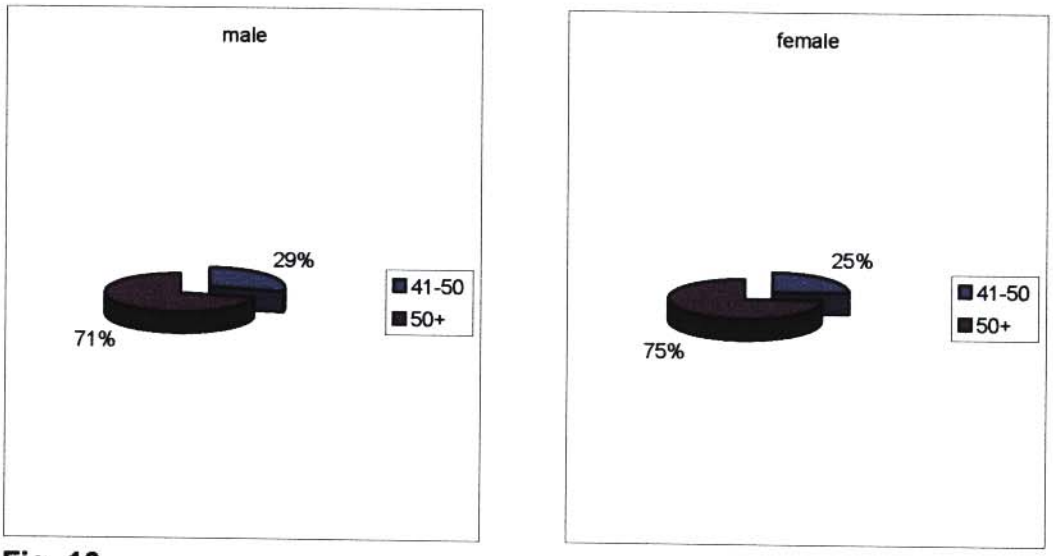

Fig. 13

The third sample comprised of traditional leaders. Those whose ages ranged between 41-50 years were 29% males and 25% females. Whereas those above the age of 50 years comprised 71% males and 75% females. Some of these traditional leaders were parents of the learners (respondents) in this study. Only respondents who were regarded as

people still believing and upholding the norms, values and conventions were selected based on their willingness to participate in the study.

4.2.3.2 Data on the marital status of the traditional/cultural leaders

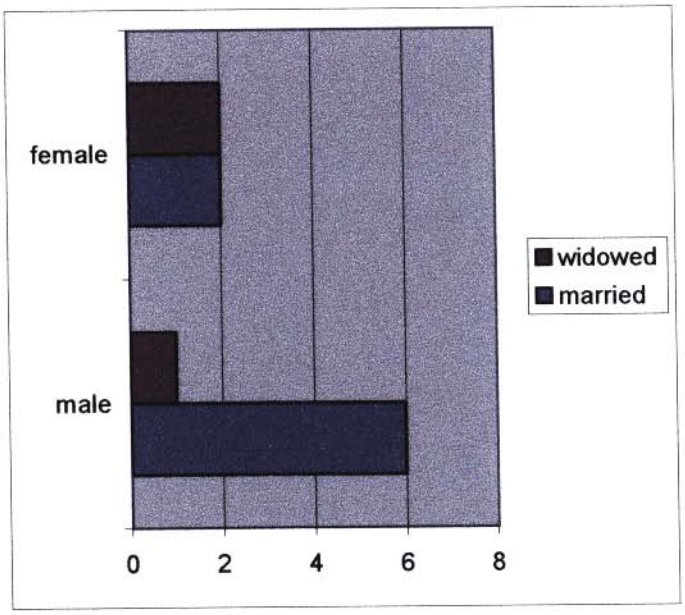

Fig. 14

As none of the respondents were below the age of 40 years, it was not surprising that all (100%) indicated that they had been married; however 14.3% males and 50% females were widowed. There were neither divorcees nor persons who were separated from their spouses in this age group. Clearly, this group still upholds cultural norms and values hence none of the respondents in this group were divorced.

4.2.3.3 Religious data of the traditional/cultural leaders

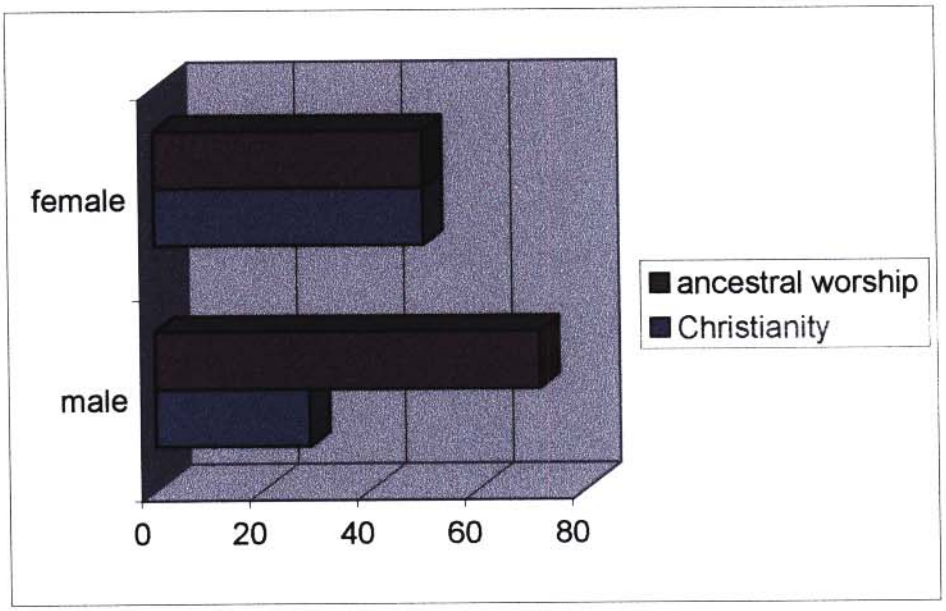

Fig. 15

In this sample, 71.4% males and 50% females indicated that they venerated their ancestors; whereas only 28.6% males and 50% females were Christians. Traditional leaders still largely subscribed to ancestral worship. Many people in Malamulele believe that ancestors control the life of those who are living. They believe that misfortunes and curses are due to poor relationship between the living and their ancestors.

4.2.3.4 Christian affiliation of traditional/cultural leaders

Table 5 indicating the Christian churches attended by cultural leaders

Christian church	Number Of Males	% For Males	Number Of Females	% For Females	Total Number	Total %
AFM	2	40	1	50	3	42.9
Roman Catholic	-	-	-	-	-	-
IPCC	-	-	-	-	-	-
Lutheran	-	-	-	-	-	-
Uniting Reformed Church (URC)	-	-	1	50	1	14.3
ZCC	3	60	-	-	3	42.9

Among the traditional leaders who attend church services, only three denominations were mentioned viz.:

- The AFM church which was attended by 40% males and 50% females
- The ZCC which was attended by 60% males and
- The URC church which was attended by 50% females

The AFM and the ZCC had an equal percentage of members. The explanation to this is that while the AFM was for a long time, the only church around Malamulele, the ZCC as a

fast growing church had became popular of late especially for its faith healing powers. Moreover, the ZCC is not against cultural practices such as polygamy hence it had more members. However the number of Christians among traditional leaders was very low and therefore the analysis of this low number of respondents is not quite reliable.

4.2.3.5 Educational level of traditional/cultural leaders

Table 6 indicating educational level of traditional leaders

Grade	Number Of Males	% For Males	Number Of Females	Females	Total Number	Total %
08	1	16.7	-	-	1	11.1
11	1	16.7	-	-	1	11.1
12	-	-	1	33.3	1	11.1
No education	4	66.7	2	66.7	6	66.7

Missing frequency = 2

The majority (66.7%) of the traditional leaders (an equal number for both males and females) had never been to school. Whereas 16.7% males had left school at grade 8, another 16.7% had left school at grade 11; while 33.3% females had left school at grade 12. Just like parents, traditional leaders had been affected by the belief that school attendance by females would promote promiscuity.

4.2.3.6 Data on the economic level of traditional/cultural leaders

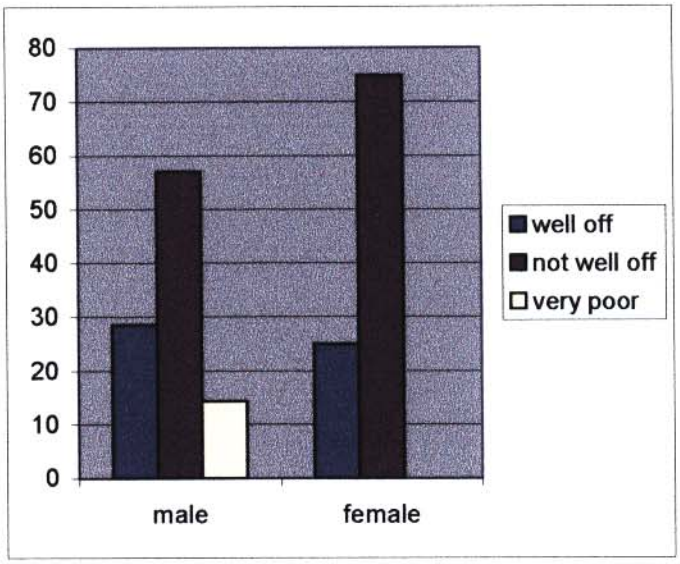

Fig. 16

Just as the parents, none of the traditional/cultural leaders regarded themselves as wealthy. Whereas 28.6% males and 25% females stated that they were well off; 57.1% males and 75% females regarded themselves as not well off; while 14.3% males indicated that they were very poor. Cultural leaders were not excluded from the problem of unemployment and poverty. Subsistence in Malamulele is largely eked out of subsistence farming. Poverty is largely due to the fact that many families in Malamulele are female headed and quite a substantial percentage of people take up employment as migrant labourers in Gauteng and other provinces

4.2.3.7 Language proficiency of traditional/cultural leaders

Table 7 indicating the languages in which respondents were proficient

Language	Number Of Males	% For Males	Number Of Females	% For Females	Total Number	Total %
Xitsonga	7	100	3	75	10	90.9
TshiVenda	3	42.9	2	50	5	45.5
Sepedi	3	42.9	1	25	4	36.4
Afrikaans	3	42.9	1	25	4	36.4
English	3	42.9	-	-	3	27.3

Whereas all (100%) men indicated that they were proficient in Xitsonga, only 75% women were proficient in Xitsonga. There was an equal number of men (42.9%) who were proficient in TshiVenda, Sepedi, Afrikaans and English respectively whereas 50% females were proficient in TshiVenda and 25% in Sepedi and Afrikaans respectively.

SECTION B

4.3 YOUTH SEXUAL BEHAVIOUR

This aspect of the questionnaire appeared only in the questionnaire that was administered to the learners. A quantitative analysis is therefore based on the responses of the learners only. The following data has been analysed quantitatively and qualitatively. With regard to quantitative analysis respondents had been provided with statements to which they had to respond either positively (Yes), or negatively (No). Occasionally the respondents were requested to give an estimation of the figure that would qualify their responses.

4.3.1 An investigation of the sexual experiences of learners

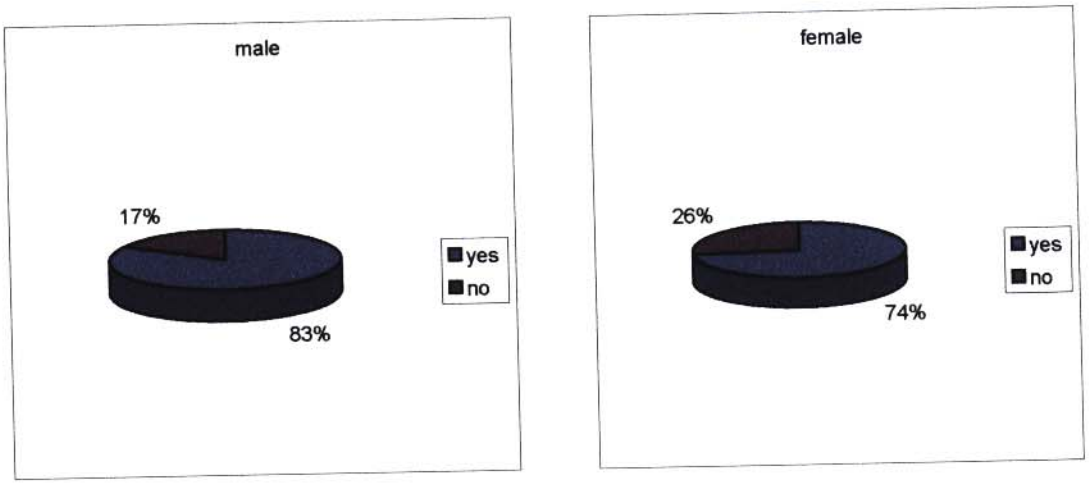

Fig. 17

Figure 17 above indicates the extent to which learners were active sexually. More males (83%) than females (74%) indicated that they were actively involved sexually. This implies that the majority of respondents (at least three-quarters), in spite of their single status were actively involved sexually. The majority of learners in grades 11 and 12 in Malamulele, regardless of their economic status (poverty) as well as their Christian values engaged in sex out of wedlock and even cohabitated with their sexual partners. Young

women were more likely to marry earlier than young men. "Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS, and they are typically poorly informed about how to protect themselves" (UN 1998:10).

4.3.2 Age of the sexual partner

Table 8 indicating age of sexual partners of learners

Age	Gender		Results
<16 years	Male and Female	Mean	17.15
		Number	13
		Standard deviation	1.994
16-18 years	Male and Female	Mean	19.23
		Number	65
		Standard deviation	3.404
19-21 years	Male and Female	Mean	20.66
		Number	85
		Standard deviation	4.837
22-30 years	Male and female	Mean	22.03
		Number	28
		Standard deviation	5.470

The ages of the sexual partners ranged from below 16 to 30 years of age. Those who were involved with sexual partners whose age was below 16 years had a mean of 17.15 and a standard deviation of 1.994 whereas respondents who were sexually involved with partners whose age ranged between 16 and 18 years had a mean of 19.23 and a

standard deviation of 3.404. The 19 – 21 years age group had a mean of 20.66 and a standard deviation of 4,837 while the last group had a mean of 22.03 and a standard deviation of 5.470. Clearly the male respondents abused younger sexual partners than themselves whereas female respondents chose older sexual partners than themselves. At times the females had sex with much older men for financial gains. It was found that HIV/AIDS is a disease associated with poverty. Poor women are least able to negotiate safer sex and more likely to accept partners with hopes of material benefit (UNFPA 2003:4).

4.3.3 Frequency of sexual activities over the past twelve months

Table 9 indicating the number of times each learner engaged in sex over the past 12 months

Age	Gender		Results
<16 years	Male and Female	Mean	3.55
		Number	11
		Standard deviation	2.841
16-18 years	Male and Female	Mean	9.66
		Number	58
		Standard deviation	10.943
19-21 years	Male and Female	Mean	11.45
		Number	80
		Standard deviation	11.181
22-30 years	Male and female	Mean	10.63
		Number	24
		Standard deviation	8.355

Table 9 above indicates that even the respondents whose age was below 16 years had been active sexually at least 3.55 times over the past 12 months with a standard deviation

of 2.841 times. Respondents who were between 16 –18 years of age scored a mean of 9.66 and a standard deviation of 10.943 times whereas those who were between 19 – 21 years of age, scored a mean of 11.45 and a standard deviation of 11.181 times of sexual intercourse in the past year. The last group comprised respondents whose age was between 22 – 30 years of age. They scored a mean of 10.63 and a standard deviation of 8.355 times of sexual activity over the past year. The 19 – 21 years age group had the highest mean of sexual activity over the past year. In Malamulele, indulgence in sexual intercourse began early and showed a high frequency among learners in high schools despite their awareness of the HIV/AIDS pandemic.

4.3.4 Time frequency for sexual activities over the past month

Table 10 indicating the extent of sexual activity of learners over the past month

Age	Gender		Results
<16 years	Male and Female	Mean	2.00
		Number	11
		Standard deviation	1.183
16-18 years	Male and Female	Mean	3.04
		Number	47
		Standard deviation	2.774
19-21 years	Male and Female	Mean	3.92
		Number	62
		Standard deviation	2.982
22-30 years	Male and female	Mean	3.05
		Number	22
		Standard deviation	2.786

Whereas learners who were under the age of 16 years scored a mean of 2.00 and a standard deviation of 1.183; those who were between ages 16 and 18 years scored a mean of 3.04 and a standard deviation of 2.774. Respondents whose ages were between 19 and 21 years scored a mean of 3.92 and a standard deviation of 2.982; while those who were between ages 22 and 30 years scored a mean of 3.05 and a standard deviation of 2.786. Clearly, nothing could be done at this stage to deter learners from sexual activity rather, programmes of safer sex could be explored with, if the learners were to be involved in primary prevention programmes on HIV/AIDS.

4.3.5 Number of sexual partners for learners

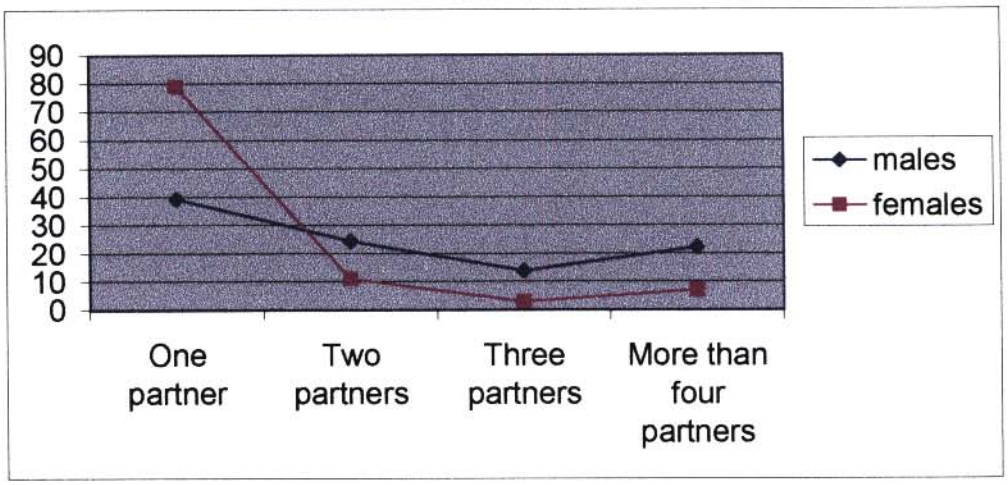

Fig. 18

All respondents indicated that they had sexual partners irrespective of their age and marital status. Males (39.4%) and females (79.0%) indicated that they each had only one sexual partner. Whereas 24.5% males and 11.0% females indicated that they each had two sexual partners, 13.8% males and 3.0% females had three sexual partners each; and 22.3% males and 7.0% females had four and/or more sexual partners each. It was found that males have more sexual partners than females (UN 1998:30). It was interesting to note that some learners admired and probably would conform to the practice of polygamy later on in their lives. Having more than one sexual partner to some learners was viewed as a noble experience as some of the learners were products of polygamous fathers.

Some learners who denied that this might be a cause of poverty too adored large families. Some learners viewed men who had many children with respect and would themselves emulate such men in future.

4.3.6. Safer sex methods

- **Condom use by learners**

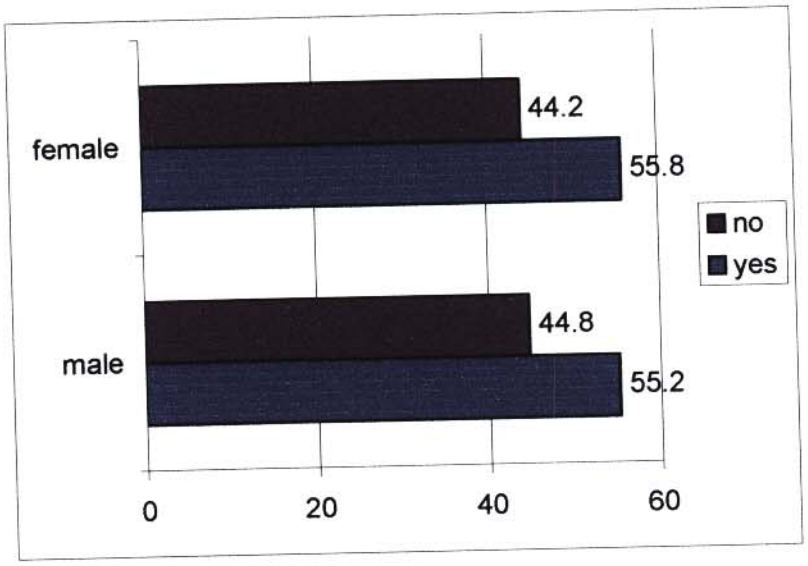

Fig. 19

Figure 19 above indicates that just above half of both genders (55.2% males and 55.8% females) indicated that they used condoms, whereas quite a substantially high percentage (44.2% Males and 44.9% females) stated that they did not use condoms. Usually condoms are the products, which are marketed, often with a "dual protection" message to help to protect against both pregnancy and sexually transmitted infections including HIV. It was found that men used condoms more frequently than women (UN 1998:94 and UNFPA 2003:26). This clearly indicates that use of condoms is well known in spite of its neglect/omission by the respondents. It would be imperative for prevention programmes and campaigns not to overlook messages about condom use and its effectiveness as there is a substantial number of learners who do not use condoms in spite of being sexually active. Witte, Cameron, Lapinski and Nzyuko (1998:350) indicated that more

people need more information verifying the effectiveness of condoms. HIV/AIDS prevention and treatment methods such as awareness campaigns should target the youth and teach them effective safer sex practices including condom use. These findings are in support of other research that was conducted by Sureender, Guruswamy and Verma (1997: 604) and Peltzer (2000: 1065), on knowledge of HIV among the youth at Maharashtra (India) and Limpopo (South Africa) respectively.

- **Willingness to have sex without a condom**

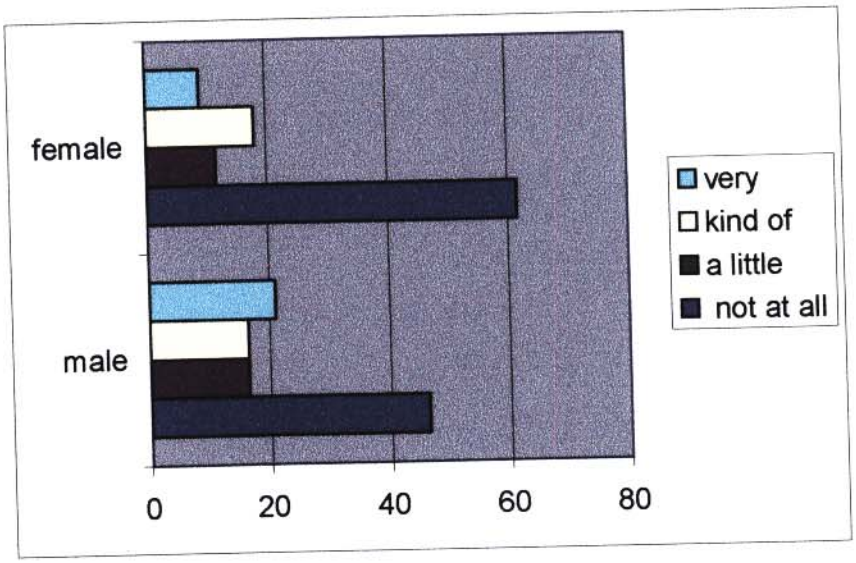

Fig. 20

Figure 20 above indicates that 61.5% females and 46.4% males indicated that they would be very willing to indulge in sex without a condom; 16.4% males and 18.0% would be willing only sometimes to have sex without a condom. Only 20.9% males and 9.0% females indicated emphatically that they would not at all indulge in sex without a condom while 16.4% females and 46.4% males would just be a little willing (were doubtful) that they would indulge in sex without a condom. Generally, there is an inconsistent and low use of condoms among adolescents (Hubbs-Tait and Garmon 1995:558; Melkote and Goswami 2000:95; Campbell 1999:31; Colón, Wiatrek and Evans 2000:560 and Vogel's, Brugman, and Van Zessen 1999:376). Youth in Malamulele have a low understanding of safer sex by using condoms. The message around sexually transmitted infections

seemingly has not been internalised by the majority of the youth. While prevention programmes were successful in raising awareness about the dangers of HIV infection and condom use, they were less successful in changing the behaviour of young people (UNFPA 2003:26).

- **Delaying having sex**

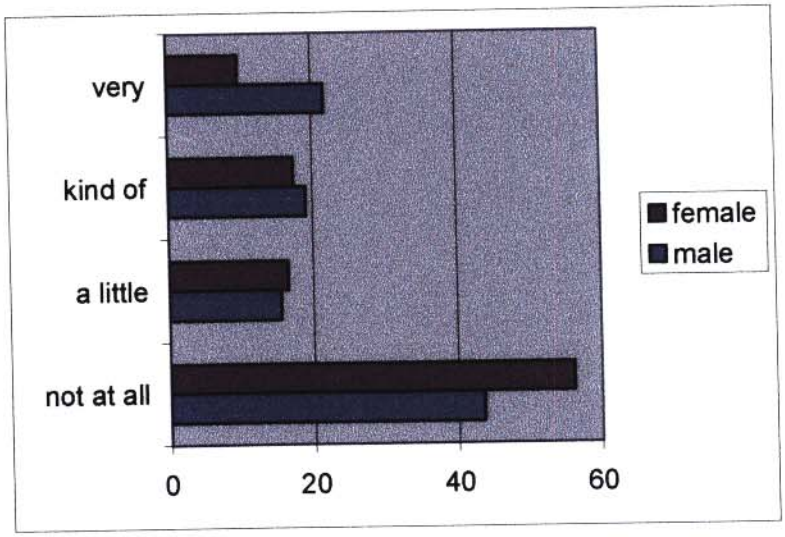

Fig. 21

Almost one-half (43.6% males and 56.2% females) of the respondents indicated that they would rather have sex than fool around and kiss. Only 21.8% males and 9.9% females would rather fool around and kiss than have sex; while 15.5% males and 16.5% females were not sure of their preference; while 19.1% males and 17.4% females would delay having sex only sometimes. Developmentally, the adolescent period is very much critical hence learners stated that they would not withstand the pressure of not having sex by fooling around. Peersman and Levy (1998:191); Piery, Foutes and Bordean as cited by Phahlamohlaka (2000: 21 – 22) and Buzi, Weinman and Smith (1998:314) stated that adolescents were reluctant to use condoms and upheld a myth that condoms reduce sexual pleasure.

4.3.7 Substance use among learners with reference to indulgence in sexual intercourse

Table 11. Types of substances which were commonly used by learners

Name of drug	Male	Percentages	Female	Percentages
Dagga	10	4.1	1	0.4
Alcohol	20	8.2	7	2.8
TOTAL	30	12.3	8	3.2

Missing frequency = 205

When asked whether they used substances or not, 205 (70%) of the learners did not answer the question. Respondents who used substances mentioned dagga and alcohol as substances they commonly used. Whereas 4.1% males mentioned using dagga, only 0.4% females indicated that they used dagga too. Alcohol was allegedly used by a higher percentage of respondents (8.2% males and 2.8 females). Substance use before indulgence in sex is common among young learners. Home brewed alcohol was the most accessible and cheap to purchase. It was stated that home brewed alcohol sold at the low price of R1.00 per litre hence learners stated that they indulged in this substance more than factory-manufactured beer. Despite the prevalence of poverty in Malamulele, substance abuse is common even among the unemployed. In Malamulele, some people cultivate cannabis in their fields amidst other crops – thus making it easily accessible at a cost-effective price (R10. 00 per match box).

- **Indulgence in sex after substance use**

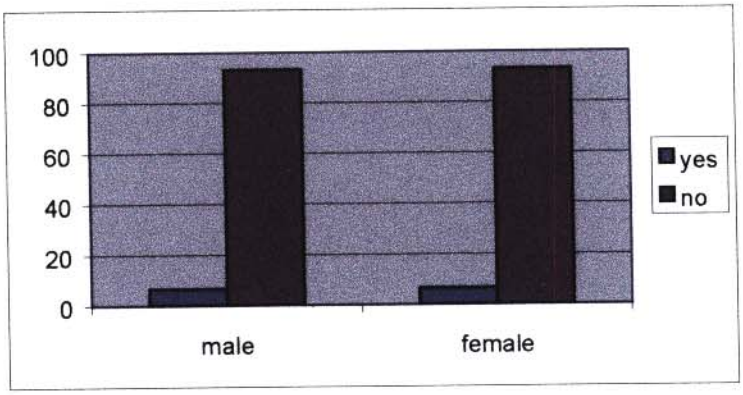

Fig. 22

Figure 22 above indicates that 6.7% males and 6.8% females admitted to use of alcohol or cannabis before engaging in sexual intercourse, as opposed to the 93.3% males and 93.2% females who stated that they did not.

- **Exploration of feelings of respondents for sex after use of substances**

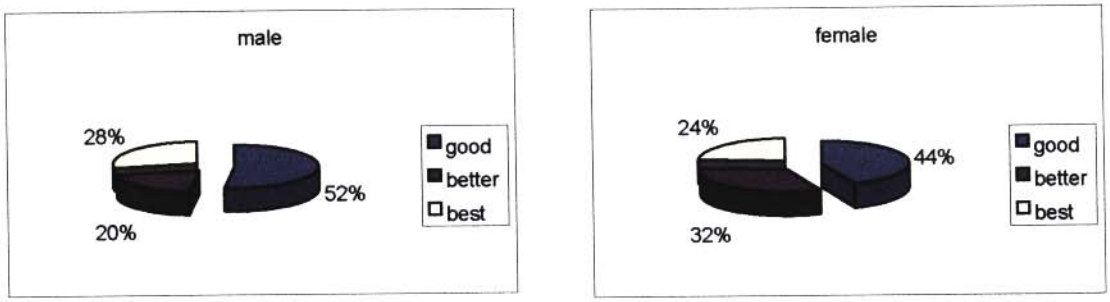

Fig. 23

Almost one-half (52% males) and 44% females stated that they felt good after the use of substances; whereas 20% males and 32% females stated that they felt better, and 28% males and 32% females alleged that they felt best after using substances. Clearly, quite a substantial number of learners used substances too, however the majority did not indicate the substances they used yet in response to the question which explored their feelings for

sex after substance use, all (100%) respondents provided the same answer. Seemingly youth used substances before indulging in sex, and this led to risk-taking behaviour, which occurs because of impaired judgement (Strunin and Hingson in Sherr 1993:126). A common belief, which prevails in Malamulele, is that dagga has an aphrodisiac effect and alcohol inhibits one hence both substances tend to increase sexual performance. This might be the reason why youth rated sex good after use of alcohol and dagga although the majority of respondents indicated in Fig. 22 that they do not use any substances before indulging in sex yet in Fig. 23 they subsequently mentioned that sex was good when one was high.

4.3.8 The extent of peer pressure in the behaviour of the learners

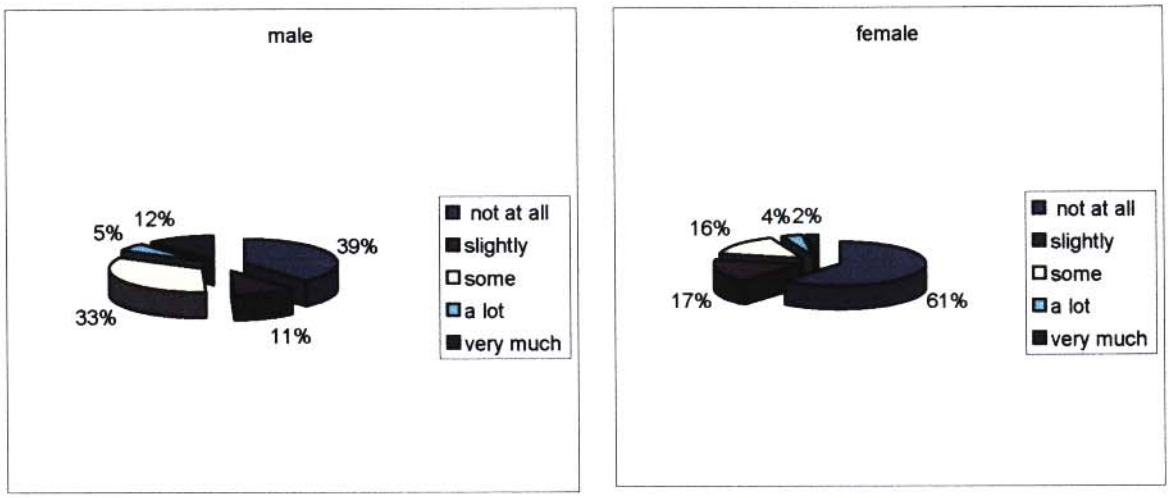

Fig. 24

Males are easily influenced by their peers. Figure 24 above, indicates that 61% females as opposed to 39% males indicated that their friends' thinking on sexual matters would not influence them. There were 11% males and 17% females who indicated that they could be influenced only slightly by their peers; while 33% males and 16% females stated that they could be influenced only sometimes by peer pressure. Those who admitted to being vulnerable very much to peer pressure were 12% males and 2% females while 5% males and 4% females stated that they could be influenced a lot by peer pressure. Learners in Malamulele are not different from adolescents throughout the world, as they bow down to

peer pressure. However, the learners in Malamulele who participated in this study were not all adolescents, as some were above the age of 21 years. The older learners do not seem to be having a positive impact on the younger learners. Peer pressure motivates youth in Malamulele towards early indulgence in sex and substance use. Lack of recreation facilities caters for liquor outlets as major forms of recreation for youth and adults in Malamulele. A lifestyle evolving around substance abuse and sex seems to be a major occupation of the people; hence community values around these activities offer youth very little opportunities for a changed lifestyle. This is explained by the idiomatic expression which says "vuxaka bya tinhwarhi i ku handza swin'we" meaning people of the same behaviour stay together.

4.3.9 Parental Influence

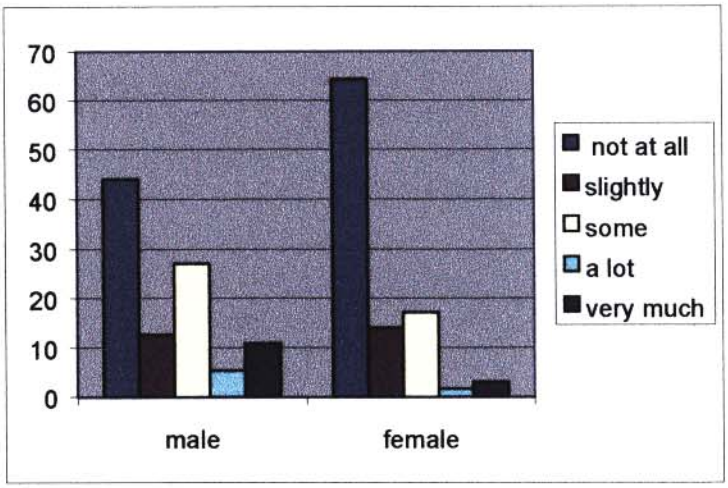

Fig. 25

Generally, parents have more influence on their daughters than they do over their sons. Parents therefore are inclined to be protective of their daughters, while they allow their sons to make their own decisions. Figure 25 above indicates that 64.3% females as opposed to 44.1% males indicated that their parents' thinking about someone of their age indulging in sexual activities might influence them. Parents seem not to have a problem when their adolescent children emulate their peers who might be indulging in sexual activities, as parents would want their children to do what their peers would be doing and they actually encourage and promote such behaviour. Parents would say "a wu va voni

vanghana, u lo loyiwa u ngo tshama la kaya". This means that a young person should not stay at home, but go outside and do what his/her peers would be doing particularly indulging in sexual activities. The rationale behind this way of behaving is that in Malamulele, parents actively participate in selecting a mate for their children. Actually, parents still have the power to decide whom their son and/or daughter would marry or be married to based on the fact that such a person has been viewed as respectful and able to maintain the family.

Nonetheless, parents could be of utmost importance in providing support and encouragement to youth to delay sexual activities. Parents could advise youth about the values of love, respect, dignity and responsibility that should shape attitudes in a relationship. They could as well advise youth about protection and safety when they are sexually active (UNFPA 2003:20).

4.3.10 Community's influence

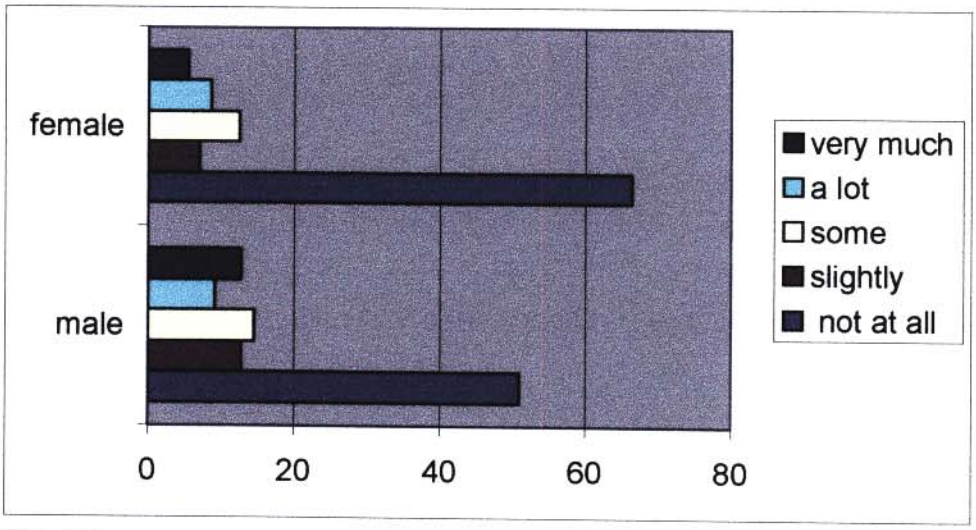

Fig. 26

The lifestyle of any community determines the sexual behaviour of youth. Culture is the sum total of the beliefs, attitudes and norms that prevail amongst groups of people. In this

study the concept of culture was understood by respondents as the general lifestyle and beliefs of the majority of community members. Figure 26 above indicates that some respondents (believed that their sexual activity was very much culturally motivated - 12.7% males and 5.5% females; while 9.1% males and 8.6% females said their behaviour was a lot more influenced by culture. The majority of respondents, however (66.4% females and 50.9% males) were adamant that their sexual behaviour was not culturally motivated. For those who indicated that sometimes culture had an influence on them, there were 14.5% males and 12.5% females. Those who acknowledged that culture had a slight influence on their indulgence in sexual activities were 12.7% males and 7% females. Community based centres on HIV/AIDS, which would concentrate on prevention, and treatment of the pandemic would be influential in changing the mindset of quite a substantial number of young people, especially if they made use of peer educators. "People belonging to the same peer group (defined by age, class, gender, or any other social construct) communicate best with each other" (UNODC 2003:7).

4.3.11 Religious values

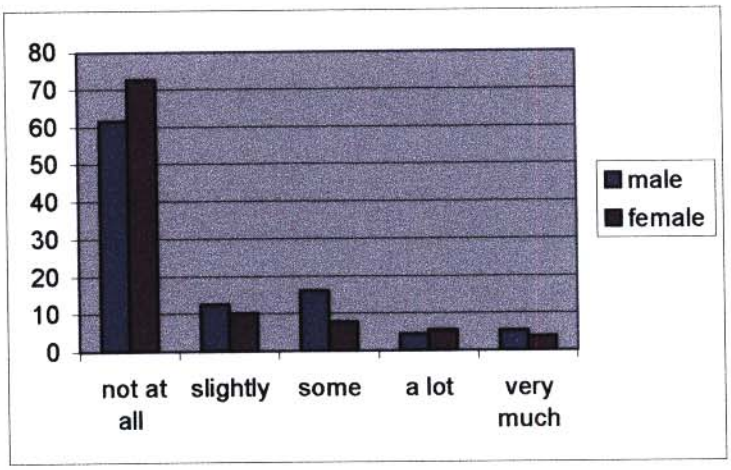

Fig. 27

Religion tends to have a great influence on the behaviour of people. Figure 27 above indicates that the majority of respondents (61.6% males and 72.7% females) of the learners acknowledged that their behaviour (being sexually active) was not at all based on

their religious values. Respondents who indicated that religious values had a slight influence on their sexual behaviour were 12.5% males and 10.2% females and those who mentioned that sometimes, religious values do influence them, were 16.1% males and 7.8% females. Whereas those who indicated that they were a lot more influenced by religious values were 4.5% males and 5.5% females while those who indicated that religious values had a great influence on them regarding indulgence in sexual activities, were 5.4% males and 3.9% females. Due to the fact that religion plays a prominent role as a cultural factor, youth are not excluded from being pressurised by the religious values they uphold with regard to their behaviour, sexual behaviour too can be influenced by the religious institutions the youth subscribe to. Mostly religion determines when to have sex. While many churches preach the gospel that sex before marriage is a sin and people who are not yet married should not indulge in sexual activities, the respondents (learners) in this study mentioned that religion to them did not play a role concerning sexual activities. This indicates that either the churches they attend are silent on these issues or the youth do not attend regularly. There is a need for an in depth investigation on the role of the church and the extent to which it can play a prominent role in the primary prevention of HIV/AIDS and substance abuse. Clearly from the reactions of the respondents, churches in Malamulele rarely ever refer to issues of HIV/AIDS hence more than 50% of the respondents indicated that religion had no influence over their behaviour.

4.3.12 Celebrity status/self actualisation

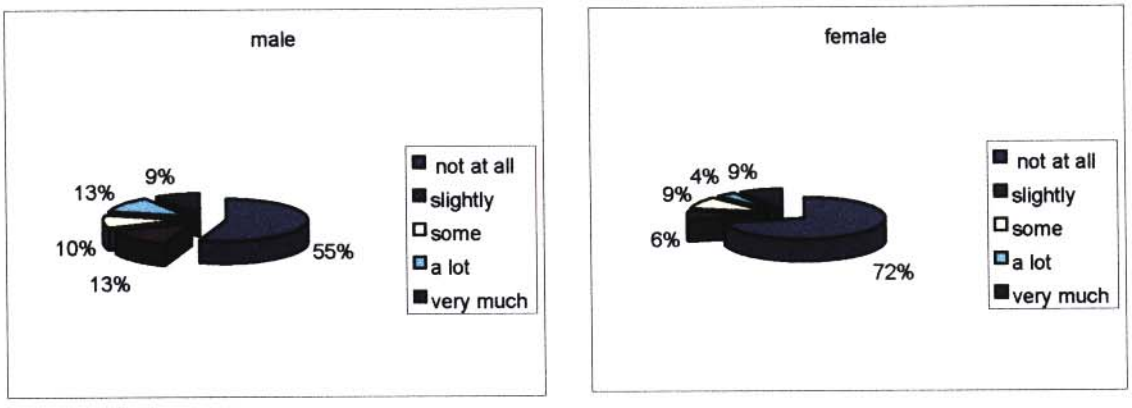

Fig. 28

Youth tend to use celebrities as their models. They usually copy anti-social behaviour that is manifested by people they regard as celebrities. The concept of being sexy, is often associated with sexual activity, hence youth believe that maintaining one's reputation is very crucial in every person's life. Respondents who mentioned that having sex comes first before thinking of tarnishing one's reputation by indulging in sexual activities were 55.4% males and 72% females; yet those who indicated that concern for their reputation has a slight influence were 13.4% males and 6.3% females. Those who indicated that this happened only sometimes were 9.8% males and 9.4% females. Those who indicated that concern for one's reputation had a lot of influence were 12.5% males and 3.9% females. Those who indicated that concern for one's reputation had a great influence were 8.9% males and 8.6% females. It was clear that since learners envy their role models, they have little concern about their reputation as against their sexual gratification as 50% of the respondents (learners) indicated this.

SECTION C

4.4 KNOWLEDGE ON HIV/AIDS

Information on the knowledge of respondents on HIV/AIDS was gathered from the three sets of respondents viz: learners, parents and traditional/cultural leaders. Aspects of knowledge that were considered in this study were causes, symptoms and the transmission of HIV/AIDS. A total of 277 respondents whose age range was from 15 years to 65 years participated in this study.

4.4.1 Causes of HIV/AIDS

The knowledge of learners, parents and traditional leaders on HIV/AIDS was tested and it was interesting to observe that some people at Malamulele are quite knowledgeable about the virus. Fig. 29 below depicts the level of knowledge about HIV/AIDS.

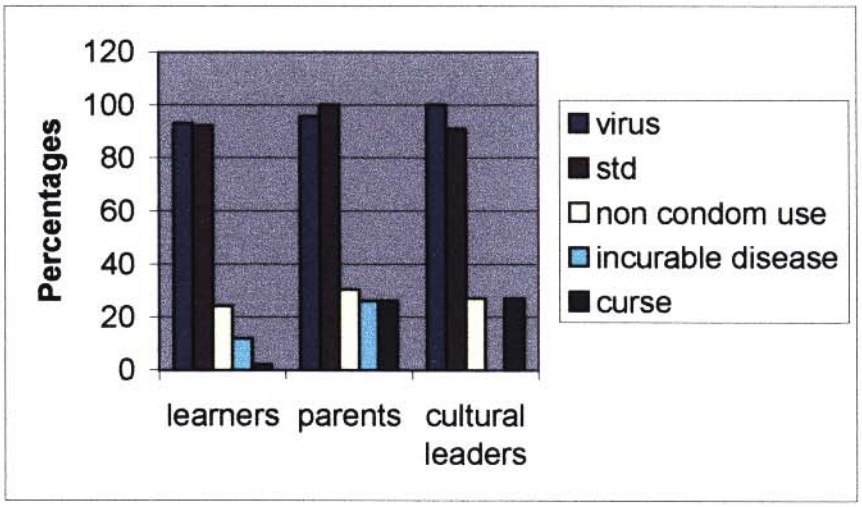

Fig. 29

Whereas all (100%) cultural leaders had knowledge that HIV is a virus, 95.7% parents and 93% learners confirmed this statement. An almost equal percentage (learners 92%, parents 100% and cultural leaders 90.9%) of the respondents knew that HIV/AIDS is a sexually transmitted disease. However, only 24.4% learners, 30.4% parents and 27.3% cultural leaders indicated that HIV/AIDS is caused by non-condom use while 12% learners and 26.1% parents indicated that HIV/AIDS is an incurable disease; and only 2.1% learners, 26.1% parents and 27.3% cultural leaders indicated that HIV/AIDS was a curse from God. From the data that was gathered, the researcher concludes that knowledge of HIV/AIDS is limited as quite a large percentage of respondents were not aware that the disease is not curable. However, it must be pointed out that bill boards, the radio and television form part of awareness campaigns that provide information to almost all people though some disregard the information. Many people still indulge in unsafe sexual practices even though they know the dangers of such practices. This carelessness may be explained by the fact that there is no known concept of the meaning of HIV in the Xitsonga language. AIDS is referred to as a disease emanating from coitus – " makhuma (Xitsonga) and bolwetsi ba thoballano (Northern Sotho)", yet most of the respondents were reluctant to admit that non-condom use contributed to infection.

4.4.2 Symptoms of HIV/AIDS

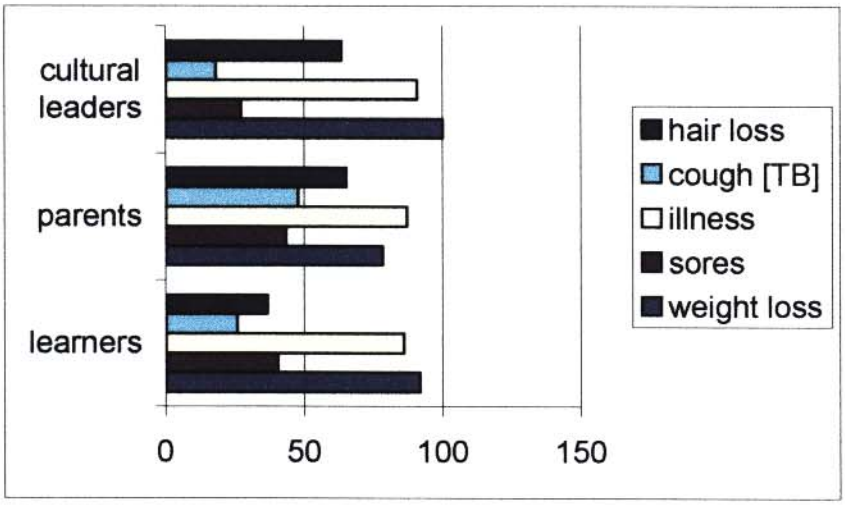

Fig. 30

In this study, respondents were requested to state in their own words what they perceived as symptoms of HIV/AIDS. They came up with a variety of symptoms such as weight loss, hair loss, too much coughing and frequent ailing and also that HIV/AIDS may sometimes manifest itself in the form of Tuberculosis (TB), or the patient may develop sores and wounds which are not easily and quickly healed. Those who indicated weight loss were 91.8% learners, 78.3% parents and 100% cultural leaders followed by 86% learners, 87% parents and 90.9% cultural leaders who indicated frequent ailing. Those who mentioned sores were 40.3% learners, 43.5% parents and 27.3% cultural leaders and coughing and hair loss were mentioned by 25.9% learners, 47.8% parents and 25.9% cultural leaders and 36.6% learners, 65.2% parents and 63.6% cultural leaders respectively. Some respondents stated that by mere looking at a person, they were able to detect whether he/she was HIV positive or not.

4.4.3 Knowledge of transmission of HIV/AIDS

In response to the questions, which were asked about transmission of HIV/AIDS, there were various reasons in support of such responses by respondents. The following

responses were noted: mother-to-child transmission, Intravenous drug use (IDU), rape, breastfeeding, mosquito bites, and sharing/using of eating utensils and food.

- **Mother-to-child transmission (MTCT)**

The respondents mentioned that even babies and children could be infected with HIV through mother to child transmission. There were (83.4% learners, 45.5% parents and 81.8% cultural leaders) who mentioned that HIV/AIDS could be transmitted from mother-to-child as opposed to those who mentioned that babies and children could not be infected (16.6% learners, 54.5% parents and 18.2% cultural leaders). The reason given was that all human beings irrespective of their age could be infected with HIV. Use of traditional midwives is still prevalent in Malamulele. Some women never attend the prenatal clinic and they evade being tested for HIV. There are a lot of unregistered births and also deaths that are not certified by health practitioners but are simply recorded as "death by natural causes" in the police stations.

- **Intravenous Drug Use (IDU)/Syringes**

With regard to use of syringes to inject drugs or blood, (5.9%) learners, (25%) parents and (10%) cultural leaders mentioned that this procedure has some risks because the person who might be receiving drugs or blood may be infected depending on whether the blood is contaminated. There are some people who believe that there are health practitioners who deliberately inject infected blood into patients in order to kill them. Such people are convinced that this is based on hatred and people ultimately suffer from HIV not through sexual activities. It is alarming to note that only a low percentage of respondents were knowledgeable about IDU, and instead the myth about medical practitioners being responsible for the spread of HIV was more prevalent.

- **Rape**

Sexual intercourse without the consent of the other partner is referred to as rape. Respondents in this study indicated that rape is one of the ways in which people can be infected with HIV/AIDS. Only 50% cultural leaders, 18.5% learners and 25% parents indicated that they believed strongly that rape could result in one of the partners being infected with HIV/AIDS. From the data provided by respondents, it is clear that some learners and parents did not view rape as a possible means of transmitting HIV/AIDS. This obviously is based on denial of the existence of HIV/AIDS, as many rape cases in this area are not reported while others are dealt with secretively as family matters.

Nonetheless, other reasons given by respondents were that babies and children could not be infected with HIV because their blood is still fresh. They mentioned that babies and children do not menstruate and are therefore not vulnerable to HIV/AIDS infection. Clearly, respondents associated menstruation as a process of releasing the HIV and therefore they believed that babies were immune from the virus.

- **Breastfeeding**

In response to the statement that HIV/AIDS could be transmitted from mother-to-child through breastfeeding, only 5.5% learners and 20% cultural leaders agreed. The explanation given by the respondents was that when a mother has sores on her breasts and suckles a child, then such a child might be infected with the HIV as s/he may suck blood from the mother who might be HIV positive. This fact was known by only a very low percentage of respondents while the majority of the respondents did not know. All parents (100%) stated that there was no danger of HIV infection through breastfeeding. The explanation given was that children suck breast-milk not blood. They further mentioned that they have been taught that HIV/AIDS is in the blood so how could it also be in the milk, moreover, breastfeeding was a method highly recommended by health practitioners. The danger of HIV infection through breastfeeding could occur if the teats of the mother

had some sores and/or the child bit the teats in the process of suckling and eventually sucks the blood which might be infected with HIV/AIDS and be infected too.

- **Mosquitoes**

Some respondents believed that mosquitoes could serve as carriers and possible transmitters of HIV/AIDS. Respondents who mentioned that mosquitoes could transmit the virus were 53.5% learners, 21.7% parents and 27.3% cultural leaders. Those who mentioned that mosquitoes cannot transmit HIV comprised of 46.5% learners, 78.3% parents and 72.7% cultural leaders. The explanation given by those who indicated that mosquitoes could transmit HIV/AIDS was that when mosquitoes sucked blood from an infected person they might transmit the virus when they bit their next victim. However, those who mentioned that mosquitoes do not transmit HIV/AIDS mentioned that mosquitoes transmit malaria not HIV/AIDS. One other reason advanced was that mosquitoes only suck blood since it is their food, and they do not regurgitate the blood into another person.

- **Sharing of utensils and food**

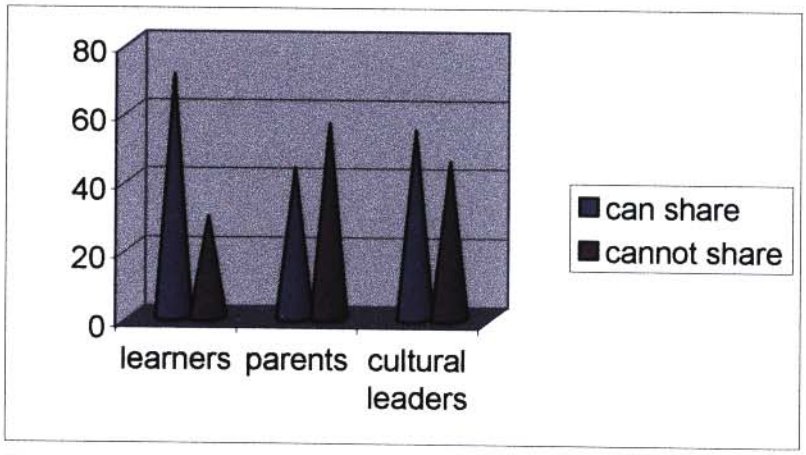

Fig. 31

As the figure above indicates, some respondents mentioned that they could share utensils and/or food with people infected with HIV/AIDS without fear of infection. There were

70.7% learners, 43.5% parents and 54.5% cultural leaders who mentioned that they could share utensils and/or food. These respondents advanced the following reasons; that

- People infected with HIV/AIDS are still human beings,
- HIV/AIDS is like any other disease such as TB,
- Whether the person is infected or not with HIV/AIDS, the fact is that he/she will die at the end and as such there is no reason to ill-treat people infected with the disease.
- Those who mentioned that they would not share utensils nor eat with people living with HIV/AIDS were 29.3% learners, 56.5% parents and 45.5% cultural leaders. The reasons they advanced were that a person living with HIV/AIDS might not want to suffer and die alone and might decide to infect others too.
- A person living with HIV/AIDS might be having an open wound or a scar which was bleeding and as s/he touches the utensils and food other people who share the food and/or utensils with him/her might be infected, so they would not risk their lives so they preferred to distance themselves from the people living with HIV/AIDS.

It was encouraging to note that almost three quarters of the learners would willingly share utensils and food with PLWHIV and PLWAIDS while the majority of the parents and cultural leaders would not.

- **Hugging and kissing**

Table 12 indicating knowledge of people as to whether HIV/AIDS could possibly be transmitted through hugging and kissing

Response	Number	Learners	Number	Parents	Number	Cultural leaders
YES	49	20.2	3	13	3	27.3
NO	194	79.8	20	87	8	72.7
Total	243	100	23	100	11	100

N = 243 (100%) – Learners

N = 23 (100%) – Parents

N = 11 (100%) – Cultural leaders

Table 12 indicates that only 20.2% learners believed that hugging and kissing could lead to HIV infection; whereas there were 13% parents and 27.3% cultural leaders who shared this idea. The reasons they advanced were that an HIV positive person might be having some open wounds on the hands and/or in the mouth, which might be bleeding and could therefore infect the other partner. Nevertheless, the majority of the respondents knew that hugging and kissing a person who is HIV positive could not infect others. They were aware of the fact that HIV is only transmitted through sexual intercourse or by direct contact with blood of an infected person. Those who held this viewpoint were 79.8% learners, 87% parents and 72.7% cultural leaders.

4.4.4 Knowledge of who is vulnerable to HIV/AIDS infection

The respondents mentioned different groups of people whom they think could be infected with the HIV. They mentioned elderly people, homosexuals, husbands and wives; whilst others stated that all people of both genders could be infected with the virus.

- **Elderly people**

Those who mentioned that elderly people could be infected with the virus were 49% learners, 26.1% parents and 27.3% cultural leaders. The reasons they advanced were that the elderly are vulnerable to the HIV/AIDS infection since the virus is non-discriminatory – i.e. whether a person is old or not she can still be infected.

However some respondents believed that the elderly were immune from HIV infection. In the focus group discussion sessions some respondents stated that old women are usually not sexually active; and therefore when a young person indulges in sexual intercourse with an aged woman, there would be no friction and the chances of one being infected are low. They further mentioned that elderly people are not promiscuous hence the risks are minimal. Some respondents elaborated by mentioning that it was much safer to indulge in sexual intercourse with an elderly woman than a young person who is sexually active and might also be having several sexual partners. These findings were also stated by Phahlamohlaka (2000:34). The myths that prevail around the elderly being immune from HIV expose them to the danger of being raped by younger men who believe that the elderly could provide them with safer sex.

- **Homosexuals**

Ignorance about homosexuality was revealed in the focus group discussions. Homosexuality refers to indulgence in sex with others of the same gender. Many respondents mentioned that the risks of contracting HIV amongst the homosexuals were minimal. Only learners (53.7%) had knowledge that HIV/AIDS could be transmitted among

homosexuals; while 69.6% parents and 63.6% cultural leaders mentioned that HIV/AIDS could not be transmitted in homosexual relations. Parents and cultural leaders viewed same sex relations as disgusting but however safe. They believed that anal penetration resulted in semen and faeces mixing and no blood contact. Accordingly such semen would therefore be excreted without any danger of infection. These respondents viewed homosexuality as a safer but a disgusting way of avoiding HIV infection. They expressed disgust towards people indulging in homosexual relations and would not recommend this "abnormal, yet safe" method. Sexual activity between males is the primary risk factor for HIV infection and transmission. Numerous studies revealed that many gay couples practise anal intercourse. Quite a substantial number of men reported having had anal sexual intercourse with men and this is a high-risk behaviour for HIV infection. (Waldo, Stall and Coates 2000:10 ; Koblin, Torian, Guilin, Ren, Mackellar and Valleroy 2000:1796; and Prins, Sabin, Lee, Devereux and Coutinho 2000:1832).

- **Men**

Reactions to the statement that only men are vulnerable to HIV infection were quite controversial. There was finger pointing between male and female respondents as each blamed the other. Respondents who mentioned that men were vulnerable were fewer: 30.7% learners, 4.3% parents and 9.1% cultural leaders. They explained that polygamy and the tendency of men to have numerous sexual partners were socially approved practices. Society however, was against women having multiple sexual partners because they were more vulnerable to HIV infection. They cited the idiomatic expression that states that men were free to have as many sexual partners as they choose in order to increase the nation - (wanuna i n'hwembe wa nava – meaning that a man could have several sexual partners). The respondents further argued that it was not normal for an African man to have only one sexual partner. Women are more vulnerable to HIV/AIDS because they lack social and economic rights and have limited decision-making power on issues that affect their lives. Women's financial dependence on men expose them to infection with HIV (Mhloyi in Reid 1995:18; Mwadi in Reid 1995: 135; Laga et al 2001:933; Feldman et al 1997:462; Jackson et al 2001:3; Gysels, Pool and Nnalusiba 2002:182 and Schoepf

1993:91)). Clearly, the majority of respondents were sceptical about any programme that would criticise male behaviour or discourage them from having multiple sex partners. Christian denominations that were popular among the adult respondents viz the ZCC and IPCC too, were not against polygamy.

- **Women**

Some respondents, however, mentioned that women were the most vulnerable group to HIV infection. There were 36.6% learners, 65.2% parents and 36.4% cultural leaders who believed that. Learners and cultural leaders explained that they were likely to be infected with HIV, by their husbands who were promiscuous. Parents also mentioned that women (adulterers) who were not faithful to their husbands could bear children out of wedlock. They further indicated that women regardless of whether they were married or not, were weak and inclined to accept any and all men who proposed marriage to them. Respondents pointed out that some women sell themselves to men in exchange of money. Women experience difficulties, as they are not free to search for jobs away from their homes. Women are powerless and subservient to their men. They are not in the position to negotiate safer sex due to cultural norms (Wood and Foster 1995:25; Anthias 2001:373; Barnett, Whiteside, Khodakevich, Kruglov and Steshenko 2000:1397 and Ickovics and Yoshikawa 1998:196). Job opportunities in Malamulele are scarce and most women are left with no option but to accept commercialised sex as a way of earning a living. Unemployment and poverty affect a higher percentage of women than men. Despite the fact that South Africa is a democratic country, people in Malamulele are still experiencing problems of poverty and unemployment and subsequent habits which make them vulnerable to the HIV infection.

- **Both men and women**

The respondents (32.8% learners, 30.4% parents and 54.5% cultural leaders) confirmed the statement that both men and women were vulnerable to HIV infection. The respondents mentioned that, the virus was non discriminatory and that it infected both

males and females. Sentiments that were expressed were that "the virus does not have eyes to see". Cultural leaders emphasised the fact that whether a person is heterosexual, homosexual or bisexual (xitavala), the risks of being infected with HIV were unavoidable. At least some respondents were aware that all people irrespective of gender, age and/or religion were vulnerable to HIV infection. It was however, alarming that some respondents (less than 50% learners as well as their parents) were not aware of this fact.

SECTION D

4.5 ATTITUDES AND PERCEPTIONS ABOUT HIV/AIDS

Attitudes and perceptions of people about HIV/AIDS influence the prevention and treatment of the pandemic. Different views, beliefs, and attitudes about HIV/AIDS as expressed by different people in different environments determine acceptance and rejection of preventative and treatment procedures which are being developed and tried in different countries. Attitudes and perceptions of the respondents on HIV/AIDS were based on the information presented in focus group discussions as well as elaborations of respondents in the questionnaire. This information is qualitative in nature.

4.5.1 Belief of respondents with regard to prevention and treatment of HIV/AIDS

When all the respondents were asked to state whether HIV/AIDS is a preventable and treatable disease or not, respondents expressed different viewpoints. While some believed that it could be prevented, others were adamant that it could not be prevented. Some respondents also believed that HIV/AIDS was treatable, while others were aware that it could only be controlled but not cured. Ideas expressed were that it could be treated with herbs and/or belief in God, abstinence and/or being faithful to one's partner. In spite of different and contrasting beliefs held around the prevention and treatment of HIV/AIDS, respondents generally were aware of the ABC of prevention of the HIV/AIDS pandemic.

- **Discussion of condom use with wife and/or children**

When asked for their opinions on whether condom use should be negotiated between spouses and whether parents should discuss condom use with their adolescent sons and daughters or not, some respondents were for the idea while others were against. Only parents (69.6%) and cultural leaders (81.8%) however maintained that condom use could help in the further spread of the pandemic, yet the majority of the respondents expressed the viewpoint that it is a taboo in the African culture for a man to discuss condom use with either his wife and/or children. Whereas the majority of learners (80.2%) were aware that condoms could prevent the spread of HIV/AIDS only 30.4% parents and 18.2% cultural leaders shared this idea. The reason might be that parents and cultural leaders are conservative or have no accurate information as was found too by Jogunosimi (2001:2). The socio-cultural norms and values in the community place girls and women at high risk of contracting HIV. Adolescent girls and married women dare not to ask their boyfriends and/or husbands to use a condom, even if they are aware that they have indulged in extra-marital relationships (Department of Social Development 2002:144).

All respondents mentioned that the decision to use a condom rests with the man. The idea that it is the man's prerogative to decide whether to use a condom or not when indulging in sexual intercourse was expressed by 92.2% learners, 100% parents and 100% cultural leaders. Almost all respondents were adamant that a woman who initiated a condom use was viewed as being unfaithful to her husband and fear was expressed too that such a woman might soon take over all other decision-making in the household – a practice that is abhorred and not acceptable culturally in this male dominated community. In Malamulele, decision-making is still a male prerogative as they are still viewed as heads of families and also as sole breadwinners. Since Malamulele is a rural settlement, women are usually unemployed and expected to stay at home looking after children. Due to the fact that men are breadwinners, women have got no say with regard to sexual matters and the use of condoms. This is strengthened by the belief that women have got no say in sexual matters, as it is a man's prerogative to take decisions. When respondents were

asked about the possibility of discussing condom use with their children, only a low percentage, (17.4%) of the parents and (18.2%) cultural leaders agreed.

- **Use of traditional herbs and/or belief in God**

Some respondents believed and were adamant that HIV/AIDS was a curable disease. While 65.2% parents and 81.8% cultural leaders mentioned that this epidemic could be treated with the use of some traditional herbs, only 20.2% learners held this viewpoint. It was found that most men believed and used muti – traditional herbs for HIV prevention (Department of Social Development 2002:131). Respondents believed that traditional healers and faith healers were capable of curing HIV/AIDS. They stated that HIV/AIDS could be cured if those infected were to put their trust and faith in God. They mentioned that some faith healers had the power to heal believers. An investigation by Enews confirmed this belief (Patta, Enews, 2002 January 23).

- **Abstinence and faithfulness**

With regard to whether abstinence and faithfulness could help in the prevention and decrease of the pandemic, respondents were sceptical, as they could not visualise themselves and other people abstaining or being faithful to only one partner. They regarded both suggestions as a tall order. The viewpoint expressed was that it was impossible for adolescents and adults to abstain from sexual activities, as everybody had a natural craving for sex after reaching puberty. However, respondents emphasised that when indulging in sex, care should be taken that sex partners were chosen meticulously and not haphazardly. They blamed the prevailing laissez faire attitude, which results in people indulging in sex with complete strangers. They maintained that sex should be done with respect. Moreover the issue of being faithful to one's partner was viewed as unrealistic, impossible and unnatural as the crave for sex made people to demand immediate satisfaction and therefore in answer to the call to nature, sometimes partners sneaked out and sought for some extra-marital affairs. The respondents indicated that in African culture, men were viewed as macho if each had more than one sex partner.

Polygamy and promiscuity were therefore condoned. The view that a man's mistresses should be known and accepted by his wife and that he in turn should stick to the known mistresses only and that the number of these additional sex partners should be restricted was expressed. This practice was viewed as being faithful and honest. In actual fact if the male partner realised that he needed a second wife, the principal wife was expected to give her consent and even to take the responsibility of finding the woman for her husband. This principle applied also in the case of a third wife as well and all other additional sex partners that the husband might seek.

- **Attitude of respondents towards HIV/AIDS patients**

When asked about their own attitudes towards PLWHIV and PLWAIDS, the respondents were inclined to be on the defensive and to use denial about the existence of HIV/AIDS. They maintained that too much hullabaloo was being made about HIV/AIDS over and above other diseases whose fatal effects were being underplayed. Respondents mentioned that diseases like Tuberculosis (TB), Asthma and Malaria too were responsible for the death of many people just as HIV/AIDS, yet very little was said about them. Respondents felt that people infected with HIV/AIDS should be treated with the same respect as people suffering from other diseases. They argued that people were mortal and whether a person was suffering from HIV/AIDS or Malaria, when the time comes for him or her to die he/she would die. Another argument advanced was that even people who claimed to be highly moral (e.g. priests) too, were dying of HIV/AIDS, so there was no way in which this pandemic could be avoided. The opinion expressed was that medication (anti-retroviral medication) should be made available to all people who requested for it without discrimination. The researcher could detect a feeling of hopelessness and helplessness towards the pandemic, hence the inclination to use defence mechanisms e.g.

- Suppression – which helps people to disregard the existence and fatal effects of HIV/AIDS,

- Rationalisation – which helps people to justify their behaviour as they state that all people are vulnerable and therefore the disease is unavoidable

- Displacement – which enables people to blame others and categorise them as most vulnerable, e.g. foreigners, the poor and the illiterate.

- Denial – claiming not to know anyone who has died of HIV/AIDS or even never having seen an AIDS patient except on TV.

4.5.2 Viewpoints of respondents on HIV/AIDS

On the question of whether HIV/AIDS was an alien, invented, dreadful and shameful disease, respondents held different views and manifested different attitudes and perceptions towards HIV/AIDS. Whereas some regarded it as an alien disease, others indicated that the virus had been invented in order to destroy enemies. All respondents described it as a dreadful and shameful disease. They referred to the disease as the white man's disease, a disease of 'others' (foreigners) and the killer disease. It was clear that none of the respondents seemed to be aware of the fact that they too were vulnerable to the disease. They all tended to disassociate themselves from it, hence their referral to it as the white man's disease or a disease of "others" (foreigners).

- **Alien disease**

There were various sentiments regarding the origin of HIV/AIDS. Most respondents mentioned that it is a disease of foreigners (particularly whites) who came from overseas and settled in South Africa. Only 14.2% learners mentioned that it is an alien disease whereas the rest of the learners (85.8%) mentioned that all people who were promiscuous were liable to be infected. The majority of parents (65.2%) and cultural leaders (54.5%) however, agreed that HIV/AIDS is an alien disease. They mentioned that HIV/AIDS is a white man's disease and that it is a tool used by whites who want to kill the black race. Those who harboured the latter idea felt helpless, they stated that the disease was a white

man's invention and the black people were victims who could do nothing to prevent infection. The researcher feels that educational programmes are essential among the people in Malamulele. Programmes introduced to all people should aim at attitude and behaviour change in order to decrease the pandemic.

- **Invented disease**

The respondents mentioned that HIV/AIDS is not a natural disease like any other disease, but rather it was a man-made disease. Parents (91.3%) and cultural leaders (72.8%) agreed that HIV/AIDS had been invented by whites in order to destroy the black race. This confirms studies conducted by Thomas and Quinn (as cited by Klonoff and Landrine 1997:56). Only (42.3%) learners agreed that HIV/AIDS is an invented disease. Those who mentioned that HIV/AIDS is an invented disease explained that scientists (whites) were reluctant to find a cure for the disease, as they had invented it themselves, whereas they were keen to find a cure for all other diseases. Respondents indicated that only black people were shown in all pamphlets on the epidemic as proof that the disease killed only black people.

- **Dreadful and shameful disease**

Respondents mentioned that HIV/AIDS is a dreadful and shameful disease. All respondents stated that they did not know nor had they ever seen any one who had died or suffered from the disease. They mentioned that they only see people who claim to be infected with HIV/AIDS on television and/or hear them speaking on radio, hence they denied the existence of the disease. They regarded TV and radio talks as a strategy used by whites to control blacks and subsequently reduce the birth rate and numbers of black people in the country. The negative attitudes and myths upheld about the disease perpetuate denial and secrecy as no one would like to be known and/or to be seen as dying from the disease. All respondents mentioned that although it is difficult to know whether the person is infected or not, to expose one and even to go for a blood test would

be more difficult. Clearly all respondents were against disclosure of the disease and preferred a cloak of secrecy around it.

4.5.3 Perceptions of respondents on promiscuity as a cause of HIV/AIDS

- **Religious views on promiscuity and HIV/AIDS**

Generally, all human beings subscribe to some form of religion whether eastern, western or African (traditional). Many people who subscribe to western religion such as Christianity usually uphold their religious values, which tend to forbid fornication and extra-marital relationships, hence some respondents viewed HIV/AIDS as a curse from God. Some faith and traditional healers in Africa teach that HIV/AIDS is a shameful disease and a punishment for those who have been sexually promiscuous. Many people are reluctant to admit to a disease that seems to imply promiscuity (Jogunosimi 2001: 2). Christians are reluctant to admit to a disease that seems to imply promiscuity as Christian doctrines are against promiscuity. Some respondents mentioned that since HIV/AIDS is currently incurable, the pandemic was therefore a sign of the end of the world as prophesised in the bible. Those who subscribed to African/traditional worship argued that God had created fewer men and more women so as to cater for man's craving for sex with numerous sex partners, hence there was nothing wrong with males having multiple sexual partners. HIV/AIDS is spreading and killing people because people no longer appease gods and do not conform to cultural practices (Woods and Ironson 1999:396; Di Lima and Schust 1997:149 and Raditapole in Reid 1995:61). They further argued that HIV/AIDS was a man-made disease. HIV/AIDS has been invented by whites to destroy the black community. These respondents regarded themselves as immune from HIV/AIDS. They said that it could not infect them if they still performed rituals to appease their ancestors. They mentioned that ancestors have power to protect people against misfortunes and also to provide people with luck and fortune. If people distanced themselves from performing rituals/rites this pandemic would destroy them, as they would be without protection from ancestors.

- **Cultural views on promiscuity and HIV/AIDS**

Respondents indicated that multiple sex partners for males were condoned and actually averred in African culture. Respondents stated that their forefathers had more than one wife. Some had as many as ten wives or more and this was regarded as a sign of wealth as each wife would bear as many children as she could and the man would then reign supreme among his wives and children. The more wives he had, the more respect he earned from others. In support of this, women are regarded as inferior, weak and passive. Men are empowered to order women about, and to use them as their sex tools in their own time without being disturbed, deterred or questioned. Respondents argued that before the "invention" of HIV/AIDS traditionalists never died of HIV/AIDS. They further argued that because black people have now distanced themselves from cultural practices, which were meant to protect them against ailments, they had now become victims to many ailments including HIV/AIDS.

4.5.4 Attitudes and perceptions of respondents on initiation schools and condom use

- **The role of initiation schools**

The respondents mentioned that initiation schools were cultural practices and therefore should not be interfered with. All respondents (100%), learners, parents and cultural leaders mentioned that initiation schools play the biggest role in shaping the lives of people. They mentioned that these schools were essential as they served to train boys into men and girls into women who are responsible. They further mentioned that some mores and values about life were taught to the initiates. Both boys and girls were taught to tolerate any harsh condition they might encounter in future. Respondents further stated that initiation schools were the sole custodian and an appropriate vehicle to carry cultural values, norms and mores to future generations and that without them there would be no African nation. Seemingly people regard initiation in high esteem and see no reason why government should participate in developing laws to regulate these schools. To them

interference means condoning moral decay amongst people. Clearly, the respondents viewed initiation schools as essential and valuable. The United Nation's emphasis of respect for cultural practices is captured in the following statement: "when considering the cultural appropriateness of a particular programme, the designers also need to understand the context of the parents and community's attitudes about (the problem) and how that affects their children's knowledge, attitudes and beliefs (UNODC 2003:14).

- **Discussion of condom use at initiation schools**

All respondents were unanimous that there should be no interference with the teachings of initiation schools and that discussions on condom use should be done elsewhere not at initiation schools. Discussions of condom use should be abhorred at all times and costs at initiation schools. They emphasised that initiation schools are traditional institutions, which do not provide certification to boys and girls to indulge in sexual activities, but rather they teach young people respect and perseverance in life. They mentioned that protection against the infection by HIV/AIDS could be done through observance of cultural norms and values with regard to sexual matters.

- **Initiation of sexual activities for boys and girls**

In Malamulele, it is not the attainment of a specific chronological age that determines that one is now an adult but rather it is through the initiation schools that are conducted for boys and girls, that children are then declared men and women. Respondents, (65.2% parents) mentioned that after circumcision, boys and girls could immediately indulge in sexual activities, whereas 39.1% learners and 36.4% cultural leaders mentioned that these young ones ought to wait for a little while due to the fact that they might still be feeling some pains after circumcision. Parents also mentioned that before sending their sons to the initiation schools they always take their age into consideration and assess whether the young person might be ready for sexual intercourse, while for girls they send them as soon as they begin to menstruate as they believe that the girls are then ready to conceive and that it is culturally incorrect for a girl to give birth before graduating from an

initiation school. It was interesting to note that parents in Malamulele were not concerned that some girls may begin to menstruate from the early age of 10 years. The researcher also observed that the parents were reluctant to acknowledge that as initiation schools were conducted once in every five years, some parents were hasty to send boys for initiation even before they reached puberty.

4.5.5 Perceptions of respondents on traditional norms and conventions

- **Practice of "ku lovolela kumbe ku lovota" – paying of bride price (lobola) by the family**

For many years back in Malamulele, when a man felt he was ready for marriage, his family members would go out of their way looking for a partner for him. A situation wherein a young man and a young woman would agree to marry each other was a taboo. Marriage was an issue of the whole family not an individual. Only 38.7% learners concurred with this practice whereas 61.3% were against it. Those who were against it mentioned that it limits their opportunities of marrying women of their choice as the choice of the family was imposed on each young person. The second reason advanced by respondents (learners) was that in modern life they, as young people wanted to prove their abilities with regard to skills and tactics of proposing marriage to ladies. Nonetheless, those who concurred with the practice together with parents and cultural leaders mentioned that choice of a bride by the family is a good practice, because when the family members search for a wife for their sons, they considered values such as whether the lady was respectful and hardworking as opposed to the values that young people look for, such as physical beauty and the economic status of the person. They emphasised the fact that most families, which exist, are products of this practice and divorce among such marriages was rare as compared to marriages in which the family had not participated in choosing a bride.

4.6 CONCLUSION

The data collected was presented, analysed and interpreted in the forms of tables, bar graphs, pie charts and histograms. Seemingly, cultural elements play a role in hindering preventative and treatment services to both infected and affected people with HIV/AIDS. The next chapter would be based on restatements of the problem, aim and objectives, findings and conclusions of the study as well as the recommendations.

CHAPTER FIVE

SUMMARY OF THE MAJOR FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter the problem statement has been restated and the aim and objectives as well as the assumptions of the study. Findings and conclusions have been drawn from the data that was gathered through a questionnaire and focus group discussions that were conducted with learners, their parents and traditional (cultural) leaders. This chapter has been concluded with recommendations that have been made by the researcher.

5.2 RESTATEMENT OF THE PROBLEM STATEMENT

Records on HIV/AIDS reveal that the incidence of the disease is higher in the Republic of South Africa (RSA) as compared to other countries in the world (Morison 2001:13). The Medical Research Council in its report for the year (2002) indicated that 1500 people in the RSA get infected with HIV/AIDS on a daily basis. This dreadful disease reportedly claims many lives daily. There are many hazards, which hinder the decrease or even the extermination of this disease in the RSA. Amongst others are poverty, cultural practices and even political haggling over the distribution of the anti-retroviral drugs (nevirapine) to the potential victims of HIV/AIDS. It is however, unfortunate that when the debate on nevirapine ends, it is mostly the urban dwellers who will benefit since rural health centres are to a large extent inadequate and not easily accessible to the majority of the poor who live in the developing provinces such as the Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo.

One major factor, which is prominent in the spread of HIV/AIDS, is the use and abuse of alcohol and drugs as these lead to risk-taking behaviour, which occurs because of impaired judgement (Strunin and Hingson in Sherr 1993:126). Some of the risks taken by people under the influence of alcohol and/or drugs entail the practice of needle sharing and unsafe sexual behaviour, which makes them vulnerable to infection. Youth, particularly adolescents are most prone to infection as they are inclined to experiment with and to take risks with alcohol, drugs and sexual intercourse. Strunin and Hingson in Sherr (1993:126) assert that the rate of unprotected sexual behaviour is high among the adolescents.

The social dimensions of HIV/AIDS are far too serious and complicated. Each situation, which requires prevention and/or treatment, is unique. This implies that both prevention and treatment strategies require an understanding of the cultural context in which both strategies have to take place. A review of both strategies at the micro-level (individuals, families, and communities) and also at the macro-level (poverty, urbanisation, and gender relations) reveals that programs on prevention and treatment must not overlook beliefs, attitudes and culture of the victims as well as potential victims of the pandemic (Bharat 2000:45).

Cyr-Delpe in Reid (1995:67) points out that culture is at the core of the struggle against HIV around the world and the hope for the future is anchored on the changing attitudes and sexual behaviour, which is inclusive of personal, religious, and social beliefs. Other researchers too, have observed that there is a tendency amongst black people, to underestimate the personal risk to HIV infection (Kalichman as quoted by Klonoff and Landrine 1997:51). It is therefore essential that a multi-disciplinary approach which amongst other disciplines, includes social work, should be used in the prevention and treatment of HIV/AIDS. Social work is described by Sheafor, Horesji and Horesji (1997:4) as the "professional activity of helping individuals, families, groups, or communities to enhance or restore their capacity for social functioning and for creating societal conditions favourable to this goal". The role of the social worker in the prevention and treatment of HIV/AIDS is that of educator – to teach and provide patients and prospective victims with

information necessary for their social functioning. Social work intervention does not only confine itself to the patients (victims), but it focuses on a broad spectrum which also involves significant others (family, friends, contacts and the entire community) in the therapy process. In this study, the impact of culture on the prevention and treatment of HIV/AIDS at the Malamulele District in the Limpopo Province will be assessed from a social work perspective. The following observations with regard to condom use have been made:

- Condom use and non-condom use among married couples

Women are forced to rely on their partners' willingness to use a condom. The final decision during sexual intercourse, for the use of a condom, rests with the male partner (Fontanet, Soba, Chandelying, Sakondhavat, Bhilaleus, Rujpao, Chongsomchai, Kiriwat, Tovanabutra, Dally, Lange and Rojanapithayakorn 1998:1852 and Hankins in Sherr 1993:31).

- Condom use and non-condom use among adolescents

Strunin and Hingson in Sherr (1993:130) found that adolescents believe that condoms reduce sexual pleasure. Young people have negative attitudes towards condoms and as such they are unlikely to use them. Studies conducted by Peersman and Levy (1998:191); Buzi, Weinman and Smith (1998:314) and Piery, Foutes and Bordean as cited by Phahlamohlaka (2000: 21 – 22) indicate that young people are reluctant to use condoms during sexual intercourse. As long as the youth uphold this myth about condoms minimizing sexual pleasure, the incidence of HIV/AIDS cannot be reduced.

5.3 RESTATEMENT OF THE AIM AND THE OBJECTIVES OF THE STUDY

5.3.1 The aim of the study

The current research is a baseline study that will provide information on the lifestyle, beliefs, and attitudes of the people in Malamulele with regard to HIV/AIDS. The study will also provide the respondents with information in order to help them change their negative lifestyle, beliefs, and attitudes towards the pandemic. The main aim of this study is to explore and assess the cultural elements, which deter HIV/AIDS prevention and treatment methods.

The main aim of the study was achieved. The researcher explored and assessed various cultural elements such as sexuality and gender diversity, power relations on sexual matters, polygamy, role of the religion and socio-political and socio-cultural elements, link between substance abuse and HIV/AIDS, condom use, and problems hindering prevention and treatment programmes. The researcher conducted some preliminary discussions with the respondents before administering the questionnaire, which too helped to challenge the behaviour of the respondents with regard to their perceptions and attitudes towards the HIV/AIDS pandemic. The researcher also conducted focus group discussion sessions with the respondents whereby respondents were given an opportunity to express their perceptions and attitudes about cultural elements on the prevention and treatment of HIV/AIDS amongst the rural people in Malamulele. The study has explored ways of removing prevailing myths around HIV/AIDS. The researcher has also made an attempt to empower people with skills towards conscientising them and encouraging them to adopt a lifestyle that will alleviate the epidemic.

5.3.2 Objectives of the study

- **To assess the perceptions and interpretations of people on HIV/AIDS within a specific cultural environment (Malamulele Central Circuit)**

There were various perceptions and interpretations with regard to HIV/AIDS by people in Malamulele. It was found that the majority of parents (65.2%) and cultural leaders (54.5%) held the idea that HIV/AIDS is an alien disease. They contended that HIV/AIDS is a white man's disease aimed at destroying the black race. In actual fact respondents mentioned that HIV/AIDS is a disease that has been invented by whites to kill black people. They argued that only black people are shown on pamphlets on HIV/AIDS and never whites. All respondents stated that HIV/AIDS is a dreadful and shameful disease. This implied that respondents would not be able to disclose their HIV statuses as the disease is associated with promiscuity and no one would be happy to be seen dying from HIV/AIDS. However, some respondents regarded HIV/AIDS as a punishment from God for misconduct. These findings are in support of those by Svekerud and Singhal (1998:99), Woods and Ironson (1999:396) and Pattillo-McCoy (1998:768) who stated that HIV is regarded as a curse from God for one's transgressions. Ancestral worshipers however, blamed HIV/AIDS on witchcraft as stated also by (Lathan as quoted by Umeh 1997: xvi and Schoffeleers 1999:413-414).

- **To explore the beliefs of young people, parents and cultural [traditional] leaders in Malamulele on the causes of HIV/AIDS**

This objective was achieved. Respondents stated that their beliefs on the causes of HIV/AIDS as indicated in Fig. 29. They provided various causes of HIV such as that: it is a sexually transmitted disease, whereas some stated that it is just a virus while others mentioned that it is caused by non-condom use. The respondents also mentioned that HIV/AIDS is a curse from God and occurs due to non-compliance to the set norms, conventions, values and mores. However, other reasons advanced were that promiscuity and polygamy play a role in enabling the further spread of HIV/AIDS and that women were

not in a position to negotiate safer sex due to cultural norms and values which relegate them to an unfair position particularly in the family. These beliefs were also found by other researchers such as Wood and Foster (1995:25). Frazier, Cochran and Olson (1995:23) indicated that women are socialised to be humble and to obey their husbands. Men are likely to have sporadic relationships and to have several sexual partners (Sigh, Wulf, Samara and Cuca, 2000:21 and 27).

- **To explore the knowledge around the means of HIV/AIDS prevention (Malamulele Central District)**

The researcher found that the majority of the respondents (82.6% parents and 81.8%cultural leaders) stated that condoms were not effective in prevention of HIV/AIDS. However, 80.2% learners were aware that condom use was an effective method in the prevention of HIV/AIDS. The majority of parents (65.2%) and cultural leaders (81.8%) mentioned that HIV/AIDS could be treated through the use of traditional herbs; while only 20.2% learners shared this viewpoint. However, respondents mentioned abstinence and faithfulness as a means to prevent the further spread of the HIV/AIDS pandemic. Nonetheless, respondents stated that it was difficult for an African man to abstain and to be faithful only to one partner; hence polygamy and multiple sex partners were condoned and found to be an acceptable practice.

- **To investigate the level of knowledge related to the transmission of HIV/AIDS**

The researcher found that respondents knew several means of HIV/AIDS transmission although some were unrealistic and difficult to prove scientifically. They mentioned mother-to-child transmission, intravenous drug use, breastfeeding, rape, mosquitoes, sharing and using utensils and food as well as hugging and kissing. The majority of the respondents were aware that unborn babies could be infected with HIV during the birth process. With regard to intravenous drug use, a very low percentages of the respondents (5.9%) learners, (25%) parents and (10%) cultural leaders stated that this method could lead to HIV infection. However, the researcher found that respondents still believed in the

myth that some health professionals inject people with contaminated blood in order to kill them.

- **To add to the knowledge base of the caring professions such as Social work, Nursing, and Clinical Psychology on the impact of culture on the prevention and treatment of HIV/AIDS**

The researcher will make the research findings available to those who will need to use them particularly social scientists and other professionals in the caring professions who work in the field of HIV/AIDS.

5.4 RESTATEMENT OF THE ASSUMPTIONS OF THE STUDY

Since the study was exploratory, only assumptions were developed to guide the study. An exploratory study generates hypotheses, which could be used as a point of departure for future research studies. The following assumptions were made for the purpose of this study:

- **Unequal power relations between men and women with regard to sexual matters, have an impact on the increasing rate of the HIV/AIDS pandemic**

This assumption tested positive. It could be observed by the low percentages of respondents (learners: 30.7%), (parents: 4.3%) and (cultural leaders: 9.1%) who stated that men were more vulnerable compared to (36.6% learners), (65.2% parents) and (36.4% cultural leaders) who mentioned that women were more vulnerable. Moreover, all respondents (100% parents and cultural leaders and 92.2% learners) mentioned that it was a man's prerogative to decide on the use of a condom during sexual intercourse. Men's extramarital relations were generally condoned and were found to be socially acceptable whilst promiscuity amongst women was punishable and referred to as prostitution. Other researchers who also found this were Little, Obbo, Larson and Caldwell et al as quoted by Rushing (1995:65). Due to the fact that men were allowed to have

multiple sexual partners, they could serve as carriers who transmit HIV/AIDS from one woman to another unconsciously.

- **Unemployment and poverty have a significant impact on the HIV/AIDS pandemic**

The above-mentioned assumption was validated by the respondents who mentioned that women's financial dependency on men expose them to HIV infection. Financial dependency often limits the (women's) subordinate's power to negotiate for safer sex and condom use. This data confirmed findings of other researchers such as Svenkerud and Singhal 1998:212; Young et al 2001:302; Melkote and Goswami 2000: 102; Janssen et al 2000:488; Mwadi in Reid 1995: 135; Laga et al 2001:933 and Feldman et al 1997:462).

- **Condom use amongst young people is low**

The researcher in Fig. 19 found that more than one half of the learners indicated that they used condoms during sexual intercourse. However, contrasting data is presented in Fig. 20, which indicated that 100% learners indicated that they would indulge in sex even if condoms were unavailable; whereas in Fig. 21 learners mentioned that they would not fool around (kiss and pet) and would rather indulge in sexual intercourse. This confirms findings by Buzi et al (1998:317); Hubbs-Tait and Garmon (1995:558); Campbell (1999:31); Vogel's, Brugman and Van Zessen (1999:376); Strunin and Hingson in Sherr (1993:130) and Peersman and Levy (1998:191) who found that there is low use of condoms amongst adolescents generally.

- **Some practices at initiation schools contribute to the spread of HIV/AIDS**

Young men (boys) and young women (girls) are trained into men and women. Young men are concerned about proving their virility while the young women tend to look forward to be mothers. They are taught that men could have several sexual partners which is a high-risk behaviour for HIV infection and women should not. Some respondents indicated that they were cohabitating as confirmed by Fig. 3.

- **Traditional norms and conventions are still prevalent in Malamulele**

It was found that in Malamulele, 100% (parents and cultural leaders) and 38.7% learners concurred with the practice of "ku lovolela kumbe ku lovota". People still believe and conform to their traditional practices particularly when it comes to issues of marriage. The reasons advanced by the respondents were that most families, which are still in existence and are operational, are products of this practice and divorce among such marriages was rare as compared to marriages in which the family had not participated in choosing a bride. The family members who participate in searching for the bride, look for a respectful and hardworking woman whereas modern young men consider wives with beauty and financial status. With regard to initiation schools, all respondents (100%) were unanimous that initiation schools are traditional institutions, which must be revered. Respondents contended that initiation schools preserve societal norms, values and mores and pass them on to future generations. Moreover, the respondents clearly mentioned that there should be no interference with the teachings of initiation schools and that discussions on condom use should be done elsewhere and not at initiation schools. Discussions of condom use should be abhorred at all times and costs at initiation schools. Whereas 65.2% parents mentioned that initiates could indulge in sexual activities immediately from circumcision, 39.1% learners and 36.4% cultural leaders were against the viewpoint that initiates could indulge in sexual activities immediately after returning from circumcision schools.

5.5 FINDINGS AND CONCLUSIONS DRAWN FROM THE STUDY

A summary of major findings from this study has been presented as follows:

5.5.1 FINDINGS OF THE STUDY

- **Age of the learners in Malamulele high schools**

A substantial percentage of learners in Malamulele high schools were beyond 21 years. Fig. 1 indicates that 24.5% learners were above the age of 21. This finding has implications on primary prevention programme designers, as they should target not only adolescents but young adults as well.

- **Some learners in high schools in Malamulele were married and/or cohabitating and they have children**

It is not surprising in Malamulele for a female learner to go to school having left a child at home with in-laws or probably with her mother or grand-mother. Some learners were staying with their spouses. They were heading or caring for the family whilst attending school. Fig. 3 indicates that 16% were married. It would be crucial for primary prevention programmes on HIV/AIDS to consider the fact that learners in Malamulele were sexually active, married and/or cohabitating and that they might be staying with their spouses.

- **High school learners in Malamulele were not proficient in English**

In Table 2 it was indicated that 75% learners were not proficient in English and programme designers should be able to design a programme which would be offered in the language respondents would be most comfortable with.

- **The majority of the respondents were Christians**

In this study the majority of the respondents were Christians as indicated in Fig. 4, Table 3 and Fig. 15 respectively. This implies that programmes on the primary prevention of HIV/AIDS should also target Christians. Most of the Christians were reluctant to discuss

about HIV/AIDS as this to them implies promiscuity and they would not want to be associated with that. This was stated too by Jogunosimi (2001: 2).

- **Learners in Malamulele were involved in sexual activities at an early age**

The onset of sexual activities among the learners in Malamulele was at a very early age, as indicated by Fig. 17. However, Table 8 revealed that some learners had sexual intercourse with children below the age of 16 years. In reality, sexual activities begin from an early age of about 13 years. Programme designers should as well target children even in primary and lower primary schools because they may be involved sexually. This is also confirmed by other researchers such as UNFPA (2003:15) and Campbell (1999:31).

- **Almost all learners in Malamulele indulge in substance use**

In spite of the fact that in Table 11, 70% learners mentioned that they did not use any substances, Fig. 23 however, indicates that they do use substances as almost all of them rated sex either good, better or best after one had used substances. This too, was found by Kesby (2000:1728) and Plant in Sherr (1993:223-226).

- **Knowledge about causes, symptoms and transmission of HIV/AIDS amongst the respondents was inaccurate and inadequate**

It was found in Chapter 4 – Section C (4.4.1 – 4.4.3) that the respondents had minimal and inaccurate information about the causes of HIV/AIDS. They mentioned for instance that HIV/AIDS is a curse from God for immoral behaviour. It could be presumed that as only a low percentage of learners (12%) and (21.6%) parents were aware that HIV/AIDS is incurable, the majority, (88%) learners, (78.4%) parents and (100%) cultural leaders, were of the opinion that HIV/AIDS is curable. With regard to the symptoms of HIV/AIDS, the respondents mentioned that by mere looking at the person they might be able to tell whether the person is HIV positive or not. Knowledge on the transmission of HIV/AIDS was minimal and froth with bias. Some information provided by the respondents was that

mosquitoes, sharing of utensils and food as well as hugging and kissing could transmit HIV/AIDS.

- **Knowledge on persons who are vulnerable to HIV/AIDS was inaccurate**

It was found that most respondents had inaccurate, minimal and biased information regarding who might be vulnerable to HIV infection. Some respondents stated that the elderly and the homosexuals could not be infected with HIV/AIDS. They argued that the elderly were immune from HIV as they are not promiscuous hence they could provide the younger people with safer sex (see Chapter 4, 4.4.4).

- **Polygamy and indulgence with several sexual partners by males is condoned**

Polygamy and/or the practice of having several sexual partners (wives and mistresses) were explained as acceptable in African culture. The majority of learners in Malamulele became sexually active even before the age of sixteen years, with more than one partner. Fig. 17 and Fig. 18 respectively indicated that the respondents (learners) were actively involved sexually. It was revealed that all youth had at least one sexual partner while some had more than one. In Malamulele, having more than one sexual partner is acceptable as it is regarded as normal conduct for men hence youth too, feel free to be involved in multiple sexual relationships. Men's superiority is bestowed to them on an intricate belief system that women are powerless and should be subservient to them (Anthias, 2001:373, Sewpaul and Rollins, 1999:260, Hankins in Sherr, 1993:29 and Mashishi, 2000:82 – 83). Respondents confirmed that polygamy is still upheld and viewed as a normal way of living by members of the community. This further indicates that youth were socialised to believe that having multiple sexual partners is a sign of maturity and being macho. Seemingly people were still conforming to their cultural practices. Respondents did not regard themselves as vulnerable to HIV infection. Garcia-Moreno and Watts (2000:254) stated that usually men use power over women, which is culturally sanctioned. Women are expected to assume a position of subordination.

- **Condom use is minimal in Malamulele as respondents were sceptical about its effectiveness**

Although more than one half of the learners (55.2% males and 55.8% females) in Fig. 19 indicated that they used condoms, quite a substantial number of learners did not use condoms at all. Those who stated that they used condoms did not do so regularly. In Fig. 20, learners mentioned that they would have sex even if there was no condom. The majority of parents (69.6%), cultural leaders (81.8%) and only 19.8% learners did not believe that condoms could prevent the further spread of HIV/AIDS. Many men abhorred using condoms while women inevitably have little control over the use of condoms (Barnett and Blaikie 1994:3; Fusilier et al 1998:208 and Bentley et al 1998:1876).

- **Senior citizens in Malamulele still upheld the belief that use of traditional herbs and/or belief in God could cure HIV/AIDS**

There is still a belief amongst people in Malamulele that HIV/AIDS could be treated through the use of traditional herbs and/or belief in God (4.5.1).

5.5.2 CONCLUSIONS

The following conclusions were drawn from the above-mentioned findings:

- In Malamulele, age limits are not set for learners hence learners of all ages intermingle and make it difficult to introduce age-specific programmes in the different classes

- Learners who are married and/or cohabiting attend school together with younger learners, hence lessons on abstention from sex to learners in high school are laughable

- Christianity is the dominant religion practiced in Malamulele but the most popular denominations are those that have no objection to polygamy and/or ignore multiple sex partners for men

- Respondents upheld the myth that substance use (alcohol) could improve performance during sexual intercourse

- There is need for extensive HIV/AIDS awareness campaigns and programmes in Malamulele, as ignorance about the causes, symptoms and transmission of the disease still abound
- There is a dearth of information about HIV/AIDS with special reference to prevention, treatment and who might be vulnerable to HIV infection generally

5.6 RECOMMENDATIONS

Based on the findings and conclusions drawn in this study the researcher recommends that:

- HIV/AIDS programme designers should target learners irrespective of age limits.

- The cooperation of traditional leaders and the entire community should be sought with regard to introduction of HIV/AIDS prevention programmes in initiation schools.

- HIV/AIDS prevention programmes should be presented in Xitsonga and pamphlets should be written in Xitsonga, as a large number of people (both old and young) are proficient in the language.

- HIV/AIDS prevention programmes should target the churches and seek their cooperation in delivering prevention and treatment messages on HIV/AIDS.

- Recreational facilities for youth should be established to deter youth from substance use and subsequent sexual activities.

- HIV/AIDS prevention programmes should discourage behavioural practices such as polygamy and promiscuity as they fuel the further spread of HIV/AIDS.

- HIV/AIDS prevention programmes in Malamulele should target the youth focusing on the effectiveness of condoms for protection against HIV infection and pregnancy.

- Human rights workshop should be held with the rural people to enlighten them about their rights particularly when making decisions that have a long-term impact on their life like choosing a life partner.

BIBLIOGRAPHY/REFERENCES

BOOKS

Bandura, A 1997. **Exercise of personal and collective efficacy in changing societies.** In Bandura, A (ed), Self-efficacy in changing societies. Cambridge: Cambridge University Press.

Bailey, WA 1995. The importance of HIV prevention programming to the Lesbian and Gay community. In Herek, G. M & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Barker, RL 1999. **The social work dictionary. Fourth edition.** Washington, DC: NASW Press.

Barnett, T & Blaikie, P 1994. **AIDS in Africa: Its present and future impact.** Chichester: John Wiley and Sons.

Black, TR 1998. **Evaluating social science research: An introduction.** London: Sage Publication.

Blackburn, C 1996. Building a poverty perspectives into health visiting practice. In Bywaters, P & McLeod, E (eds), **Working for equality in health.** London: Routledge Publishers.

Blair, C; Ojakoa, D; Ochola, SA & Gogi, D 1997. Barriers to behaviour change: Results of Focus Group Discussions conducted in a high HIV/AIDS incidence area of Kenya. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education.** Eritrea: Africa World Press, Inc.

Bonnel, C & Imrie, J 2001. Behavioural interventions to prevent HIV infection: Rapid evolution, increasing rigour, moderate success. In Weiss, R.A; Adler, M.W & Rowland-Jones, SL (eds), **British Medical Bulletin-The changing face of HIV/AIDS**. Oxford: Oxford University Press.

Bor, R 1993. The family and HIV disease. In Sherr, L (ed), **AIDS and the heterosexual population.** Switzerland: Harwood academic Publishers.

Boulton, M 1994. **Challenges and Innovations: Methodological advances in social research on HIV/AIDS.** London: Taylor and Francis Publishers.

Bunch, L; Carrillo, R & Shore, R 1998. Violence against women. In Stromquist, NP (ed), **Women in the Third World: An Encyclopaedia of contemporary issues.** New York: Garland Publishing Company.

Bywaters, P & McLeod, E 1996. Can social work deliver on health. In Bywaters, P & McLeod, E (eds), **Working for equality in health.** London: Routledge Publishers.

Campbell, CA 1999. **Women, families and HIV/AIDS: A sociological perspectives on the epidemic in America**. Cambridge: Cambridge University Press.

Cyr-Delpe, MS 1995. On the eve of destruction. In Reid, E. (ed). **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

De Miranda, S 1996. **The South African Guide to Drugs and drug abuse.** South Africa: Michael Collins Publications cc.

Denzin, NK & Lincoln, YS 1998. **The landscape of Qualitative Research: Theories and Issues.** London: Sage Publication.

Deocampo, N & Fleras, J 1995. Struggling with contradictions. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Department of Social Development (Chief Directorate – Population and Development) 2002. **Documenting HIV/AIDS Case Studies in South Africa.** Vol 1. Pretoria: Department of Social Development Publication.

De Vos, AS 1998. Intervention research. In De Vos, AS (ed), **Research at Grass Roots: A primer for the caring professions.** Pretoria: J.L. Van Schaik.

De Vos, AS; Schurink, EM & Strydom, H 1998. The nature of research in the caring professions. In De Vos, AS (ed), **Research at Grass Roots: A primer for the caring professions.** Pretoria: J.L. Van Schaik.

DiClemente, RJ & Wingood, GM 1997. Prevention of Human Immunodeficiency Virus infection among African-American adolescents: The importance of understanding cultural and psychosocial influences in the development of HIV prevention programs. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education.** Eritrea: Africa World Press, Inc.

Di Lima, SN & Schust, C S 1997. **Community Health Education and Promotion: A Guide to Program Design and Evaluation**. Maryland: Aspen Publications.

Doyle, P; Muhr, T; Steinberg; M & Broomberg, J 1998. Towards optimisation of the HIV modelling process in South Africa. In Whiteside, A (ed), **Implications of AIDS for demography and policy in Southern Africa**. Pietermaritzburg: University of Natal Press.

Esu-Williams, E 1995. Clients and commercial sex work. In Reid, E (ed). **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Foreman, M 1999. **AIDS and Men: Taking Risks or Taking Responsibility?** London: Panos Institute and Zed Books.

Fouché, CB & De Vos, AS 1998. Selection of a researchable topic. In De Vos, AS (ed), **Research at Grass Roots: A primer for the caring professions**. Pretoria: JL Van Schaik.

Fransen, L 1998. HIV in developing countries. In Whiteside, A (ed), **Implications of AIDS for demography and policy in Southern Africa.** Pietermaritzburg: University of Natal Press.

Friendman, SR; De Jarlais, DC; Ward, TP; Jose, B; Neaigus, A & Goldstein, M 1993. Drug injectors and heterosexual AIDS. In Sherr, L (ed), **AIDS and the heterosexual population.** Switzerland: Harwood academic Publishers.

Gilks, C F 2001. HIV care in non-industrialised countries. In Weiss, R.A; Adler, M.W & Rowland-Jones, SL (eds), **British Medical Bulletin-The changing face of HIV/AIDS**. Oxford: Oxford University Press.

Gómez, CA 1995. Lesbians at risk for HIV: The unresolved debate. In Herek, G M & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Hankins, C 1993. Women and HIV infection. In Sherr, L (ed), **AIDS and the heterosexual population**. Switzerland: Harwood academic publishers.

Harris, M 1997. **Culture, People and Nature: An introduction to general Anthropology. Seven edition**. New York: Addison-Wesley educational publishers, Inc.

Hemien, RH & Rabkin, JG 1995. Long-term survival with AIDS and the role of community. In Herek, GM & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Hepworth, DH & Larsen, JA 1993. **Direct social work practice: Theory and skills. Fourth edition.** California: Brooks/Cole Publishing Company.

Johnson, LC 1995. **Social work practice: A generalist approach. Fifth edition.** Boston: Allyn & Bacon.

Keesing, RM & Strathern, AJ 1998. **Cultural Anthropology: A contemporary perspective.** Third edition. Fort Worth: Hartcourt Brace college publishers.

Kottak, CP 1997. **Anthropology: The exploration of human diversity. International edition.** New York: McGraw-Hill Company, Inc.

Malama, M 1994. Community involvement in AIDS care and prevention in a rural hospital . In Kasonde, JM & Martin, JD (eds), **Experiences with primary health care in Zambia.** Switzerland, Geneva: WHO.

Margow, R 1999. **Successful Single Parenting**. Cape Town: University of Cape Town Press.

Mayaud, P & McCormick, D 2001. Interventions against sexually transmitted infections (STI) to prevent HIV infection. In Weiss, R.A; Adler, M.W & Rowland-Jones, SL (eds), **British Medical Bulletin-The changing face of HIV/AIDS**. Oxford: Oxford University Press.

McDowell, L & Pringle, R 1992. **Defining Women: Social institutions and gender divisions.** Cambridge: Polity Press.

McMahon, MO 1996. **The general method of social work practice: A generalist perspective –Third edition**. Boston: Allyn & Bacon.

Mhloyi, MM 1995. Racing against time. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Morison, L 2001. The Global epidemiology of HIV/AIDS. In Weiss, R.A; Adler, M.W & Rowland-Jones, SL (eds), **British Medical Bulletin-The changing face of HIV/AIDS.** Oxford: Oxford University Press.

Mugemana, RES 1995. Our future is at stake. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Mwadi, A 1995. The power to silence us. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Nataraj, S 1995. In the epidemic's shadow. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Notter, LE and Hott, JR 1994. **Essentials of Nursing Research.** New York: Springer Publishing Company.

Parahoo, AK 1997. **Nursing Research: Principles, Processes and Issues.** London: McMillan Publishers.

Peterson, JC 1995. AIDS-Related Risks and same sex behaviours among African American men. In Herek, GM & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Phahlamohlaka, AM 2000. **A study of the knowledge, behaviour and attitudes related to HIV/AIDS among male students at More-Motse High School (Zebediela-Limpopo province).** Unpublished mini-dissertation: University of the North.

Piot, P 2001. Introduction. In Weiss, R.A; Adler, M.W & Rowland-Jones, SL (eds). **British Medical Bulletin-The changing face of HIV/AIDS.** Oxford: Oxford University Press.

Pisani, E 1998. Data and decision – making. In Whiteside, A (ed), **Implications of AIDS for demography and policy in Southern Africa.** Pietermaritzburg: University of Natal Press.

Plant, MA 1993. Alcohol, AIDS and Sex. In Sherr, L (ed), **AIDS and the heterosexual population.** Switzerland: Harwood academic Publishers.

Raditapole, DK 1995. The economics of HIV transmission. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Ross-Frankson, J 1995. A challenge to the powerless woman. In Reid, E (ed), **HIV and AIDS: The Global Inter-connection**. Connecticut-USA: Kumarian Press.

Rotheram-Borus, MJ; Hunter, J & Rosario, M 1995. Coming out as Lesbian or Gay in the Era of AIDS. In Herek, GM & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Rothman, J & Thomas, EJ 1994. **Intervention research: Design and Development for human service.** New York: Haworth publishers.

Rushing, WA 1995. **The AIDS epidemic: Social dimensions of an infectious disease**. Boulder: Westview Press.

Sandfort, TGM 1995. HIV/AIDS prevention and the impact of attitudes towards homosexuality and bisexuality. In Herek, GM & Greene, B (eds), **AIDS, Identity and community – The HIV epidemic and lesbians and gay issues.** Vol 2. Thousand Oaks: Sage Publications.

Schoepf, BG 1993. AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire. In Bolton R & Singer, M (eds), **Rethinking AIDS prevention: Cultural approaches.** USA: Gordon and Breach Science publishers.

Schwarzer, R & Fuchs, R 1997. Changing risks behaviours and adapting health behaviours: The role of self-efficacy beliefs. In Bandura, A (ed), **Self-efficacy in changing societies**. Cambridge: Cambridge University Press.

Sheafor, BW; Horesji, CR & Horesji, GA 1997. **Techniques and Guidelines for social work practice. Fourth edition.** Boston: Allyn and Bacon.

Stevens-Smith, P 1998. Introduction to substance abuse counselling. In Stevens-Smith, P & Smith, RL (eds), **Introduction to substance abuse counselling: Substance abuse counselling – Theory and Practice.** New Jersey: Prentice-Hall Publishers.

Strunin, L & Hingson, R 1993. Adolescents. In Sherr, L (ed) **AIDS and the heterosexual population.** Switzerland: Harwood academic publishers.

Thomas, L & Howard, J 1998. AIDS and development planning. In Whiteside, A (ed), **Implications of AIDS for demography and policy in Southern Africa.** Pietermaritzburg: University of Natal Press.

Umeh, DC 1997 Introduction. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education**. Eritrea: Africa World Press, Inc.

United Nations Office on Drugs and Crime (UNODC) 2003. **Peer to peer: using peer to peer strategies in drug abuse prevention.** Austria: United Nations Publications.

United Nations Population Fund (UNFPA) 2003. **State of World Population 2003**: **Investing in adolescents' health and rights.** New York: United Nations Publications.

United Nations Secretariat – Population Division 1998. **World Population Monitoring – 1996: Selected aspects of reproductive rights and reproductive health.** New York: United Nations Publications.

Uwakwe, CBU 1997. Socio-cultural factors that predispose women to HIV/AIDS in the Middle Belt of Nigeria. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education**. Eritrea: Africa World Press, Inc.

Watney, S 1994. **Practices of freedom: Selected writings on HIV/AIDS**. London: Rivers Oram Press.

Webb, D 1997. **HIV/AIDS in Africa.** Scottsville: University of Natal Press.

Wilson, HS & Hutchinson, SA 1996. **Consumers guide to Nursing Research: Exercises, Learning activities, Tools and Resources**. New York: Delmar Publishers.

Windal, CL 1997. Cultural and societal impediments to HIV/AIDS education in the American Indian community: MITAKUYE OYASIN. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education.** Eritrea: African World Press. Inc.

Wingood, GM & DiClemente, RJ 1997. Prevention of Human Immuno Deficiency Virus infection among African American women: Sex, Gender and Power and Women's risk for HIV. In Umeh, DC (ed), **Confronting the AIDS epidemic: Cross cultural perspectives on HIV/AIDS education.** Eritrea: African World Press. Inc.

Wood, F 1998. Injecting Drug use and the HIV epidemic. In Bloor, M & Wood, F (eds), **Addictions and problem drug use: Issues in behaviour, policy and practice.** London: Jessica Kingsley Publishers.

Zikmund, WG 1994. **Exploring marketing research. Fifth edition.** New York: The Dryden Press.

JOURNALS

Anthias, F 2001. The material and the symbolic in theorising social stratification: Issues of gender, ethnicity and class. **The British Journal of Sociology,** 52(3): 367 – 390.

Antle, BJ; Wells, LM; Goldie, RS; DeMatteo, D & King, SM 2001. Challenges of parenting for families living with HIV/AIDS. **Journal of the National Association of Social Workers,** 46(2): 159 – 169.

Auvert, B; Ballard, R; Campbell, C; Caraël, M; Carton, M; Fehler, G; Gouws, E; MacPhail, C; Taljaard, D; Van Dam; J & Williams, B 2001. HIV infection among youth in a South African mining town is associated with herpes simplex virus-2 seropositivity and sexual behaviour. **AIDS,** 15(7): 885-898.

Barnett, T; Whiteside, A; Khodakevich, L; Kruglov, Y & Steshenko, V 2000. The HIV/AIDS epidemic in Ukraine: Its potential social and economic impact. **Social Science and Medicine,** 51(9): 1487 – 1403.

Bentley, ME; Spratt, K; Shepherd, ME; Gangakhedkar, RR; Thilikavathi, S; Bollinger, RC & Mehendale, SM 1998. HIV testing and counselling among men attending sexually transmitted diseases clinics in Pune, India: Challenges in condom use and sexual behaviour over time. **AIDS,** 12(14): 1869 – 1877.

Bharat, S 2000. Perception of AIDS in Mumbai: A study of low-income communities. **Psychology and Developing societies,** 12(1): 43-65.

Brown, T 2000. Social, cultural and political issues. **AIDS,** 14(3): S235 – S337.

Buzi, RS; Weinman, ML & Smith, PB 1998. Ethnic differences in STD rates among female adolescents. **Adolescence,** 33(130): 313-318.

Campbell, C & Hayes, G 1998. Editorial special issue: Social Approaches to HIV/AIDS. **Psychology in Society,** 24:1.

Carli, LL 1999. Gender, interpersonal power and social influence. **Journal of Social Issues,** 55(1): 81 – 99.

Cecil, H; Pinkerton, SD & Bogart, LM 1999. Perceived benefits and barriers associated with the female condom among African American adults. **Journal of Health Psychology,** 4(2): 165 – 175.

Chimere-Dan, O 1996. Contraceptive prevalence in rural South Africa. **International Family Planning Perspectives,** 22(1): 4 –9.

Colón, RM; Wiatrek, DE & Evans, RI 2000. The relationship between psychosocial factors and condom use among African American adolescents. **Adolescence,** 35(139): 559 – 570.

Darrow, W 2001. Latex condoms, human behaviour and public health. **AIDS,** 15(2): 267 – 269.

Davidovich, U; De Wit, JBF & Stroebe, W 2000. Assessing sexual risk Behaviour of young gay men in primary relationships: The incorporations of negotiated safety and negotiated safety compliance. **AIDS,** 14(6): 701 – 706.

Deaux, K 1995. How basic can you be? The evolution of research on gender stereotypes. **Journal of Social Issues,** 51(1): 11-20.

Des Jarlais, D & Caraël, M 1999. Behaviour and Social Science: Overview. **AIDS,** 13(A): S235 – S237.

Dubois-Arber, F & Haour-Knipe, M 2001. HIV/AIDS institutional discrimination in Switzerland. **Social Science and Medicine,** 52(10): 1525 – 1535.

Duncan, ME; Tibaux, G; Kloos, H; Pelzer, A; Mehari, L; Perine, PL; Peutherer, J; Young, H; Jamil, Y; Darougar, S; Lind, I; Reimann, K; Piot, P & Roggen, E 1997. STD's in women attending family planning clinics: A case study in Addis Ababa. **Social Science and Medicine,** 44(4): 441-454.

Erwin, J & Peters, B 1999. Treatment issues for HIV+ Africans in London. **Social Science and Medicine,** 49(11): 1519-1528.

Feldman, DA; O'Hare, P; Baboo, KS; Chitalu, NW & Lu, Y 1997. HIV prevention among Zambian adolescents: Developing a value utilisation/norm change model. **Social Science and Medicine,** 44(4): 455-468.

Fontanet, AL; Soba, J; Chandelying, V; Sakondhavat, C; Bhilaleus, P; Rujpao, S; Chongsomchai, C; Kiriwat, O; Tovanabutra, S; Dally, L; Lange, JM & Rojanapithayakorn, W 1998. Protection against sexually transmitted diseases by granting sex workers in Thailand the choice of using the male and female condom: Results from a randomised controlled trial. **AIDS,** 12(14): 1451-1459.

Foster, G & Williamson, J 2000. A review of current literature on the impact of HIV/AIDS on children in Sub-Saharan Africa. **AIDS,** 14(S3): S275 – S284.

Frazier, PA; Cochran, CC & Olson, AM 1995. Social science research on lay definitions of sexual harassment. **Journal of Social Issues,** 51(1): 21 – 37.

Fusilier, M; Manning, MR; Villar, AJS & Rodriguez, DT 1998. AIDS knowledge and attitudes of health care workers in Mexico. **Journal of Social Psychology,** 138(2): 203 – 210.

Garcia-Moreno, C & Watts, C 2000. Violence against women: Its importance for HIV/AIDS. **AIDS,** 14(A): S253-S265.

Garner, R 1998. Christian belief, economic development and churches in Edendale Township. **Journal of the South African Sociological Association: Society in Transition,** 29(3-4): 152 – 161.

Gross, WC & Billingham, RE 1998. Alcohol consumption and sexual victimisation among college women. **Psychological Reports,** 82(1): 80 – 82.

Gysels, M; Pool, R & Nnalusiba, B 2002. Women who sell sex in a Ugandan Trading Town: Life histories, survival strategies and risk. **Social Science and Medicine,** 54(2): 179 – 192.

Hamel, CE 1999. The transmission of Islamic knowledge in Moorish society from the rise of the ALMORAVIDS to the 19th century. **Journal of Religion in Africa,** Xxix(1): 62 – 87.

Heath, J & Rodway, MR 1999. Psychosocial Needs of women infected with HIV. **Social Work in Health Care,** 29(3): 43 - 57

Hubbs-Tait, L & Garmon, LC 1995. The relationship of moral reasoning and AIDS knowledge to risky sexual behaviour. **Adolescence,** 30(119): 549 – 564.

Huszti, HC; Parsons, JT; Cotton, D; Mendoza, J; Harlow, L; Rich, L; Parish, KL; Nuss, R & Riske, B 1998. Determinants of safer sexual behaviour in a long- term HIV seropositive population: The multisite Hemophilia behaviour Intervention Evaluation Project. **Journal of Health Psychology,** 3(4): 507-522.

Ickovics, JR & Yoshikawa, H 1998. Preventive interventions to reduce heterosexual HIV risk for women: Current perspectives, future directives. **AIDS,** 12(A): S197 – S208.

Jackson, TD; Hobfoll, SE; Jackson, AP & Lavin, J 2001. Life stressors, mastery and perceived partner engagement in HIV-Risk behaviour. **Journal of community Psychology,** 29(1): 1 – 17.

Jakobsen, R & Rise, J 1997. Adolescents knowledge about HIV/AIDS. **Journal of Health Psychology,** 2(1): 57 – 65.

Janssen, M; De Wit, J; Stroebe, W & Van Griensven, F 2000. Educational status and risk of HIV in young gay men. **Journal of Health Psychology,** 5(4): 487-499.

Joshi, PC 2000. Relevance and utility of traditional medical systems in the context of Himalayan tribe. **Psychology and developing societies,** 12(1): 5-29.

Kesby, M 2000. Participatory diagramming as a means to improve communication about sex in rural Zimbabwe: A pilot study. **Social Science and Medicine,** 50(12): 1723-1741.

Klonoff, EA & Landrine, H 1997. Distrust of whites, acculturation, and AIDS knowledge among African-Americans. **The journal of Black Psychology,** 23(1): 50-57.

Koblin, BA; Torian, LV; Guilin, V; Ren, L; Makeller, D.A & Valleroy, LA 2000. High prevalence of HIV infection among young men who have sex with men in New York City. **AIDS,** 14(12): 1793 – 1800.

Krause, SK; Jones, RK & Purdin, SJ 2000. Programmatic Responses to Refugees Reproductive Health Needs. **International Family Planning Perspectives,** 26(4): 182 – 188.

Laga, M; Schwärtlander, B; Pisani, E; Sow, PS & Caraël, M 2001. To stem HIV in Africa, prevent transmission to young women. **AIDS,** 15(7): 931-934.

Lagarde, E; Enel, CZ; Seck, K; Gueye-Ndiaye, A; Piau, JP; Pison, G; Delaunay, V; Ndoye, I & Mboup, S 2000. Religion and protective behaviours towards AIDS in rural Senegal. **AIDS,** 14(13): 2027-2033.

Lagarde, E; Auvert, B; Caraël, M; Laourou, M; Ferry, B; Akam, E; Sukwa, T; Morison, L; Maury, B; Chege, J; N'doye, I & Buvé, A 2001. Concurrent sexual partnership and HIV prevalence in five urban communities of Sub-Saharan Africa. **AIDS,** 15(7): 877-884.

Laurichesse, HAA; Mortimer, J; Evans, BG & Farrington, CP 1998. Pre-AIDS mortality in HIV infected individuals in England, Wales and Northern Ireland, 1982 – 1996. **AIDS,** 12(6): 651 – 658.

Lauver, DR 2000. Commonalities in women's spirituality and women's health. **Advances in Nursing Science,** 22(3): 76 – 88.

Lee, MY; Campbell, RA & Mulford , CL 1999. Victim-Blaming tendency towards people with AIDS among college students. **Journal of Social Psychology,** 139(3): 300 – 308.

Leggett, T 1999. Poverty and sex work in Durban, South Africa. **Journal of the South African Sociological Association – Society in Transition,** 30(2): 157 – 167.

Livingstone, MM 1998. HIV/AIDS prevention through changing risky sexual behaviour among heterosexual college students: A 1990's bibliography. **Psychological Reports,** 83(3): 781-782.

Lurie, A & Monahan, K 2001. Prevention principles for practitioners: A solution or an illusion? **Social Work in Health Care,** 33(1): 69 – 86.

MacPhail, C & Campbell, C 2001. 'I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in a Southern African Township. **Social Science and Medicine,** 52(11): 1613 – 1627.

Manhart, LE; Dialmy, A; Ryan, CA & Mahjour, J 2000. Sexually transmitted diseases in Morocco: Gender influences as prevention and health care-seeking behaviour. **Social Science and Medicine,** 50(10): 1369 – 1383.

Mansergh, G; Marks, G; Miller, L; Appleby, PR & Murphy, S 2000. Is knowing people with HIV/AIDS associated with safer sex in men who have sex with men? **AIDS,** 14(12): 1845 – 1851.

Marcenko, MO & Samost, L 1999. Living with HIV/AIDS: The voices of HIV-Positive mothers. **Journal of the National Association of Social Workers,** 44(1): 36 – 45.

Mashishi, A 2000. Wife battering: An exploration of the abuse of African women at two shelters in Johannesburg. **Journal of the South African Sociological Association-Society in Transition,** 31(1): 82-87.

Mechanic, D 1998. Topics for our times: Managed care and public health opportunities. **American Journal of Public Health,** 88: 874 – 875.

Melkote, SR & Goswami, D 2000. Predictors of attitudes to persons with AIDS among young adults in India. **The Indian Journal of Social Work,** 61(1): 89-105.

Mill, JE & Anarfi, JK 2002. HIV risk environment for Ghanaian women: Challenges to prevention. **Social Science and Medicine,** 54(3): 325 – 337.

Moore, S & Halford, AP 1999. Barriers to safer sex: Beliefs and attitudes among male and female adult heterosexual across four relationship groups. **Journal of Health Psychology,** 4(2): 149 – 163.

Morisky, DE & Coan, DL 1998. Asia-The new epidemic zone for HIV/AIDS. **Journal for Health Communication: International Perspectives,** 3(3): 185-191.

Muller, A & Steyn, M 1999. Culture and the feasibility of a partnership between westernised medical practitioners and traditional healers. **Journal of the South African Sociological Association: Society in Transition** 30(2): 142 – 156.

Nicholas, LJ 1998. Black South African Student's beliefs and attitudes about condoms. **Psychological Reports,** 83(3): 891-894.

Njoroge, NJ 1997. The missing voice: African women doing theology. **Journal of Theology for Southern Africa,** 99: 77 – 83.

O`Hare, T; Williams, CL & Ezoviski, A 1996. Fear of AIDS and homophobia: Implications for direct practice and advocacy. **Journal of the Association for Social Workers,** 41(1): 51 – 58.

Painter, TM 2001. Voluntary counselling and testing for couples: A high-leverage intervention for HIV/AIDS prevention in Sub-Saharan Africa. **Social Science and Medicine,** 53(11): 1397-1411.

Pattillo-McCoy, M 1998. Church culture as a strategy of action in the black community. **American Sociological Review,** 62(6): 767 – 784.

Peersman, GV & Levy, JA 1998. Focus and effectiveness of HIV prevention efforts for young people. **AIDS,** 12(A): S191-S196.

Peltzer, K 2000. Knowledge and attitudes about HIV/AIDS of a sample of school teachers in South Africa. **Psychological Reports,** 83(3): 1065.

Phiri, IA 1997. Doing theology in community: The case of African women theologians in the 1990's. **The Journal of Theology for Southern Africa,** 99: 68 – 76.

Poindexter, CC & Linsk, N L 1999. HIV-Related stigma in a sample of HIV-Affected Older female African American Caregivers. **Journal of the National Association of Social Workers,** 44(1): 46 – 57.

Prins, M; Sabin, CA; Lee, CA; Devereux, H & Coutinho, RA 2000. Pre-AIDS mortality and its association with HIV disease progression in haemophilic men, injecting drug users and homosexual men. **AIDS,** 14(12): 1829 – 1837.

Rey, LD 1997. Religion as invisible culture: Knowing about and knowing with. **Journal of Social Work,** 2(2): 157 – 177.

Rhodes, T; Stimson, GV; Crofts, N; Ball, A; Dehne, K & Khodakevich, L 1999. Drug injecting, rapid HIV spread and the 'risk environment': Implications for assessment and response. **AIDS,** 13(A): S259 – S269

Ridgeway, CL 2001. Gender, status and leadership. **Journal of Social Issues,** 57(4): 637 – 655.

Sadie, Y & Van Aard, M 1995. Women's issue in South Africa, 1990 – 1994. **Africa Insight,** 25(2): 80 – 89.

Sagrestano, LM; Heavey, CL & Christensen, A 1999. Perceived power and physical violence in marital conflict. **Journal of Social Issues,** 55(1): 65-79.

Schilling, RF 1997. Developing intervention research programs in social work. **Social Work Research,** 21(3): 173 – 180.

Schoffeleers, M 1999. The AIDS pandemic, The Prophet Billy Chisupe and the democratisation process in Malawi. **Journal of Religion in Africa,** Xxix(4): 406 - 441

Schwarzwald, J & Koslowsky, M 1999. Gender, self-esteem and focus of interest in the use of power strategies by adolescents in conflict situations. **Journal of Social Issues,** 55(1): 15 – 32.

Sewpaul, V & Rollins, N 1999. Operationalising developmental social work: The implementation of an HIV/AIDS project. **A professional Journal for the social worker,** 35(3): 250 – 263.

Shell, RCH & Zeithin, R 2000. The chances of acquiring HIV/AIDS during the school-going years in the Eastern Cape, 1990 – 2000. **The Social Work Practitioner – Researcher,** 12(3): 139 – 154.

Shirahase, S 2001. Women and class structure in contemporary Japan. **The British Journal of Sociology,** 52(3): 391 - 408

Shor-Posner, G & Miguez, MJ 2001. Heavy alcohol use hinders HIV therapy: study. **AIDS Alert,** 16(7): 88 –93.

Siegel, K; Karus, D; Raveis, VH and Hagen, D 1998. Psychological adjustment of women with HIV/AIDS: Racial and ethnic comparisons. **Journal of Community Psychology,** 26(5): 439 – 455.

Sigh, S; Wulf, D; Samara, R & Cuca, YP 2000. Gender Differences in the timing of first intercourse: Data from 14 countries. **International Family Planning Perspectives,** 26(1): 17 – 30.

Somlai, AM; Kelly, JA; Wagstaff, DA & Whitson, DP 1998. Patterns, Predictors and situational context of HIV risk behaviour among homeless men and women. **Journal of the National Association of Social Workers,** 43(1): 7 –20.

Stein, JA; Nyamathi, A & Kington, R 1997.Change in AIDS Risk behaviours among impoverished minority women after a community-based cognitive-behavioural outreach program. **Journal of Community Psychology,** 25(6): 519-533.

Strydom, H 2000. The knowledge base of high school pupils in the North West Province on HIV/AIDS. **The social work practitioner/researcher,** 12(3): 195-207.

Suarez, ZE & Siefert, K 1998. Latinas and sexually transmitted diseases: Implications of recent research for prevention. **Social Work in Health Care,** 28(1): 1 – 19.

Sureender, S; Guruswamy, M & Verma, RK 1997. Knowledge and attitude of school children about HIV/AIDS: Evidence from a rural Maharashtra. **The Indian Journal of Social Work,** 58(4): 559-615.

Svenkerud, PJ & Singhal, A 1998. Enhancing the effectiveness of HIV/AIDS prevention programs targeted to unique population groups in Thailand: Lessons learned from applying concepts of diffusion of innovation and social marketing. **Journal of Health Communication,** 3(3): 193 – 216.

Tawil, O; O`Reilly, K; Coullibaly, IM; Tiémélé, A; Himmich, H; Boushaba, A; Pradeep, K & Caraél, M 1999. HIV prevention among vulnerable populations: Outreach in the developing world. **AIDS,** 13(A): S239-S247.

Temin, MJ; Okonofua, FE; Omorodion, FO; Renne, EP; Coplan, P; Heggenhougen, HK & Kaufman, J 1999. Perceptions of sexual behaviour and knowledge about sexually transmitted diseases among adolescents in Benin City, Nigeria. **International Family Planning Perspectives,** 25(4): 186 – 190.

Thomas, J 1997. Social context and community perception of HIV/AIDS prevention and care among IDU's and their communities. **The Indian Journal Of Social Work,** 58(4): 557-581.

Thuy, NTT; Nhung, VT; Van Thuc, N; Lien, T.X & Khiem, HB 1998. HIV infection and risk factors among female sex workers in Southern Vietnam. **AIDS,** 12(4): 425-432.

Van Den Hoek, A; Yuliang, F; Dukers, NHTM; Zhiheng, C; Jiangting, F; Lina, Z & Xiuxing, Z 2001. High prevalence of syphilis and other sexually transmitted diseases among sex workers in China: Potential for fast spread of HIV. **AIDS,** 15(6): 753 – 759.

Vogels, T; Brugman, E & Van Zessen, G 1999. AIDS-Related knowledge, attitudes and behaviour: A comparison of Dutch students and dropouts. **Adolescence,** 34(134): 369 – 379.

Waldo, CR; Stall, RD & Coates, TJ 2000 Is offering post-exposure prevention for sexual exposures to HIV related to sexual risk behaviour in gay men? **AIDS,** 14(8): 1035 – 1039.

Williams, JK & Boykin, F 1999. The role of social work in HIV/AIDS clinical trials. **Social Work in Health Care,** 29(1): 35 – 54.

Witte, K; Cameron, KA; Lapinski, MK & Nzyuko, S 1998. A theoretically based evaluation of HIV/AIDS prevention campaigns along the Trans-Africa High in Kenya. **Journal of Health Communication: International perspectives,** 3(4): 345 – 363.

Wood, C & Foster, D 1995. "Being the type of lover...": Gender-differentiated reasons for non-use of condoms by sexually active heterosexual students. **Psychology in society,** 20:13-35.

Woods, TE & Ironson, G.H. 1999. Religion and Spirituality in the face of illness: How cancer, cardiac and HIV patients describe their spirituality. **Journal of Health Psychology,** 4(3): 393 – 412.

Young, TM; Martin, SS; Young, ME & Ting, L 2001. Internal poverty and teen pregnancy. **Adolescence,** 36(142): 289 – 304.

PERIODICALS

SOURCES FROM MAGAZINES AND NEWSPAPERS

Bhengu, C 2002: Unsafe sex ups youth AIDS rate. **Sowetan.** 11 July 2002. Page 8

Bhengu, C 2002: HIV prostitute wants to start anew. **Sowetan**. 21 February: Page 6

De Villiers, A 2002. Economic impact of HIV/AIDS: **Masa.** July 2002. Page 05.

Hlongwa, W 2002. Mtshali pushes ahead with Nevirapine plan: KZN Premier stands firm and insist the nevirapine drug will be distributed to major hospitals in the province within six months. **City Press**. 03 February. Page 09

HIV increases on campus. **Masa**. 1999. 01 March. Page 03. Sovenga – Polokwane. University of the North Publication

Jogunosimi, T 2001. The HIV/AIDS pandemic among youth in Sub-Saharan Africa. **Advocates for Youth – Rights, Respect and Responsibility**. February 2001

Lamont , J 2002. South African health ministry attacked over AIDS grant delay. **Financial Times**. 18 July. Page 06.

Lekganyane, BE 1999. Sermon delivered by His Grace The Very Right Reverend Bishop BE Lekganyane – The leader of the Zion Christian Church in Gaborone (Botswana) on the 03rd October 1999. **The ZCC Messenger.** Issue no 45: 5 – 8.

Lekganyane, BE 2000. Easter 2000 Speech Sunday, 23 April 2000 by His Grace The Very Right Reverend Bishop BE Lekganyane. **The ZCC Messenger.** Issue no 47: 6 – 8.

Lekganyane, BE 2000. Molaetša wa His Grace The Very Right Reverend Bishop BE Lekganyane – Moria – Pulo ya ngwaga o moswa – September 2000. **The ZCC Messenger**. Issue no 48: 4 – 5.

Lekganyane, BE 2001. Molaetša wa Paseka 2001 ka His Grace The Very Right Reverend Bishop BE Lekganyane. **The ZCC Messenger.** Issue no 50: 4 – 6.

Lekganyane, BE 2001. Pulo ya ngwaga ka His Grace The Very Right Reverend Bishop BE Lekganyane. **The ZCC Messenger.** Issue no 51: 4 – 11.

Makhubele, JC 2000. Silent killer that knows no boundary. **The ZCC Messenger.** Issue no 46: 10 – 12.

Makhubele, JC 2000. Who is He? You better answer it now! **The ZCC Messenger.** Issue no 47: 10 – 13.

Makhubele, JC 2001. Christian culture versus Human culture. **The ZCC Messenger.** Issue no 49: 22 – 26.

Malatjie, N 2001. Break the silence on HIV. **Capricon-Voice.** 31 October – 02 December 2001. Page 7.

Misbach, W 2002: Mbeki will speak on Zim, the economy and health. **Sowetan.** 07 February. Page 7.

Nessman, R 2001. Africa... still in a fix. **Sowetan**. 28 December. Page 8.

None, S 2001. Let's mark World AIDS Day each and every day. **City Press**. 25 November 2001. Page 18.

Sapa – AP, 2002: HIV/AIDS: 'Dramatic changes needed. **Sowetan.** 25 June : Page 11.

Sapa, 2002: Premier Marais calls for unity to fight the invisible HIV/AIDS enemy. **City Press**. 17 February. Page 10.

Sesanti, S 2002. Doing God's work fighting AIDS: A spiritual healer is making a difference helping AIDS sufferers. **City Press.** 03 March 2002. Page 18

SunColums, 2002. Break this AIDS superstitions. **Sunday Sun.** 10 March 2002. Page 10

Tengrove-Jones, T 2002: Sacrificed to red tape. **Sowetan**. 14 March. Page 12.

Victor, R 2002. " Campaign for 'safer sex' may boost promiscuity" **Sowetan Sunday World.** 21 July 2002. Page 24.

Zuma, J 2002. Valentine's day can curb AIDS: South Africans and the government should use the day to promote the Abstain, Be faithful or use a condom message. **Sowetan.** 14 February 2002. Page 16

SOURCES FROM THE MEDIA (TV)

Patta, D 2002.Third Degree programme. **eTV**. January, 23.

Reddy, S 2001. Enews at 07h00. **eTV.** December, 03.

INTERVIEW

Mabasa, M & Madweva, R 2002. **Preliminary Interview: Discussion on initiation (circumcision) schools.** Mapapila Village: Malamulele.

SOURCES FROM THE INTERNET.

ABC CONDOMS (2002) Always be careful – condoms. **http://www.abccondoms.org**

ADARG. 2003. Report to parliament: Alcohol and drug Abuse Research Group – Alcohol, drug use and risky sex. **http://www.mrc.ac.za/adarg/report.htm**

AEST (2001). The sexual abuse of males. **http://www.aest.uk6/survivor/male/the-sexual-abuse-of-males.html**

AVERT (2002). Condoms: History, effectiveness and testing. **http://www.avert.org/condoms.htm**

B-FREE CONDOMS. (2002). Wearing a condom will not protect against contraction of disease if exposed skin comes in contact with an infected person or object. **http://b-freecondoms .com**

DEPARTMENT OF HEALTH. 2002. Discussion papers from the health summit: Section 2C – communicable diseases, HIV/AIDS and TB. **http://www.doh.gov.za/docs/index.html**

EPIGEE (2002). Condoms (condoms for man - links – proper use. **http://www.epigee.org/guide/condoms. html**

IAFRICA. 2000. HIV and women. **http://health.iafrica.com/doconline/hiv-and-aids/africawomen.htm**

IAFRICA. 2000. HIV in Africa: the epidemic continues. **http://health.iafrica.com/doconline/hiv-and-aids/epijune2000.htm**

MEDICAL RESEARCH COUNCIL (Galloway, MR). 2002. Rape in schools a 'substantial public health problem' in South Africa. **http://www.mrc.ac.za/aids/march2002/rape.htm**

MEDICAL RESEARCH COUNCIL (Frizelle, K and King), J. 2002. Learning through action – university students input into HIV preventions. **http://www.mrc.ac.za/aids/decem2002/learning.htm**

PANOS. 2003. Men drive the epidemic. **http://www.panos.org.uk/resources/reportdetails**

SAHR (2000). HIV/AIDS – Current issues. **http://www.hst.org.za/sahr/2000/chapter**14.htm

SAHR (2000). HIV/AIDS – Facts, figures and the future. **http://www.hst.org.za/sahr/2000/chapter15.htm**

STATISTICS SOUTH AFRICA (2003). Census in brief – the population of South Africa. http://www.statssa.gov.za/default3.asp

THE BODY. 1998. Can you have safer sex without latex condoms? **http://www.thebody.com/sawadsky/nonlatex.html**

THE BODY. 1997. So many condoms, so little time... **http://www.thebody.com/sowadsky/condoms.html**

UNESCO (2002). A cultural approach to HIV/AIDS prevention and care. **http://www.unesco.org/culture/aids/html**

UNICEF. 2002. What young people are saying – voices of youth. **http://www.unicef.org/voy/new/new.2002-12.doc**

WORLDBANK. 2002. HIV/AIDS – WORLDBANK (HIV/AIDS AT A GLANCE). **http://www.worldbank.org/hiv-aids**

APPENDIX A

INTERVIEW SCHEDULE [QUESTIONNAIRE] FOR LEARNERS

INSTRUCTIONS

1. RESPONDENTS ARE NOT REQUIRED TO WRITE THEIR NAMES ON THIS INTERVIEW SCHEDULE OR TO ATTACH THEIR SIGNATURES.
2. RESPONDENTS ARE REQUESTED TO GIVE ANSWERS FREELY AND PROVIDE INFORMATION TO THE BEST OF THEIR ABILITIES.
3. SUPPLY AN ANSWER IN THE SPACE PROVIDED, HOWEVER , WHERE THERE ARE ALTERNATIVE ANSWERS TO QUESTIONS MAKE A CROSS [X] IN THE ANSWER OF YOUR OWN CHOICE.
4. CONFIDENTIALITY WILL BE PRESERVED AT ALL COST BY THE RESEARCHER.
5. PLEASE NOTE THAT THERE ARE NO RIGHT AND/OR WRONG ANSWERS.
6. HIGH SCHOOL LEARNERS SHOULD ANSWER ALL THREE SECTIONS [SECTION A, B AND C].

THANKS

JABULANI CALVIN MAKHUBELE
RESEARCHER

SECTION A.

DEMOGRAPHIC FACTORS

1. AGE:
   - Less than 16 years
   - 16-18
   - 19-21
   - 21-30
   - 31-40
   - 41-50
   - 50+

2. GENDER:
   - Male
   - Female

3. MARITAL STATUS:
   - Married
   - Never married
   - Divorced
   - Widowed
   - Separated

4. RELIGIOUS AFFILIATION:
   - Christianity
   - Muslim
   - Hinduism
   - Ancestral worship

Other [specify]----------

5. CHRISTIAN DENOMINATIONS:

Apostolic Faith Mission	☐
Roman Catholic	☐
I.P.C.C	☐
Lutheran	☐
U. R. C.	☐
Z.C.C	☐
	☐

Other [specify]----------

6. GRADE LEVEL AT SCHOOL:

Grade	11	☐
Grade	12	☐

OR STATE THE LEVEL AT WHICH YOU LEFT SCHOOL----------

7. ECONOMIC STATUS OF THE FAMILY:

Wealthy	☐
Quite well off	☐
Not very well off	☐
Very poor	☐

8. AMONG THE FOLLOWING LANGUAGES, INDICATE THE ONES YOU CAN SPEAK AND /OR WRITE:

Xitsonga	☐
TshiVenda	☐
Sepedi	☐
Afrikaans	☐

Other [specify]----------

SECTION B

CULTURAL ELEMENTS THAT IMPACT ON PREVENTION ANDTREATMENT OF HIV/AIDS

B.1. YOUTH SEXUAL BEHAVIOUR

B.1.1. Have you ever had sexual intercourse with a boy/girl?

YES ☐
NO ☐

B.1.2. How many times in the past twelve months have you had sexual intercourse with a girl/boy? ----------times.

B.1.3. How many times in the past month have you had sexual intercourse with a boy/girl? ----------times.

B.1.4. The last time you had sex, did you use a condom?

YES ☐
NO ☐

B.1.5. How many people have you had sexual intercourse with?

One person	
Two people	
Three people	
More than four people	

B.1.6. How old was the oldest person you had sex with? ----------years old

B.1.7. Do you use any substances?

YES	
NO	

Name the substances you use: 1.----------

2.----------

3.----------

B.1.8. Whenever you have sex, is it after you have used some drugs [substances]? e.g. alcohol, dagga and/or benzene.

YES	
NO	

B.1.9. Is sex good, better, or best after you have used some substances?

Choose

Good	
Better	
Best	

B.2. CONDOM USE AND NON-CONDOM USE

Suppose you are alone with your [boyfriend/girlfriend]. He/she wants to have sex, but neither of you has a condom. In this situation how willing would you be to do each of the following.

B.2.1. Not have sex?

Not at all	
A little	
Kind of	
Very	

B.2.2. "Fool around" [kiss and pet], but stop before having sex?

Not at all	
A little	
Kind of	
Very	

B.2.3. Go ahead and have sex?

Not at all	
A little	
Kind of	
Very	

B.3. PEER PRESSURE

B.3.1. How much would what your friends think about having sex have an influence on whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

B.3.2. How much would what your parents think about someone of your age having sex would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

B.3.3. How much would your cultural values discussed with your friends would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

B.3.4. How much would your religious values discussed with your friends would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

B.3.5. How much would your concern about your reputation amongst your friends would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

SECTION C

CULTURAL BELIEFS AND CONVENTIONS OF LEARNERS

C.1.1. What do you understand by HIV/AIDS?

Explain----------

C.1.2. What symptoms indicate that a person has HIV/AIDS?

Mention and explain----------

C.1.3. Do you believe that babies and children can get infected with HIV?

YES ☐

NO ☐

Motivate your response----------

C.1.4. Do you believe that one cannot get infected with HIV if he sleeps with an elderly woman?

YES ☐

NO ☐

Motivate your response----------

C.1.5. What is your understanding about the homosexuals with regard to HIV/AIDS?

Explain----------

C.1.6. According to your understanding, what is the most vulnerable group to HIV infection between men and women?

Men	☐
Women	☐
Both genders	☐

Motivate your response----------

C.1.7. Do you think hugging and kissing can lead someone to be infected with HIV?

YES	☐
NO	☐

Motivate your response----------

C.1.8. According to your understanding, how is HIV transmitted?

Explain----------

C.1.9. Do you believe that condoms can prevent HIV transmission?

YES ☐

NO ☐

Motivate your response----------

C.1.10. Can HIV/AIDS be treated?

YES ☐

NO ☐

Motivate your response----------

C.1.11. How do you understand the issue that mosquitoes can transmit HIV?

Explain----------

C.1.12. People believe that if one person in the family is infected with HIV/AIDS, the whole family is infected. What is your opinion in this regard ?----------

---

C.1.13. People believe that if a person already has a baby, the person cannot be infected with HIV. What is your opinion in this regard? ----------

---

C.1.14. How do you understand the issue of sharing and/or using same eating utensils and food with a person infected with HIV? Explain----------

---

C.1.15. Some people say that HIV/AIDS is an alien disease, the disease of "others" referring to other racial groups. What is your opinion in this regard? ----------

---

C.1.16. Who do you think is the carrier of HIV/AIDS between men and women?

Men	
Women	
Both genders	

Motivate your response----------

C. 1.17. HIV/AIDS is a dreadful and shameful disease. What are your views on this ?--

---

C.1.18. Some people indicate that HIV/AIDS is an invented disease. What are your views on this ?----------

---

C.1.19. What are your religious views about HIV/AIDS?----------

---

C.1.20. Having several sexual partners is it culturally approved or not? Explain----------

---

C.1.21. Would you use a condom with your partner?

Yes	
No	

Motivate your response----------

C.1.22. What is your view on circumcision/initiation schools regarding their role in the transmission of HIV? Explain----------
---

C.1.23. It is believed that circumcision schools train boys into men and girls into women, what is your opinion on this?----------
---

C. 1.24. Do you think condom use should be discussed at initiation schools? Explain---
---

C.1.25. Can you discuss condom use with your children? Explain----------
---

C.1.26. In your opinion, is it proper for the girl immediately after circumcision to indulge in sexual activities? Explain----------

---

C.1.27. Some people say that the emergence of HIV/AIDS is due to people having lost respect for their culture and having distanced themselves from it. What is your opinion on this?----------

---

C.1.28. What do you think about the practice of "ku lovolela kumbe ku lovota"? Explain----------

---

C.1.29. Do you think according to your culture women should take decision with regard to condom use? Explain----------

---

C.1.30. Who should take decision with regard to when to have sex and when to have children? Name and explain----------

---

C.1.31. How should the people infected with HIV be treated? Explain----------

---

Thanks for your time and information provided

_____

JABULANI CALVIN MAKHUBELE

(RESEARCHER)

APPENDIX B

INTERVIEW SCHEDULE [QUESTIONNAIRE] FOR PARENTS AND CULTURAL LEADERS

INSTRUCTIONS

1. RESPONDENTS ARE NOT REQUIRED TO WRITE THEIR NAMES ON THIS INTERVIEW SCHEDULE OR TO ATTACH THEIR SIGNATURES.
2. RESPONDENTS ARE REQUESTED TO GIVE ANSWERS FREELY AND PROVIDE INFORMATION TO THE BEST OF THEIR ABILITIES.
3. SUPPLY AN ANSWER IN THE SPACE PROVIDED, HOWEVER , WHERE THERE ARE ALTERNATIVE ANSWERS TO QUESTIONS MAKE A CROSS [X] IN THE ANSWER OF YOUR OWN CHOICE.
4. CONFIDENTIALITY WILL BE PRESERVED AT ALL COST BY THE RESEARCHER.
5. PLEASE NOTE THAT THERE ARE NO RIGHT AND/OR WRONG ANSWERS.
6. PARENTS AND TRADITIONAL LEADERS SHOULD ANSWER ONLY SECTION A AND C.

THANKS

JABULANI CALVIN MAKHUBELE
RESEARCHER

SECTION A.

DEMOGRAPHIC FACTORS

1. AGE:

- Less than 16 years
- 16-18
- 19-21
- 21-30
- 31-40
- 41-50
- 50+

2. GENDER:

- Male
- Female

3. MARITAL STATUS:

- Married
- Never married
- Divorced
- Widowed
- Separated

4. RELIGIOUS AFFILIATION:

- Christianity
- Muslim
- Hinduism
- Ancestral worship

Other [specify]----------

5. CHRISTIAN DENOMINATIONS:

Apostolic Faith Mission	☐
Roman Catholic	☐
I.P.C.C	☐
Lutheran	☐
U. R. C.	☐
Z.C.C	☐
	☐

Other [specify]----------

6. GRADE LEVEL AT SCHOOL:

Grade	11	☐
Grade	12	☐

OR STATE THE LEVEL AT WHICH YOU LEFT SCHOOL----------

7. ECONOMIC STATUS OF THE FAMILY:

Wealthy	☐
Quite well off	☐
Not very well off	☐
Very poor	☐

8. AMONG THE FOLLOWING LANGUAGES, INDICATE THE ONES YOU CAN SPEAK AND /OR WRITE:

Xitsonga	☐
TshiVenda	☐
Sepedi	☐
Afrikaans	☐

Other [specify]----------

SECTION B

CULTURAL BELIEFS AND CONVENTIONS OF PARENTS AND CULTURAL LEADERS ABOUT HIV/AIDS

B.1.1. What do you understand by HIV/AIDS?

Explain----------

B.1.2. What symptoms indicate that a person has HIV/AIDS?

Mention and explain----------

B.1.3. Do you believe that babies and children can get infected with HIV?

YES ☐

NO ☐

Motivate your response----------

B.1.4. Do you believe that one cannot get infected with HIV if he sleeps with an elderly woman?

YES ☐

NO ☐

Motivate your response----------

B.1.5. What is your understanding about the homosexuals with regard to HIV/AIDS?
Explain----------

B.1.6. According to your understanding, what is the most vulnerable group to HIV infection between men and women?

Men ☐
Women ☐
Both genders ☐

Motivate your response----------

B.1.7. Do you think hugging and kissing can lead someone to be infected with HIV?

YES ☐
NO ☐

Motivate your response----------

B.1.8. According to your understanding, how is HIV transmitted?

Explain----------

B.1.9. Do you believe that condoms can prevent HIV transmission?

YES ☐

NO ☐

Motivate your response----------

B.1.10. Can HIV/AIDS be treated?

YES ☐

NO ☐

Motivate your response----------

B.1.11. How do you understand the issue that mosquitoes can transmit HIV?

Explain----------

B.1.12. People believe that if one person in the family is infected with HIV/AIDS, the whole family is infected. What is your opinion in this regard ?----------

---

B.1.13. People believe that if a person already has a baby, the person cannot be infected with HIV. What is your opinion in this regard? ----------

---

B.1.14. How do you understand the issue of sharing and/or using same eating utensils and food with a person infected with HIV? Explain----------

---

B.1.15. Some people say that HIV/AIDS is an alien disease, the disease of "others" referring to other racial groups. What is your opinion in this regard? ----------

---

B.1.16. Who do you think is the carrier of HIV/AIDS between men and women?

Men	
Women	
Both genders	

Motivate your response----------

B. 1.17. HIV/AIDS is a dreadful and shameful disease. What are your views on this ?--

---

B.1.18. Some people indicate that HIV/AIDS is an invented disease. What are your views on this ?----------

---

B.1.19. What are your religious views about HIV/AIDS?----------

---

B.1.20. Having several sexual partners is it culturally approved or not? Explain----------

---

B.1.21. Would you use a condom with your partner?

Yes	
No	

Motivate your response----------

B.1.22. What is your view on circumcision/initiation schools regarding their role in the transmission of HIV? Explain----------

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B.1.23. It is believed that circumcision schools train boys into men and girls into women, what is your opinion on this?----------

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B. 1.24. Do you think condom use should be discussed at initiation schools? Explain---

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B.1.26. In your opinion, is it proper for the girl immediately after circumcision to indulge in sexual activities? Explain----------

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B.1.27. Some people say that the emergence of HIV/AIDS is due to people having lost respect for their culture and having distanced themselves from it. What is your opinion on this?----------

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B.1.28. What do you think about the practice of "ku lovolela kumbe ku lovota"? Explain----------

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B.1.29. Do you think according to your culture women should take decision with regard to condom use? Explain----------

---

B.1.30. Who should take decision with regard to when to have sex and when to have children? Name and explain----------

---

B.1.31. How should the people infected with HIV be treated? Explain----------

---

Thanks for your time and information provided

_____

JABULANI CALVIN MAKHUBELE

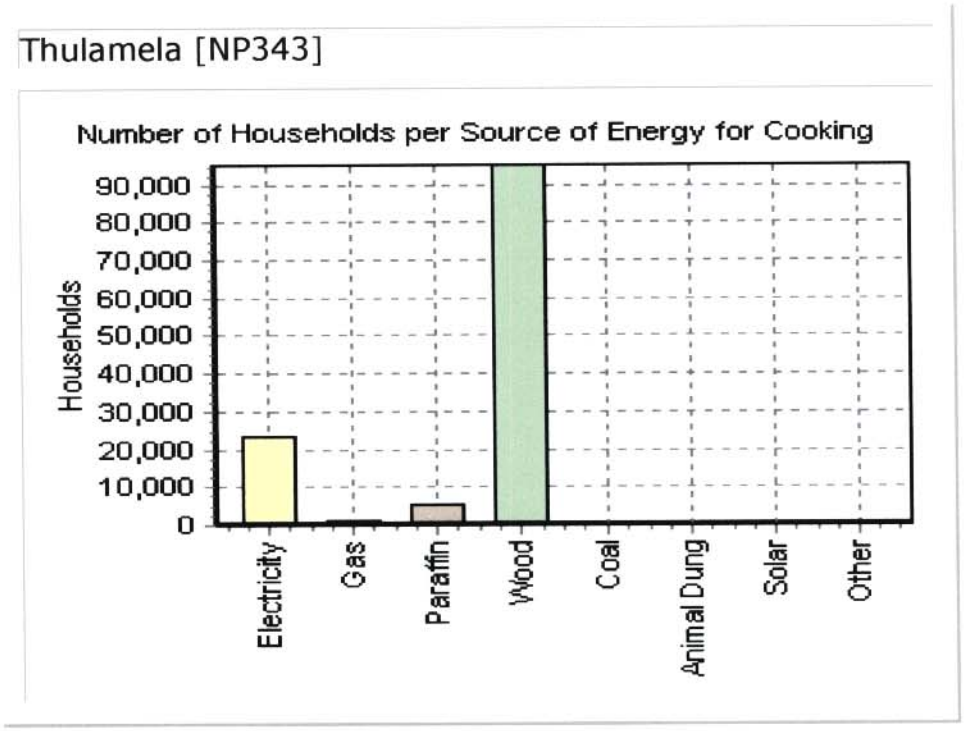
(RESEARCHER)

APPENDIX C

DATA ADAPTED FROM STATISTICS SOUTH AFRICA

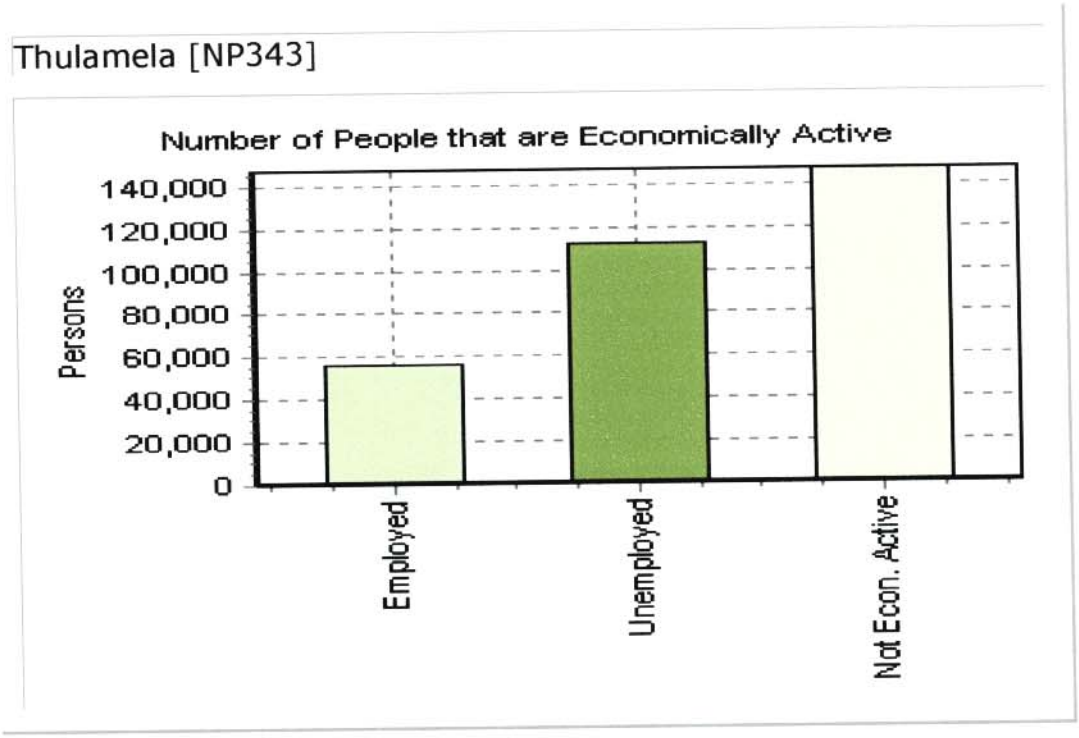
In this appendix, the data pertaining to the source of energy people in Malamulele use, those who are economical active, access to piped water, the dominant home language and highest level of education of over 20 year olds.

Dominant* Energy Source for Cooking, 2001



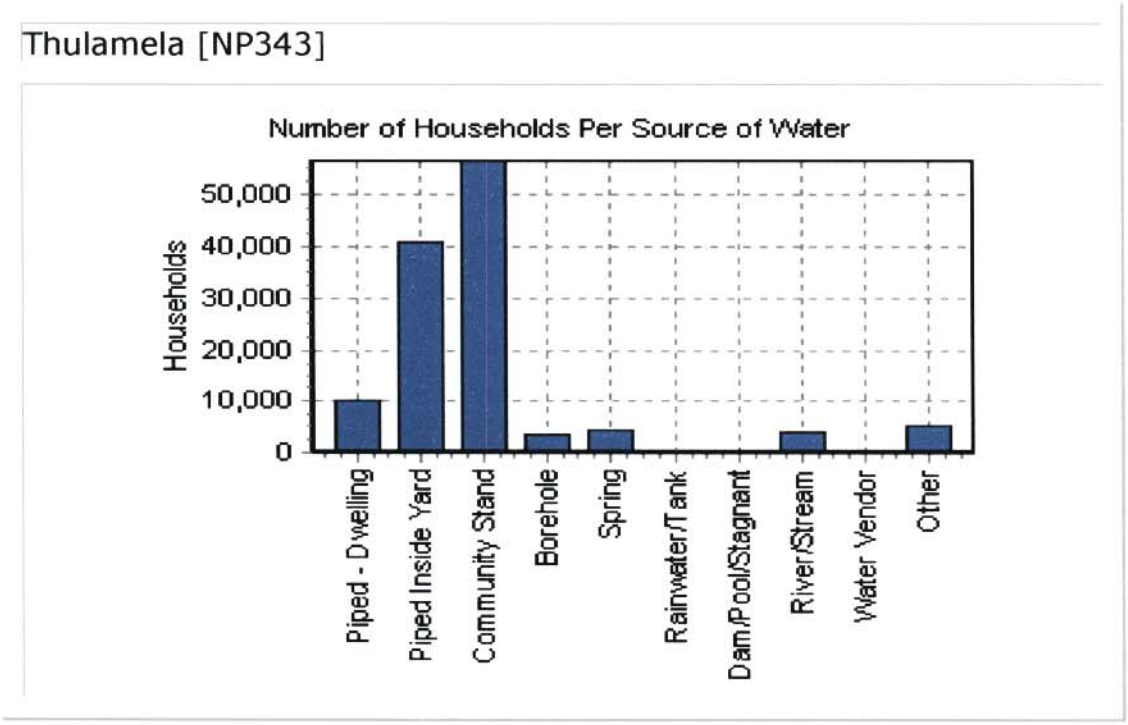
Source: Statistics South Africa –census 2001

Economically Active Population, 2001



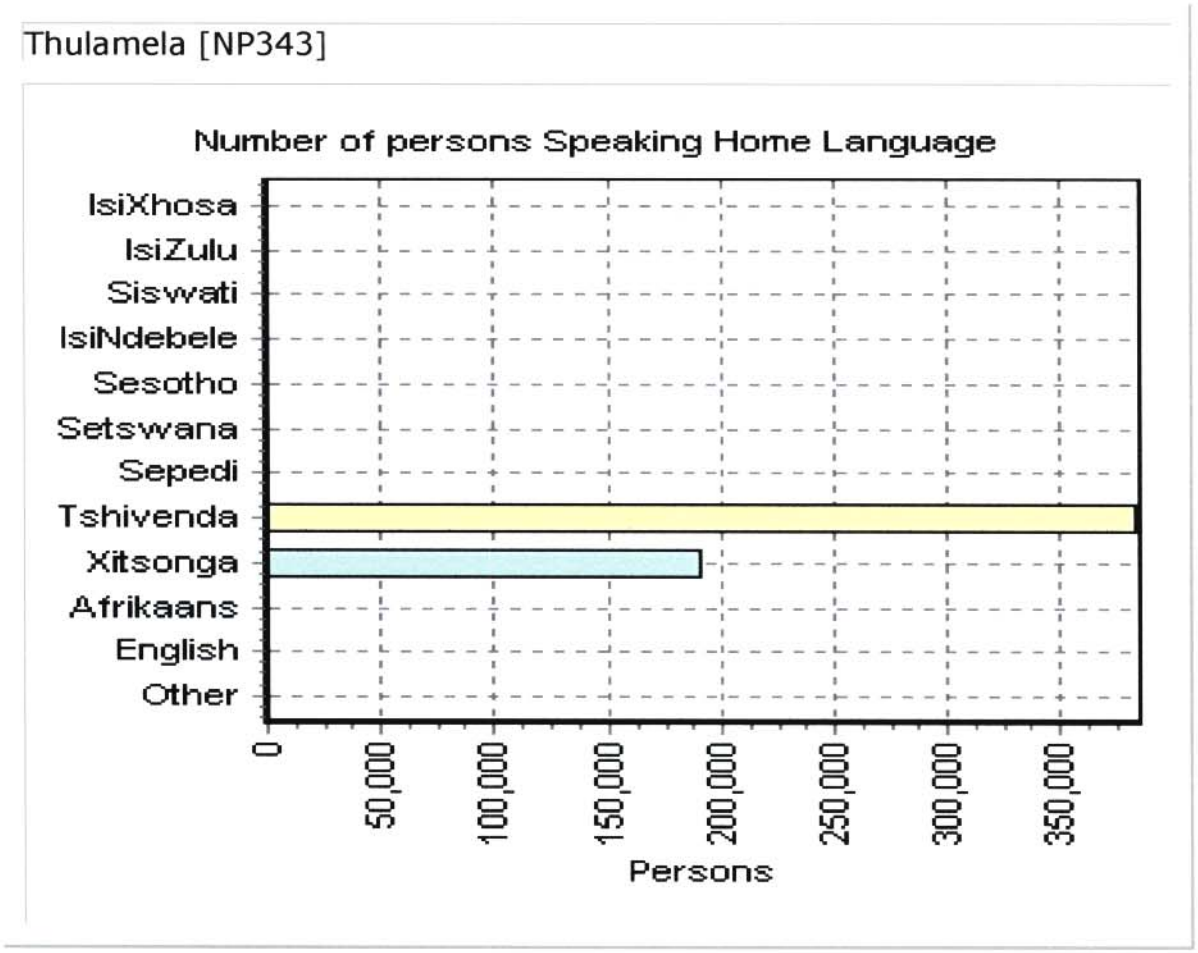
Source : Statistics South Africa - census 2001

Percentage Households with Access to Piped Water, 2001



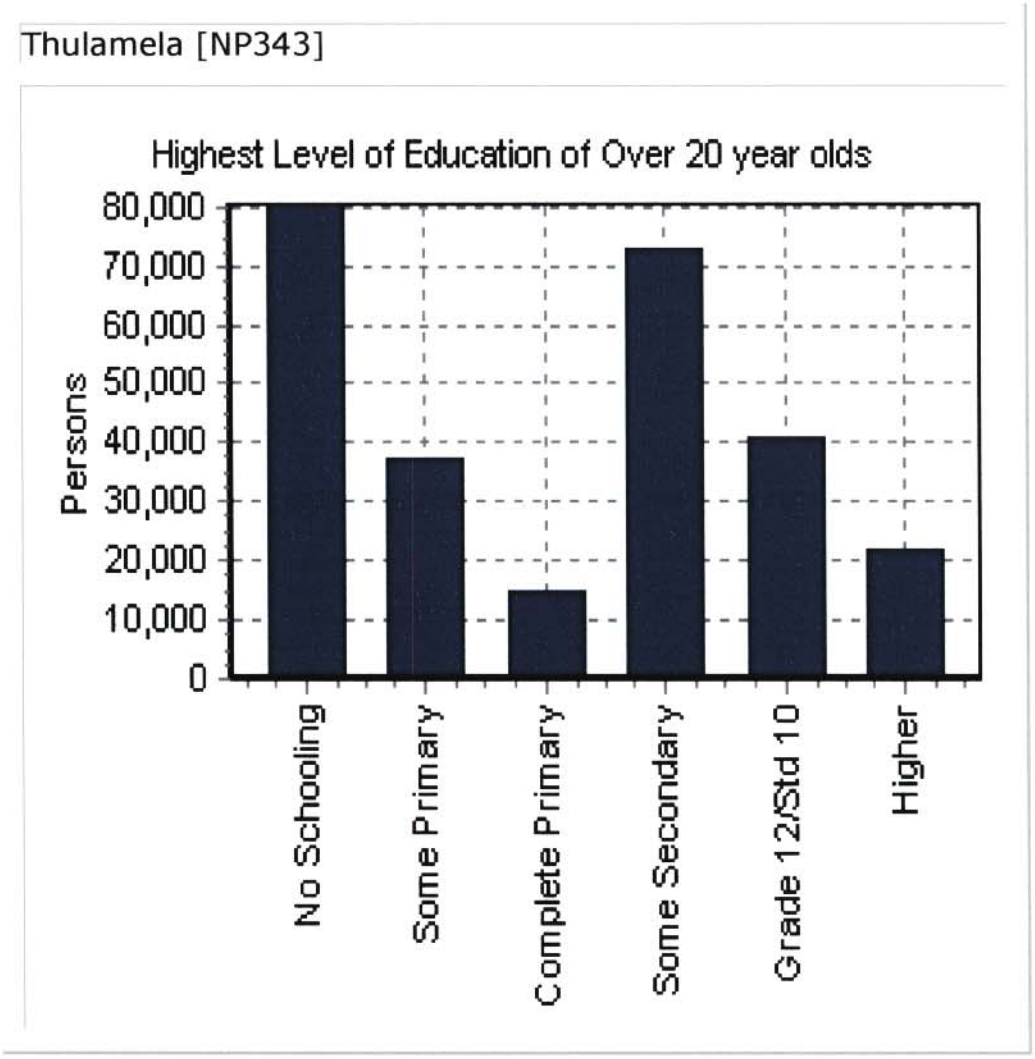
Source: Statistics South Africa – Census 2001

Dominant* Home Language, 2001



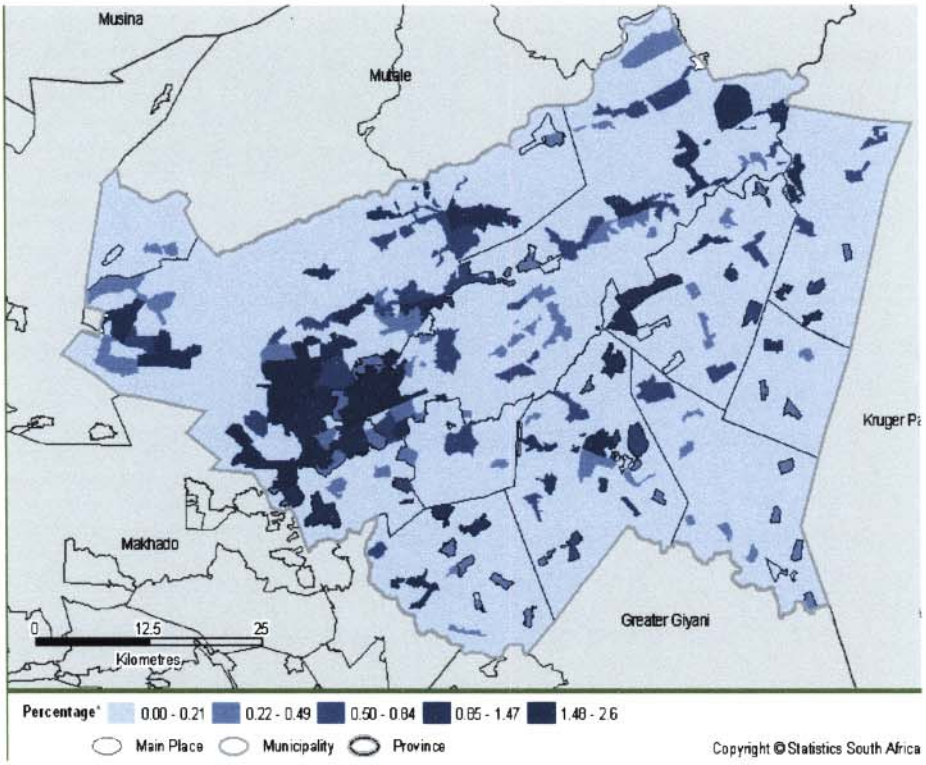
Source: Statistics South Africa – Census 2001

Age 20+ with No Schooling, 2001



Source: Statistics South Africa – Census 2001

MAP OF THULAMELA MUNICIPALITY IN THE VHEMBE DISTRICT LIMPOPO PROVINCE



Source: Statistics South Africa – Census 2001