

**The study of socio-cultural values and practices that
influence the escalation of HIV and AIDS amongst the youth:
A Social Work Perspective**

By

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DECLARATION

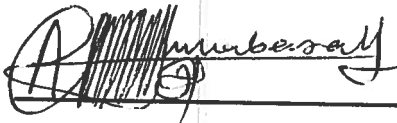
I, Mabasa Matimba Allan declare that **The study of socio-cultural values and practices that influence the escalation of HIV and AIDS amongst the youth: A Social Work Perspective** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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Surname and Full names

[REDACTED]

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A handwritten signature in cursive script, appearing to read 'Mabasa Matimba Allan', written over a horizontal line.

Signature

05/12/2012

Date

DEDICATION

This study is dedicated to my late father - Mabasa Gidja Jack. Moreover, I also dedicate this research project to my mother - Mabasa Mbhazima Elisah and my grandmother, Mabasa Mhlava Gavaza who have never failed to give me financial and moral support, for giving all my needs from my early age of development and for teaching me that even the largest task can be accomplished if it is done one step at a time.

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ABSTRACT

The overall aim of this study was to explore the socio-cultural values and practices that give rise to the escalation of HIV and AIDS in a low resourced Mapapila rural community. The objectives of the study were to describe young people's values and practices regarding HIV and AIDS as a foreign disease in Mapapila rural community; to establish young people's values and practices regarding condoms and condom use in Mapapila rural community; to investigate Mapapila rural community young people's values and practices into sex with girls and virgin cleansing; and to establish how rural community young people relate HIV infection to witchcraft. It was proven that the socio-cultural values and practices that give rise to the escalation of HIV and AIDS are valid and reliable.

The researcher used the explorative-qualitative research design as a way of approaching the studied theme. The purposive sampling which is one of the non-probability sampling methods was used to select participants whereby 120 participants were interviewed through the use of individual face-to-face and group interviews. The researcher collected data through synthesising of literature review emanating from focus groups discussion and individual interviews, the researcher used semi-structured interview schedule, utilized journal articles, text books, dissertations, and annual reports for this purpose. Whilst reviewing the literature, the researcher also considered theories, perspectives, and paradigms related to the study in understanding the behaviour of the sample studied. The theoretical frameworks considered by the researcher were the eco-systems and narrative theory. The researcher used qualitative data analysis which involves planning for the recording of data; data collection and preliminary analyses; organizing data; reading and writing memos; generating categories, themes and patterns; coding the data; testing the emergent understandings; searching for alternative explanations; representing, and visualizing (writing the report).

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CHAPTER ONE

General Orientation of the Study

1.1 INTRODUCTION

Of the 42 million living with HIV and AIDS world-wide some 90% live in developing countries. The HIV and AIDS epidemics in Africa started in the 1980s and came at a time of economic decline and cut backs in public spending for social services, including health. Further to this, in some of these countries governance tended to be poor and there was a lack of public accountability which led to inefficient use of the meagre resources. There is no doubt that the HIV epidemics have a further devastating impact on socio-economic development in the worst affected countries (UNAIDS, 2000).

Human immunodeficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) continue to be a major global health priority. HIV and AIDS affects every country in the world, although significant progress has been made in preventing new HIV infections and in lowering the annual number of AIDS related deaths, the number of people living with HIV continues to increase (Shisana & Simbayi, 2002:1). AIDS-related illnesses remain one of the leading causes of death globally. The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million (31.1 million–35.8 million).

The total number of people living with the virus in 2008 was 20% higher than the number in 2000, and the prevalence was roughly threefold higher than in 1990 (UNAIDS, 2009:7- 8). Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 22.4 million people are living with HIV in the region - around two thirds of the global total. In 2008 around 1.4 million people died from AIDS in sub-Saharan Africa and 1.9 million people became infected with HIV (UNAIDS, 2009:21).

HIV is a virus that is transmitted from person to person through the exchange of body fluids such as blood, semen, breast milk and vaginal secretions. Sexual contact is the most common way to spread HIV and AIDS, but it can also be transmitted by sharing needles when injecting drugs, or during childbirth and breastfeeding. Moreover, homosexuality is one of the ways in which HIV may be transmitted. Research on the burden of HIV among men who have sex with men (MSM) is currently being conducted in South Africa, and it points to a high prevalence (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-Van-Wyk, Mbelle, Van Zyl, Parker, Zungu & Pezi, 2009:xv).

As HIV reproduces, it damages the body's immune system and the body becomes susceptible to other illnesses and infections. AIDS is a condition that describes an advanced state of HIV infection. However, there are socio-cultural values and practices which propel the escalation of HIV, particularly amongst the youth. With regard to the values, they can be defined as broad preferences concerning appropriate courses of action or outcomes. As such, values reflect a person's sense of right and wrong or what "ought" to be whereas practices refer to actions that are learned informally or formally. Many practices are learned informally through experience, family, friends, and community.

In South Africa in 2008, it was estimated that 5.2 million people were living with HIV and AIDS, more than in any other country. It is believed that in 2008, over 250,000 South Africans died of AIDS. National prevalence is around 11%, with some age groups being particularly affected. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV. HIV in South Africa is predominantly transmitted heterosexually between sexual partners. Young adults, particularly females, are at greatest risk of acquiring HIV. It is important to note that HIV prevalence in 2008 in the Limpopo Province was at 8.8% (Shisana *et al.*, 2009:xvi) which is fairly very high.

1.2 OPERATIONAL DEFINITIONS OF CONCEPTS

The following concepts were operationalized for the study:

1.2.1 HIV and AIDS

HIV stands for human immunodeficiency virus (Mahan & Escott-Stump, 2008:992). HIV is a virus that is only found in human beings which slowly attacks and damages the body's immune system (A Resource Manual, HIV/AIDS & the law, 2003:10). This is a stage where the body's immune system can no longer fight off infections (A Resource Manual, HIV/AIDS & the Law, 2003:10). Van Dyk (2008:4) stipulates that AIDS is short for Acquired Immune Deficiency Syndrome. In this study the researcher adopted the above-mentioned definitions.

1.2.2 Values and Practices

The word value refers to enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable (New Dictionary of Social Work, 1995) whilst practices refer to the manifestation of a culture or sub-culture, especially in regard to the traditional and customary practices of a particular cultural group. The researcher will use values and practices referring to the actions based on misconceptions, superstitious stories and unfounded truth about HIV/AIDS.

1.2.3 Low-resourced community

For the purpose of this study, a low resourced community refers to a community which lacks basic services such as water, good housing, good road infrastructure, sewage system and health care facilities. This type of community is still characterised by strong socio-cultural practices.

1.3.1 BACKGROUND TO THE PROBLEM

The scourge of HIV and AIDS today is probably one of the most widely talked about illnesses in history and almost everybody has heard about HIV and AIDS, but the

unfortunate part of it is that many people still do not understand the real cause of AIDS and developed misconceptions towards the pandemic due to influence from different environments and cultural background (A Resource Manual, HIV and AIDS & the law, 2003:10). There are many untrue and superstitious stories circulating about HIV and AIDS (A Resource Manual, HIV and AIDS & the Law, 2003:10). According to Rice and Farquhar (2000:186) "about 50 per cent of new HIV infections affect young people between the ages of 10 and 24". The recent study by the UNAIDS (2009:1) argues that in 2007, young people aged 15-24 accounted for an estimation of 45% of the new HIV infections worldwide.

1.3.2 Problem statement

As indicated on the background of the problem, young people are the ones mostly infected amongst other age groups and socio-cultural values and practices contribute to the escalation of HIV infection to this age group. Firstly, amongst other problems due to the influence of socio-cultural values and practices, is having multiple sexual partners and youth sexual debut. It has been observed that youth sexual debut has dropped to the age of 9 years. The study conducted by Hunter (2005:389) in Kwazulu-Natal show that having multiple sexual partners and having sex at an early age is mostly practiced in Africa. To be seen being a *macho or mjita*, an individual should have multiple partners (Pattman, 2005:507; Leclerc-Madlala, 2008:12). Some of the cultures, for instance, amongst the Vha-Venda, VaTsonga and AmaZulu speaking people allow men to have multiple sexual partners (Matoane, 2008:20).

Secondly, is the myth towards condom use. According to Schoepf, (1992:33), "there is a widespread belief in many parts of Africa (East Africa, Democratic Republic of Congo - DRC) and among the Zulu speaking people in (South Africa) that repeated contributions of semen are needed to form or nurture the growing fetus in the womb and the use of condoms solely prevent that. One of the objections often raised against condoms is that condoms are not natural; they inhibit pleasure during sexual intercourse and interfere with the natural foetal development. It is also believed that semen contains important nutrients necessary for the continued physical and mental health, beauty and future fertility of women (Van Dyk, 2008:210). Adolescents

believe that the use of condoms during the sexual intercourse inhibit the sexual pleasure (Klepp, Flisher & Kaaya, 2008:41).

Thirdly, is the problem of spate of rape of girls and babies who are regarded as virgins. Leclerc-Madlala (2002:87) contends that most people mistakenly believe that having sexual intercourse with virgins cures AIDS. Similarly to that, 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 & 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 and 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 and are at great risk of being infected with HIV (Campbell, 1999:85; Janssen, De Wit, Stroebe & Van Griensven, 2000:488).

Fourthly and lastly, there is a problem of linking HIV infection with witchcraft. The findings by Munk (1997:10) in Kwazulu-Natal also show that there are some people who believe that AIDS is caused by witchcraft. Wreford (2008:7) indicated that AIDS is the work of "*Ukuthakatha*" which literally means witchcraft. Malema (2008:36) also contends that people in rural areas of the Limpopo Province in South Africa believe that HIV is caused by witchcraft, and they view HIV and AIDS as '*Isidliso*' or '*black poison*'. These socio-cultural values and practices of HIV and AIDS are some of the contributing factors to the high prevalence of HIV/AIDS. This also creates a dilemma on people of different cultures to get clear understanding of the pandemic and they also lead to the high prevalence of HIV and AIDS.

1.3.3 Assumptions of the study

As this will be an exploratory study, only assumptions may be provided to guide the study. According to (Fouché & De Vos as cited 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 purposes of this study, the following assumptions made are that:

- Having multiple sexual partners is regarded as an indication of African virility
- Rural people think HIV and AIDS is a foreign disease
- People think a condom inhibits sexual pleasure
- Having sex with virgins cures AIDS, and
- HIV is caused by witchcraft

1.3.4 Rationale of the study

There are several reasons that made the researcher to propose this study. Firstly, his personal experience on working in a low-resourced community and with young people played a role. He wants to know whether socio-cultural values and practices influence the escalation of HIV and AIDS and to establish to what extent. He has observed that most people who passed on in this community, the main cause of death was attributed to witchcraft in spite of the real issue which is HIV and AIDS.

Another issue which came out frequently during the personal discussions with people is the use of condoms during sexual intercourse. These discussions showed that people view condom and its use as un-African. They have said that condom use is not healthy and it is associated with higher rates of youth contracting sexually transmitted infections. Socio-cultural values and practices influence almost everyone in spite their age, educational and religious background. It is true that people are influenced by different cultural, religious and social backgrounds and environments, which are the contributing factors to the misconceptions about HIV and AIDS.

Furthermore, the statistics on the number of people living with HIV and AIDS motivated the researcher. According to UNAIDS (2009:21) South Africa is experiencing the largest HIV and AIDS epidemic in the world. An estimated 5.6 million South Africans are HIV positive in 2008, the largest number of any country in the world. Sub-Saharan Africa remains the region most heavily affected by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008.

Different Provinces in South Africa however experience different levels of HIV infections and AIDS related deaths. This illustrates the fact that the epidemic is in different stages of development in each Province and that a different approach to addressing the epidemic in each Province is necessary to stem the course of new infections and deaths. The total HIV prevalence rate in South Africa is 12% whereas 20% of adults between the ages of 20 and 64 are estimated to be HIV positive. Limpopo is still experiencing high numbers of new infections relative to AIDS deaths leading to rapidly growing HIV prevalence rates.

1.4 AIM AND OBJECTIVES OF THE STUDY

The aim and objectives of the study were as follows:

1.4.1 Aim of the study

The overall aim of this study is to explore the socio-cultural values and practices that give rise to the escalation of HIV and AIDS in a rural community.

1.4.2 Objectives of the study

The objectives of the study are as follows:

- To describe people's values and practices regarding HIV and AIDS as a foreign disease
- To establish people's values and practices regarding condoms and condom use

- To investigate people's values and practices into sex with girls and virgin cleansing
- To establish how people relate HIV infection to witchcraft

1.5 RESEARCH METHODOLOGY

With regard to research methodology, the following were considered and employed:

1.5.1 Research Design

For the purposes of this study, an exploratory research study will be undertaken. Sarantakos (1997:7) and Bless, Higson-Smith and Kagee (2006:43) assert that exploratory research study is usually undertaken when there is not enough information available about the research topic. It is undertaken in order to provide a basis for further research, to define certain concepts or to formulate hypotheses. By employing explorative-qualitative design, the researcher will be able to observe, study, and find new information related to the socio-cultural values and practices that give rise to the escalation of HIV and AIDS amongst the youth in a low-resourced community.

With regard to the research approach, the researcher will use qualitative research approach. According to Creswell (2003:182), there are two types of research approaches, namely qualitative approach and quantitative approach. Qualitative research approach uses complex reasoning that is multifaceted, interactive and simultaneous, while quantitative research approach follows statistical procedures and uses statistical techniques to test hypothesis and predict human behaviour (De Vos *et al.*, 2002:79). The researcher is more concerned about in-depth data and wants to gain insight into the socio-cultural values and practices that give rise to the escalation of HIV and AIDS amongst the youth at the low resourced community school. The research design will comprise of procedures that include population to be studied, sampling methods, data collection as well as methods of data analysis and interpretation.

1.5.2 Population and sampling

For the purpose of this study, purposive sampling which is one of the non-probability sampling methods will be used to select participants. Neuman (1997:204), Creswell (1998:118) and Erlandson, Harris, Skipper and Allen (1993:33) state that purposive sampling is a suitable type of sampling for special situations and researchers will be having a clear criterion in mind and have rationales for their decisions and the search for data must be guided by processes that will provide rich detail to maximise the range of specific information that can be obtained from and about that context. It is appropriate when the researcher uses it to select unique cases that are especially informative; to select members is difficult to research the population or when the researcher wants to identify particular types of cases in depth investigations.

According to Silverman (2000:104) in purposive sampling a particular case is chosen because it illustrates some feature or process that is of interest for a particular study. In this study, 20 participants will be selected based on the following characteristics:

- Holders and practitioners of socio-cultural practices in Mapapila Community
- Members of the community who openly assert that socio-cultural practices like multiple sexual relationships should be maintained and using a condom is un-African
- Members of the community who openly assert that their loved ones died due to witchcraft irrespective of risky sexual behaviours of their next-of-kin

1.5.3 Data collection methods

In a qualitative study the focus of the researcher is on spoken and written representatives and records of human experience, using multiple methods and multiples sources of data (Punch, 2005:168). Several types of data collection methods are employed in a qualitative project. Sarantakos (1997:166) contends that qualitative methods have the same goal as quantitative methods which are to collect data that will provide the basis for further thinking and operation. For the purposes of this study, the researcher will use the following: literature review, focus groups

discussion and individual interviews. With regard to focus groups discussion and individual interviews, the researcher will use semi-structured interview schedule. The semi-structured interview schedule uses a written questionnaire to guide interviews (De Vos *et al.*, 2002:302).

1.5.3.1 Document analysis

The researcher will utilize journal articles, text books, dissertations, and annual reports for this purpose. Whilst reviewing the literature, the researcher will also consider theories, perspectives, and paradigms related to the study in understanding the behaviour of the sample to be studied.

1.5.3.2 Individual interviews (one-to-one-interviews)

Individual interview incorporate the direct personal or one-on-one contact with the participant who is asked to answer questions relating to the research problem (Bless *et al.*, 2006:116). In this study, semi-structured interviews will be incorporated. These will allow the researcher to gain a detailed picture of the participants' beliefs, or perceptions, values and practices that influence the escalation of HIV and AIDS (De Vos *et al.*, 2002:302).

1.5.4 Data analysis

The researcher will use qualitative data analysis in the study. Data analysis is the process which allows the researcher to interpret and generalize the findings from the sample used in the research, to the larger population in which the researcher is interested (Bless *et al.*, 2006:163). Qualitative data analysis is the interaction which is presented in a linear form and has steps which move in circles (De Vos *et al.*, 2005:334). They further note that there are specific steps to be followed in qualitative data analysis. They are: planning for the recording of data; data collection and preliminary analyses; organizing data; reading and writing memos; generating categories, themes and patterns; coding the data; testing the emergent understandings; searching for alternative explanations; representing, and visualizing (writing the report).

1.6 RELIABILITY AND VALIDITY OF STUDY

Reliability is a matter of whether a particular technique applied repeatedly to the same object yields the same result each time. Reliability suggests that the same data would have been collected each time in repeated observations of the same phenomena (Delport in De Vos 2005:168; Blanche, Durrheim & Painter, 2006:152). Researchers have developed several techniques for cross checking reliability. An informal method of establishing reliability is to question respondents about issues that are relevant to them and be clear in what is asked. In addition, to enhance the reliability of a measurement instrument it should be administered in a consistent fashion, that is, there should be standardization in the use of the instrument from one situation to the next (Blanche et al., 2006:153). For the purposes of this study, the researcher will conduct a pilot study.

Validity is a term describing a measure that accurately reflects the concept it is intended to measure (Blanche *et al.*, 2006:147). In terms of Babbie (2004:143) in Des Vos *et al.*, (2007:160) "validity refers to the extent to which an empirical measure reflects the concepts it is intended to measure". This means that the measure process measures the variable it claims to measure (De Vos *et al.*, 2007:160). Validity takes different forms, each of which is important in different situations. They include face, content, criterion and construct validity.

For the purposes of this study, only content validity will be important. Content validity refers to the degree to which a measure covers the range of meaning included within a concept, that is, the extent to which an instrument is a representative sample of the content area (domain) being measured (Royse, 2004:129; Blanche *et al.*, 2006:149). Concerning content validity an extensive literature review of the area under investigation will be conducted. This will ensure that the content covered by the interview schedule for both focus group discussions and one-to-one interviews will be relevant to the topic under discussion. To check the reliability and validity of measuring instruments, a preliminary study will be conducted with a limited number of learners.

1.7 ETHICAL CONSIDERATIONS

The following ethics codes were considered in the study:

1.7.1 Voluntary participation

The researcher will ensure that respondents' participation is voluntary. This also involves informed consent that is the consent of the respondents to participate in the study (Babbie *et al.*, 2001:521). The researcher will first agree with each respondent to voluntarily participate or not.

1.7.2 Anonymity and confidentiality

The protection of respondents' identity will be ensured by the researcher. The researcher will not identify the responses with a given respondents. This means that the respondent will never be identified (Babbie *et al.*, 2001:523). The information given by the respondent will be kept confidential by the researcher.

1.7.3 Seeking permission to authorities

The researcher will request the Department of Education at Vhembe District to conduct the study. The school authorities and the community leader will also be requested.

1.8 SIGNIFICANCE OF THE STUDY

The findings of this study could serve as a reliable benchmark for social work teaching and social work service providers in the rural settings that focus on the prevention and treatment of HIV and AIDS in order to enhance cost-effectiveness in service delivery. Findings of this research study could also help the Department of Education to consider the relevance and importance of school social workers. The findings could further enhance the current HIV and AIDS literature that is Eurocentric in nature to be added to the knowledge base of the social work profession and education.

With regard to the value of this study to the community, exploration of the socio-cultural values and practices may, on the one hand, contribute to dispelling and rejecting of these values and practices which are harmful, derogatory and highly influential in the spread of HIV. While the study will be to exploring socio-cultural values and practices that give rise to the escalation of HIV and AIDS, research participants will be conscientised about the need and relevance of indigenous knowledge in their everyday life. The study would enable the Department of Health and Social Development to consider developing policies and programmes which would address socio-cultural values and practices which fuel the escalation of HIV and AIDS using the findings as the benchmark. The study will allow for the assessment of the nature, appropriateness and adequacy of existing HIV and AIDS interventions and policies focusing on the youth.

CHAPTER TWO

Socio-Cultural Values and Practices Compounding to the Escalation of HIV and AIDS amongst the Youth.

2.1 INTRODUCTION

This chapter presents the theoretical frameworks, background information including the definitions and the causes of HIV and AIDS. Subsequently, followed by the socio-cultural values and practices which compound towards the escalation of HIV and AIDS. These socio-cultural values and practices, in true sense, are myths and Van Dyk (2001:33; 2008:47) contends that there are truly horrifying and extremely dangerous socio-cultural values and practices circulating in some communities about how to avoid HIV infection and AIDS. Socio-cultural values and practices are critical for the establishment of social order and stability in society. HIV and AIDS are a complicated global problem. It is a global health crisis. Health has always been an essential component of development policies. However, health has a socio-cultural dimension. In this sense, socio-cultural values have a fundamental role to play. There can be a cultural approach to HIV and AIDS Prevention and Care.

The following will be discussed with regard to socio-cultural values and practices that compound to the escalation of the HIV and AIDS: Gendered power relations, Multiple sexual relationships, Promiscuous behaviour due to economic factors (commercial sex work), Age-disparate relationships, Wife inheritance, Having sexual intercourse with a fat woman, Virgin cleansing socio-cultural values and practices, Having sex with girls and babies, Virginity test, The use of condoms socio-cultural values and practices, Attitudes towards contraceptives, Witchcraft socio-cultural values and practices as a cause of HIV and AIDS, Faith healing, Traditional healing, Traditional healers' beliefs of HIV and AIDS, and The perception of HIV and AIDS as a foreign disease.

2.2 THEORETICAL FRAMEWORK

There are a plethora of perspectives, theories, models and approaches in the prevention and treatment of HIV and AIDS. For the purposes of this study, the eco-systems theory will serve as the overarching theory for the study. However, Narrative Theory will be used also. The ecological and systems (eco-systems) theories are regarded as the biopsychosocial-cultural framework (Ambrosino, Heffernan, Schuttlesworth & Ambrosino, 2005:55). These theories were selected because values and practices compounding to the high prevalence of HIV and AIDS cannot be perceived and effectively interpreted by one perspective, theory, model, or approach. The researcher will define each theory, explaining in detail its relevance to this study.

Firstly, the Eco-systems theory also called Life Model gives the guiding framework for understanding social work practices (Franklin & Jordan, 1999: 9; Fisher & Karger, 2000:14). The ecological metaphor helps the social work profession to enact its social purpose of helping people and promoting responsive environments that support human growth, health and satisfaction in social functioning (Germain & Gitterman, 1996:5-7; Zastrow, 2000:56; Zastrow, 2006:42). It focuses on the social and cultural factors with regard to behaviour change and learning about the historical traditions, beliefs and values in a particular environment, and how that social and cultural factors influence individual's behaviour (Keys, MacMahon, Sánchez, London & Abdul-Adil, 2004:177).

It assists the worker to grasp the problem of concern within the situation of the person-in-context and contributes to the problem intervention process (Compton, Galaway & Cournoyer, 2005:23). According to Potgieter (1998:54), eco-systems theory asserts that systems are always sub-systems of other larger systems in an environment, but can at the same time be divided into smaller subsystem units. The subsystems influence each other behaviourally. Eco-system theory provides a framework for seeing individuals, families, groups, and communities and institutions holistically and viewing their problems as encased in the web of difficulties intertwined with other systems.

One basic tenet of the eco-system theory is the belief in the hierarchical nature of the systems. With regard to the values and practices which compound to the escalation of the HIV and AIDS amongst the youth, young people should be viewed within the framework of the families, groups and communities with varying socio-cultural values and practices. Young people as members of the entire system are taught behaviour, values, traditions and customs as well as influenced to values and practices by their parents and other significant others. Since systems are bi-directional within and between systems, families, schools and churches, they may be viewed as some systems among many others (Franklin & Jordan, 1999:8). This theory focuses on the mutual relationship between the person and environment in which each shapes and influences the other over time. The theory gives an assessment on the negative interactions between people and their physical and social environments and squarely fit well for exploring the values and practices which influence on the escalation of the HIV and AIDS particularly amongst the people in low-resourced community.

Secondly and lastly, the Narrative Theory is the perspective that assumes the linguistic means of communication between individuals, communities, and cultures (Miller, 2006:105). This theory contends that stories are powerful representations of people's values, thinking styles and aspirations. This theory also corresponds with the aim of social work as it is linked to people and their lived experiences, past, present, and future. This approach also assists in the exploration and resolution of problems through stories. This approach originates from the sociological assumptions and perceptions (Miller, 2006:107). The social structures such as beliefs and values upon which the society has developed and continues to function, and the elements that create these structures, are born out of the repetition and re-enactment of dominant themes and objectives (Goffman as cited in Miller, 2006:107). For the purpose of this study, narrative theory will be used as a framework in which stories about how socio-cultural values and practices should be done as well as how HIV and AIDS could be prevented.

2.3 BACKGROUND INFORMATION ON HIV AND AIDS

By the end of the year 2002 an estimated 42 million people world-wide were living with HIV. Some 90% of these people were living in developing countries. Especially sub-Saharan Africa takes the brunt of the HIV pandemic: 70% of all HIV-infected people in the world were living in sub-Saharan Africa, which is home to less than 10% of the world's population (UNAIDS and World Health Organization, 2002:2). The worst affected regions in the world are in Eastern and Southern Africa. In the large cities of these regions the prevalence of HIV infection in adults can reach up to 40% (UNAIDS, 2000:1).

The proportion of women living with HIV has remained stable at 50% globally, although women are more affected in sub-Saharan Africa (59% of all people living with HIV) and the Caribbean (53%). Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although there was a notable decline in the regional rate of new infections. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world. Almost half of the deaths from AIDS-related illnesses in 2010 occurred in Southern Africa. AIDS has claimed at least one million lives annually in sub-Saharan Africa since 1998. Since then, however, AIDS-related deaths have steadily decreased, as free antiretroviral therapy has become more widely available in the region (UNAIDS, 2011:6).

There is need for a comprehensive understanding of socio-cultural values and practices. The need to understand what motivates peoples' behaviour, knowing how to address these motivations appropriately, and taking into consideration peoples' cultures when developing programs addressing HIV and AIDS are essential to change behaviour and attitudes towards HIV and AIDS.

2.3.1 Perception towards HIV and AIDS

Behaviour is a conscious process driven by perceptions, after-images, private thoughts and dreams of which only the person himself is aware of. According Airhihenbuwa and Webster (2004:10) perception refers to the "knowledge, beliefs and values in decision making that are focused on either individuals or groups, or the complementarities of emotion and rational cues to behavioral actions". Perceptions are rooted in socio-cultural values and practices and serve as driving force behind decisions and behavior. This is evident when people openly express their knowledge and belief that HIV causes AIDS and the knowledge and belief that HIV and AIDS is a problem of Black Africans. Perception is described as positive and being negative towards the pandemic.

- **Positive perception**

Positive perception refers to knowledge, attitudes and/or beliefs that positively influence decisions about HIV and AIDS prevention, care and support. A critical aspect of this category is contextual values that allow one to see HIV as the result of one's behaviour rather than one's identity (Airhihenbuwa et al., 2004:11). It has been argued (Airhihenbuwa & Obregon, 2000:09) that identifying positive aspects of community perception should be a requirement for initiating any behavioural intervention that is anchored in culture. An interventionist who is not able to identify positive aspects of a culture relative to a given disease has no business being in such cultural contexts, because he or she would end up blaming the culture for their failure at the end of the programme. For example, it is indeed the cultural practice of taking care of loved ones at home that made it possible to capitalize on home-based care as an effective strategy for care and support of persons living with HIV and AIDS.

- **Negative perception**

This refers to knowledge, attitudes and/or beliefs that negatively influence decisions about HIV and AIDS prevention, care and support. This represents quite often the only focus of behaviour intervention, to the exclusion of others (Airhihenbuwa et al., 2004:11). Socio-cultural values and practices about HIV infection lead to

discrimination and human rights abuses. The attitude and the perception that exist is that only prostitutes use condoms. It is also contended that if a woman suggests the use of a condom, she might be accused of being unfaithful or hiding an STD. In addition, it appears that men think and feel insulted if a condom is suggested, as it casts doubts on their faithfulness (Schoepf, 1992:33; Ackermann et al., 2002:170).

Changing these perceptions often depends on a clear understanding of the other category of perceptions described above. For example, addressing the belief that HIV is somebody else's problem often requires an understanding of what is considered (and why) a health problem within the cultural frame of reference and what types of health behaviours are considered to be positive. Mothers, who claim that their child died of witchcraft, when AIDS is the actual cause of death, are considered ignorant of HIV knowledge and transmission. In a climate of stigma, it is quite plausible for a mother to defer to a culturally acceptable explanation for a child's death even when she is aware of the actual cause of death (Airhihenbuwa et al., 2004:11). This is not unlike an Overweight woman in a study, whose explanation for her weight status was to state falsely that she was the mother of two children. When she later gave an Explanation, it was that being overweight was culturally more acceptable for a woman who had had children than a woman like her who had never had a child.

Structural and socio-cultural factors affect individuals' perceptions and behaviour but they do so differently based on various factors. There are many socio-economic forces which influence the agency of individuals in terms of their risk perception, behaviour and decisions. But such factors have different impacts based on a person's age, social networks and relationships, the social characteristics of the individual's age group and the history of the society the individual is living in. The challenge is therefore to study these factors in order to determine their interaction. Therefore, using an eco-systems theory, it is necessary to integrate the historical and cultural location of an individual's life, the linked nature of human lives in social relationships and the human agency of individual lives in relation to timing of life events.

2.3.2 Causes of HIV and AIDS

Mbizvo and Bassett (1996:86) argue that sexually transmitted diseases (STDs) serve as a marker of the extent of multiple or casual sexual encounters. In addition, they believe that the high rates of STDs may explain the apparent efficiency of heterosexual transmission of HIV in Africa. In all societies today sexual relationships can be a source of pleasure and reproduction as well as risk to health. Martin, Gresenguest, Massanga, Georges, & Testa (1992:205) reported that there is an association between HTV-1 infection and STDs among men in Central Africa and concluded that the association was simply a marker of promiscuity.

Human immunodeficiency virus (HIV) causes immunodeficiency and ultimately leads to the death of infected patients several years after infection (Coffin, Hughes, & Varmus (1997:36). Mayer and Piltzer (2005:17) contend that AIDS is caused by HIV, whilst AIDS is an irreversible destruction of the immune system. AIDS is the end stage disease manifestation of HIV infection (Schoub, 1999:21). Stine (2005:25); and Zastrow (2000:517) outlines how HIV causes AIDS.

The authors states that HIV depletes a subset of lymphocytes called T4 cells or CD4 counts+ cells that are vital in the proliferation of cells necessary to cell-mediated immunity and in the production of antibodies. The cell-mediated immunity and antibodies are critical components of the immune system. Without the ability to produce a sufficient number of immune specific cells and immune specific antibodies, the body is vulnerable to a large variety of infections caused by organisms and viruses that normally do not cause human disease. These infections create the symptoms and progression of illness that eventually kill AIDS patients. Thus, AIDS begins with HIV infection, AIDS is the end stage of chronic HIV infection. People do not die of AIDS per se. They die of opportunistic infections, cancers and organic failures brought on by the results of a failed immune system (Stine, 2005:25).

2.3.3 Transmission of HIV and AIDS

Epidemiological evidence indicates that sexual contact continues to be the major mode of the spread of HIV transmission in developing countries, leading to high prevalence of HIV infection in women of childbearing age (Schmid *et al.*, 2004:22). The degree to which men and women are able to control the various aspects of their sexual lives, that is, their ability to negotiate the timing of sex, conditions under which it takes place, and the use of condoms, plays a critical role in determining their vulnerability to HIV infection. Personal risk of contracting HIV is determined by numerous social and cultural factors that shape sexuality perceptions, attitudes and behaviours.

Transmission of HIV appears to depend on a large number of variables that incorporates donor, recipient and portal entry (Stine, 2005:195). According to Schoub (1999:91) HIV can be transmitted in one of these three ways: through sexual intercourse with an infected person, by a pregnant woman to the fetus or after birth during breastfeeding, and through exposure to contaminated blood (sharing needles and syringes that are contaminated, through needle stick injuries, or through blood transfusions). Stine (2005:192) contends that the mode of HIV transmission is via exposure mucosal surfaces, of the vagina, vulva, rectum, mouth, to infected sexual fluids and during birth. The transmission in terms of sexual intercourse is in the forms of male-to-male sexual transmission and heterosexual transmission (Stine, 2005:195).

Certain cultural practices make groups susceptible to HIV infection. Risky behaviours are sometimes culturally sanctioned and require attention in corrective interventions to reduce the transmission of HIV. There are key cultural rites of passage that contribute towards infectivity of the young and old. Essential to this understanding, is awareness of the context in which decisions regarding health, health-seeking behaviour, and sexual behaviour are constructed (Falola & Heaton, 2007: 8). For the purpose of this study, the following will be the focus of literature review: anal sexual intercourse, mother-to-child transmission, HIV transmission through breastfeeding, and exposure to contaminated blood and syringes

- **Anal sexual intercourse**

Sexuality consists of attitudes, feelings and desires about sexual expressions. Sexuality influences every aspect of people's lives. Sexuality is shaped by a person's values, standards, beliefs, emotions and personality. Male-to-Male sexual transmission is identified as one of the patterns of HIV transmission and this now shows the troubling signs of resurgence, largely due to unsafe sexual practices among gay men (Stine, 2005:195). Schoub (1999:96) shows that rectal intercourse is likely to promote the transmission of HIV.

In this particular manner, the receptive partner is in danger of HIV infection due to high frequency of trauma to the mucosal lining of the rectum during rectal intercourse (Schoub, 1999:96). The rectum is indicated to be an organ which is far less adapted to sexual intercourse than the vagina and this put it at special risk of HIV infection. The rectal mucosa may also be damaged by other activities commonly used by homosexual men, such as insertion of the hand into the anus and rectum, pushing of foreign objects, such as sex toys (Schoub, 1999:96). Female homosexuality on the other hand, played almost no role in the epidemiology of AIDS (Schoub, 1999:98).

- **Mother-to-child transmission**

Mother-to-child transmission (MTCT) is the most significant source of HIV infection in young children. The virus may be transmitted during pregnancy, labour or delivery, or through breastfeeding (De Cock *et al.* 2000:1175). The other essential mechanism for HIV infection is the so-called "vertical" transmission from a pregnant woman to her unborn child (Van Niekerk & Prins, 2001:4). Without specific interventions, HIV-infected women will pass the virus to their infants during pregnancy or delivery in about 15–25% of cases; and an additional 5–20% of infants may become infected postnatally during breastfeeding (De Cock *et al.*, 2000:1175; Nduati *et al.*, 2000:1167).

In the absence of both a cure and/or a vaccine, prevention of Mother-to-Child Transmission of HIV, however, does represent the one area where a significant reduction in the infection rate, and the concomitant saving of lives and relief of

suffering, can be achieved (Van Niekerk & Prins, 2001:4). A pregnant woman who has the HIV virus can pass it on to her baby when she is pregnant or gives birth (Soul city, 2007:5). Soul city (2007:5) stipulates that a woman is more likely to pass on the virus if she is sick with AIDS when she becomes pregnant and while she is pregnant. Strategies to prevent all MTCT should be linked to primary prevention programmes that provide education about safer sex, condoms, and diagnosis and treatment of sexually transmitted infections, and that ensure the safety of medical procedures (WHO, 2007:22).

- **HIV transmission through breastfeeding**

WHO (2007:9) indicates that breastfeeding is the best food for infants, and is an effective method of reducing the risk of common childhood morbidity, particularly gastrointestinal and respiratory infections, and of promoting child survival and maternal health through child spacing. While breastfeeding carries significant health benefits to infants and young children, HIV can be transmitted during breastfeeding from an HIV-infected mother to her infant. Mother-to-child transmission of HIV can occur during pregnancy, labour or delivery, or through breastfeeding.

Zastrow (2006:515) indicates that breastfeeding is a contributing factor capable of transmitting the HIV disease. It has been found that babies can be infected before or after birth from their infected mothers and through breastfeeding (Zastrow, 2006:514). A woman can pass HIV when she breast-feeds the child (Soul city, 2007:5). The infection takes place after birth by breast feeding (Schoub, 1999:119). The best approach to preventing HIV infection in infants and young children, including transmission through breast milk, is to prevent HIV infection of young girls and women of childbearing age (De Cock, Mbori-Ngacha, & Marum, 2002:67). In Sub-Saharan Africa, Asia and the Caribbean, the main mode of HIV transmission is heterosexual contact (Buve, Bishikwabo-Nsarhaza & Mutangadura, 2002:201).

- **Exposure to contaminated blood and syringes (not done)**

Van Niekerk (2004:4) indicates that HIV is transmitted through the exchange of bodily fluids during homosexual and heterosexual intercourse. Van Dyk (2008:40)

concur with Van Niekerk that HIV can be transmitted through contaminated needles and sharp instruments in hospitals or clinics where medical hygiene is poor, or through, accidental exposure to contaminated needles or sharp instruments. The transmission of HIV is also through sharing of needles and syringes by abusers and users of drugs administered intravenously; this is known as "horizontal" transmission, transmission from one person to another (Van Niekerk, 2004:4).

Zastrow (2006:516) also contends that someone can get infected with HIV by using hypodermic needles that were also used by someone who has the virus, and by also reviving contaminated blood transfusions or other products derived from contaminated blood. The high risk factor of contracting HIV can be sharing intravenous needles (Zastrow, 2006:516). Lesbians are at low risk unless they utilize intravenous drugs or have sex with people in high risk groups. Female-to-female transmission is possible, however through vaginal secretions or blood (Zastrow, 2006:515). The virus can pass from a person who has it to another person if they share needles and syringes that are not properly cleaned (Soul City, 2007:5). It is also passed on if they both have a cut or an open wound and their blood get mixed. Sick people can be given extra blood through a blood transfusion (Soul City, 2007:5).

2.4 THE SOCIO-CULTURAL VALUES AND PRACTICES

The rapid spread of HIV and AIDS has created challenges for everyone who is involved in the fight against it. Many of the strategies to prevent the spread of the pandemic have focused on promoting condom use, reducing the numbers of sexual partners and treating sexually transmitted diseases (STDs). However, by failing to address the social, economic and power relations between men and women, such strategies have not been effective in tackling women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic.

There are varieties of traditional or cultural practices which directly and indirectly fuel the spread of HIV in communities. Other contributing factors that lead to the rapid spread is certain cultural values, practices, traditions and belief systems (Buseh, Glass & McElmurry, 2002:32; Sithole, 2001:24; Van Dyk, 1999:49). The evidence

indicates that many factors, which are behavioural, social and biological in nature that play a role in the spread of sexually transmitted HIV epidemic (Stine, 2005:192). Among the behavioural and social factors are condom use, proportion of the adult population with multiple partners, overlapping sexual partnerships-individuals are highly infectious when they first acquire HIV and thus more likely to infect any concurrent partners, sexual networks, age mixing, typically between older men and young or girls, poverty and in particular women's economic dependency on marriage or prostitution, robbing them of control over circumstances or safety of sex (Stine, 2005:192).

The biological factors include high rates of sexual transmitted infections, especially those causing genital ulcers, low rate of male circumcision, and high viral load HIV levels in the bloodstream that are highest when a person is first infected and again in the late stages of illness (Stine, 2005:192). The patriarchal structures in certain cultures extend to men being allowed to have multiple wives due to promiscuity or practicing polygamy. Some of the cultures in South Africa like the Tsonga and Venda cultures mostly and genuinely practice polygamy (Matoane, 2008:20).

2.4.1 Gendered power relations

'Masculinity' requires men to be more dominating, knowledgeable and experienced about sex. This assumption puts many young men at risk of HIV infection as such norms prevent them from seeking information or admitting their lack of knowledge about sex or methods of protection. These norms also promote promiscuity and reinforce risk-taking behavior. In many societies men are socialized to be self-reliant, to conceal their emotions, and not to seek assistance in times of need or stress. This expectation of invulnerability associated with masculinity runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk. Men subordinate women as they are dependent on them, and men tend to have multiple partners because women are dependent on them (Hunter, 2005:14). Sub-Saharan African women are disempowered to negotiate the use of condoms with their sexual partners who disadvantage their lives and this compound to women susceptibility to HIV (Ackermann & De Klerk, 2002:170).

The Department of Health (2007:34) in the National Strategic Plan 2007-2011 outlines that there is an evidence of cultural attitudes and practices which exposes South Africans to HIV infections. Firstly, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place. Such decisions are frequently constrained by coercion and violence in the women's relationships with men.

In particular, male partners' either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood. Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, and prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection.

2.4.2 Multiple sexual relationships

Gender inequality and patriarchy (social structures where men take primary responsibility and dominate in their households) encourages multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. The Soul City Institute for Health and Development Communication (2008:15) noted that there are socio-cultural values and practices about why men and women have multiple partners.

The socio-cultural values and practices about why men and women have multiple partners are as follows: men cannot resist attractive women, men cannot control their sexual urges, young women cause married men to have affairs, there is nothing that a woman can do if her partner is having other affairs, it is the fault of a woman

that influences a man to have multiple affairs, and all men have affairs. Engaging in concurrency can correlate with being less religious and with knowledge that the primary partner also had concurrent partners (Emah, 2008:5). Concurrency is increasingly being contended to be an element of sexual partnerships that plays an important part in HIV transmission dynamics (SADC HIV & AIDS Unit - SADC Secretariat, 2003:16).

Encouragement of multiple sexual partners contributes to making efficient HIV protection more difficult (Levine and Ross, 2002 as cited in Baxen & Breidlid, 2004:16). The prominent aspect that drives the HIV and AIDS pandemic is having multiple partners (HSRC, 2002:13; Hunter, 2005:123). Hudson (1993:53) contended that observed differences in HIV prevalence between and within countries could be partially determined by varying levels of prevalence of concurrent sexual partnerships. The epidemic spread of HIV would tend to occur in populations that have high rates of simultaneous partners (Emah, 2008:5). Tabane (2009:30) asserts that in Botswana, it is believed that "a man is like a bull and should not be confined to one pasture".

Kalipeni, Cradock, Oppong and Ghosh (2004:52) contend that most Africans do not judge having multiple sexual partners as immoral and being unfaithful. The acceleration of STD's and AIDS in both urban and rural areas are products of deeply ingrained promiscuous sexual behavior (Kalipeni et al., 2004:50). Even though, while poly-partner sexual activity may be the vehicle for spreading HIV, polygamy does not automatically produce rapid transmission of sexually transmitted diseases, it depends on marital norms (Kalipeni et al., 2004:51). Kalipeni et al (2004:51) stipulate that multiple sexual relationships are one of the major etiological factors in the pattern of HIV and AIDS.

2.4.3 Promiscuous behaviour due to economic factors (commercial sex work)

For years, promiscuous behavior or 'prostitution' has been a major theme in discussions about the global HIV and AIDS epidemic. The media often run stories about HIV that focus on sex workers, individuals who sell sex, and both governments and HIV related Organisations frequently talk about prostitutes and prostitution in the

context of AIDS. HIV and AIDS cases are increasing among women and girls involved in commercial sex work and poverty is the primary reason that women become commercial sex workers.

Hunter (2004:14); and Basu (2003:23) contend that due to economic hardships and unemployment, young females tend to engage themselves in relationships with sugar daddies to find the money for their living. Kalapeni et al., (2004:53) argues that women in Africa trade in sex both within and outside marriage for economic gain and that most Africans experience little guilt about sex, and they enter into sex more casually and have more sexual partners than non-Africans do. Some women also engage themselves in the explicit and implicit investments in the sexual economy to satisfy their needs. Women engage in multiple relationships or have multiple partners with the motive behind of getting needs such as money, groceries and clothes (Hunter, 2005:144).

The drives of having multiple partners play a role in the escalation of HIV and AIDS which shorten the life expectancy of both males and females. According to Leclerc-Madlala (2008:11) 'the older men viewed the young women as being 'clean', and the young women regarded the older men as 'safe' partners'. Girls say that currently there is 50/50, that is why they believe that when their boyfriends are not unfaithful, and they go ahead and have other relationships with other males. In relation to the promiscuous behavior due to economic factors, the age-disparate relationships will be discussed.

2.4.4 Age-disparate relationships

Leclerc-Madlala (2008:12) contends that older men are more likely to be employed and able to provide greater economic security than younger men. Young girls from poor backgrounds would see wealthier older men as 'meal tickets', providing them with basic needs such as food, housing, cellphones, luxury cars and clothing. She further contends that those young women's motivations for age-disparate relationships are as follows: financial gain, vulnerable victims engage in these types of relationships because of hunger, pressure or coercion (by peers, man, family) manipulation, pressure to obey and show 'respect', need for protection, employment;

active agents do this due to boast of 'taking charge', 'milking the cow', seeking fun, adventure or opportunities to make contacts among 'sponsors'/ 'investors'/'ministers' for present or future social mobility. It is indicated that urban young girls have age-disparate partnerships for fashion clothing, cell phones, jewellery, desires consistent with urban lifestyle/glamour & entertainment; and rural girls do this to accumulate food, school fees, clothing, cosmetics (Leclerc-Madlala, 2008:12)

The finding argues that a girl that was seen alighting from an expensive sports car or 'right' parties and mixed with the 'right' people, scored vital points and considered to be having self-esteem. A girl that could attract the attention of a wealthy older man, maintain a relationship with him and use him as a passport to the 'easy life' was considered as being 'clever' by her peers (Leclerc-Madlala, 2008:12)..

Leclerc-Madlala (2008:12) also noted that older sexual partners have colloquial names such as 'investors' (Tanzania and Mozambique), 'sponsors' (Botswana) or even 'ministers' (South Africa). Across socio-economic strata, young women have been culturally conditioned to view their sexuality as a valuable resource, to be used to satisfy the primarily male need for sex. She indicated that men motivations of age-disparate partnerships is due to the following reasons: need for variety/entertainment/ relief from stress or boredom, desire for 'clean' partners, desire for sexual rejuvenation, desire to socially demonstrate manhood and social worth, manipulation/reaction to being challenged, some see themselves as victims of young women's seductions and social expectations (Leclerc-Madlala, 2008:13).

2.4.5 Wife inheritance

Wife inheritance is a practice among the traditions and customs which gives for a provision for a continuity in the family. When a husband dies, his wife is expected to be inherited for continuity of the family, more so women who are within the bracket of child bearing age. The practice of wife inheritance is widespread and has come a long way since its existence in ancient Judaism and even in the Indian sub-continent. Central to this practice is the feeling that the widow "owes" her in-laws a child in return for the bride wealth (Centre for Rights, Education and Awareness – CREAM, 2008:2).

The "widow inheritance" still exists in some Southern African countries including South Africa. This means the younger brother or relative who marries again the wife of the deceased husband (Sithole, 2001:26). This has been supported by the UNAIDS (2003:5) that in Zambia this practice still exist. Mantoane (2008:21) supported that this will be risky if one of the partners within the new relationship is infected with the virus, this will increase the spread of the epidemic. Rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection (DOH, 2007:34).

2.4.6 Having sexual intercourse with a fat woman

There are some people in the society who believe that having sex with the fat woman will make them not contaminate HIV. Van Dyk (2008:47; 2001:33) contends that some people mistakenly believe that they will not get AIDS if they have sexual intercourse with a fat woman, who evidently does not have slim body. People believe that a fresh person cannot be infected. This circulating socio-cultural values and practices mostly disadvantages the vulnerable groups such as women

2.4.7 Virgin cleansing socio-cultural values and practices

It is also mistakenly contemplated that an infected patient or person can actually be cured if he or she can have sex with virgins, or with girls younger than 12 years and with very young boys (Van Dyk, 2008:47; 2001:33; Leclerc-Madlala, 2002:87). This circulating socio-cultural value and practice mostly disadvantages the vulnerable groups such as women and children and children are raped due to this. Van Dyk (2001:33; 2008:47) support that beliefs like these can be the cause of abhorrent criminal behavior and can also cause HIV infection to spread like wildlife.

According to Leclerc-Madlala (2002:87) the socio-cultural value and practice that to have sex with a virgin cures AIDS has been identified as the contributing factor to the rape of babies and children in South Africa. Whereas the prevalence of this socio-cultural value and practice has been a concern in local communities for some time, there have been recent attempts to discern the extent to which this belief is exacerbating perceived increases in child rape and the rate of new HIV infections

nationwide. Leclerc-Madlala (2002:87) contends that "closer attention paid to the shaping influence of cultural schemas is critical to better understanding belief-behaviour linkages in the context of rape and AIDS".

The belief that sexual intercourse with a virgin can 'cure' a man of HIV and AIDS is embedded in metaphoric associations of sexually active women with 'wet/dirty' vaginas. "According to the virgin cleansing socio-cultural value and practice, a man can 'cleanse' his blood of HIV and AIDS through intercourse with a virgin, but the girl herself would not be infected in the process" (Leclerc-Madlala, 2002:87). The broad category of prevention treatment-cure is encompassed in virgin cleansing therapy, whereby sexual intercourse with a virgin is also thought to provide a type of vaccination against the threat of future HIV infection.

Therefore, virgin cleansing is believed to have both a therapeutic and a prophylactic effect. According to Leclerc-Madlala (2002:87), several interviewed traditional healers, beliefs that virgin cleansing or sexual intercourse with a virgin was said to be a way in which a man thought he could obtain a measure of 'strength' against HIV infection. It was unclear whether this meant that additional 'cleansing' was needed periodically in order to maintain the strength of the inoculation. Although these particular healers said they were opposed to this practice and rejected claims of its efficacy, they all professed to have first-hand knowledge of other healers who did actually recommend virgin cleansing as a way of treating or a cure for AIDS.

Leclerc-Madlala (2002:87) stipulates that the healers had no agreement as to what qualities associated with virginity were believed to give the girl a special 'immunity' against acquiring HIV infection from the infected male sexual partner. She further contends that the vagina of a young girl is not associated with the vaginal lubrications of the adult woman. The virgin's vaginal tract, yet undeveloped, is conceptualized as 'clean', 'dry', 'uncontaminated'. Being a dry surface, it is believed that 'dirt' cannot easily attach itself. One informant used the analogy of taste: "You can only taste something on your tongue because it's wet, the taste can stick there. You can't taste things on your hand. It's dry" (Leclerc-Madlala, 2002:87).

2.4.8 Having sex with girls and babies

Matoane (2008:20) stipulated that young females are given to older men and women by their own parents in exchange for money. Sithole (2001:24) also contends that this exchange takes place in the young females' lives, which puts them on the risk of contracting HIV and AIDS. This is more risky more especially in cases wherein men have multiple sexual partners. In ethnic groups where multiple sexual partnership is genuinely practiced there are proverbs used. To support such practices, for instance within the Northern Sotho group in South Africa, there is a proverb such as "*Monna ke selepe o lala a adimilwe*" (a man is like an axe which is borrowed at night) and "*Monna ke phoka owa boshego*" (a man is like dew that falls at night) (Mantoane, 2008:20). This correlates to the Tsonga and Pedi proverbs like "*Nwanuna i N'whembe wa nava*" (in Tsonga) and "*Monna ke taka oa naba*" (in Sepedi). All these proverbs send the message that encourages men to practice promiscuous behaviour and subordinates women, and have potential to influence young people to indulge in multiple sexual relationships.

2.4.9 Virginity test

In neighboring countries like Swaziland, ceremony called the "Reed Dance of maidens" maintains support for virginity and abstinence, with the male counterpart for this being the picking of the "*Lusekwana*" (holly tree) (Sithole, 2001:26). Some South African communities believe that young females should be tested for virginity by a group of older women at a big ceremony attended by many women from the community (Nafale, 2001:16). This is prevalent amongst the Swazi, Zulu and Venda speaking people. Matoane (2008:21) notes that a girl who is positively tested for virginity receives sense of great pride and dignity. Mothers are anxious for their children to remain virgins so as to avoid contracting HIV and AIDS (McGeary, 2001:12). Mantoane (2008:21) contends that the "most of these practices with no doubt have the potential to facilitate the spread or the prevention of HIV infection".

2.4.10 HIV as a foreign disease and the un-Africanness of condoms

There are some pretty irrational socio-cultural values and practices about condoms. These socio-cultural values and practices are currently circulating out there in the

real world, mostly through the Internet. The worst thing is that there are people who actually believe these socio-cultural values and practices about condoms. According to Van Niekerk *et al.*, (2001:334) HIV was introduced by foreigners, who intend to stop black people from having sex, and reduce the black population. It is also argued that AIDS was introduced by white people as a way to control black people after the end of apartheid (Coleman, 1996:3; McGeary, 2001:48; Van Niekerk *et al.*, 2001:334). Tabane (2009:18) notes that in Botswana some people believe AIDS comes from white people and that people from other countries and white people slept with gorillas, got infected and these, in turn, infected black people. It is also believed that government has a way of infecting people so they can control the population (Tabane, 2009:18).

The study conducted in Swaziland on attitude towards condoms (Green, 1994:77) revealed how un-African contraceptives and condoms in particular are. The following are some of the reasons advanced about condoms. As one way of family planning, the condom use will make Swazi nation and culture diminish, whereas white culture will predominate. Condom use and oral contraceptives weaken or kill babies in the womb. It is also believed that condoms burst and can threaten women's life. For Africans, it is unacceptable and immoral to discharge semen in container or over oneself. Use of contraceptives such as condoms can lead to sterility and impotence. Other reasons given were that condoms are related to prostitution and promiscuity as in any case they are used only for extramarital sex.

Furthermore, the government condoms are perceived as the main ones that spread HIV and it is noted that the government is using the free condom to spread the virus, because since these free condoms were introduced, the virus came (Parker, Nkosi, Birdsall & Hajiannis, 2004:8). Leclerc-Madlala (2002:9) contends that there is a belief that a condom might 'go up' and 'get lost' and women show an anxiety that should a condom break or slip off the penis, it may 'float around inside' and eventually find its way up into the body cavity and cause grave illness. It is indicated that the condom can choke a person and die. Another socio-cultural value and practice on condom use is that condom could become 'twisted' and thus obstructs the blood flow and cause high blood pressure (Leclerc-Madlala, 2002:9).

Parker *et al.*, (2004:4) argues that condom socio-cultural values and practices includes the following: condoms have holes that can make the virus pass from one person to another, some condoms are unsafe, condoms contain HIV and condoms have worms. Above all these socio-cultural values and practices, most people subscribe to the fact that condoms are un-African. Adolescents believe that the use of condoms during the sexual intercourse inhibit the sexual pleasure (Sherr, 1993:130; Klepp, Flisher & Kaaya, 2008:41). The research findings shows that some women in Rwanda believed the use of condoms is risky, because they believe that the condom might remain behind in the vagina and eventually suffocate them by moving through the body to the throat (Zazayoke, 1989; Van Dyk, 2008:209). Many Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction represents the exchange of 'gifts of self' which they regard as being of the utmost importance in a relationship. The use of condoms should block this essential flow (Van Dyk, 2008:209).

According to Schoepf, (1992:33), "there is a widespread belief in many parts of Africa (East Africa, DRC and among the Zulu speaking people in South Africa) that repeated contributions of semen are needed to form or 'ripen' the growing fetus in the womb and the use of condoms solely prevent that. One of the objections often raised against condoms is that condoms are not natural; they inhibit pleasure and interfere with the natural fetal development. It is also believed that semen contains important nutrients necessary for the continued physical and mental health, beauty and future fertility of women (Van Dyk, 2008:47).

Females are generally more interested and positive toward the use of condoms rather than men, as they believe it will protect them from HIV and other STIs (Ackermann & De Klerk, 2002:170). The denial of men toward condoms arises from two issues. The first is physical: Men claim that condoms reduce pleasure. The second is attitudinal: The perception exists that only prostitutes use condoms. If a woman suggests the use of a condom, she may be accused of being unfaithful or hiding an STD. In addition, it appears that men feel insulted if a condom is suggested, as it casts doubts on their faithfulness (Ackermann *et al.*, 2002:170). Leclerc-Madlala (2008:12) stipulated few reasons for the lack of condom use. First,

is that the partners viewed one another as being 'low risk' as far as HIV is concerned.

2.4.11 Witchcraft as a cause of HIV and AIDS

Munk (1997:10) and Malema (2008:36) contend that there are some people who believe that AIDS is caused by witchcraft in Sub-Saharan Africa. According to Wreford (2008:7) AIDS is the work of "*Ukuthakatha*" which literally means AIDS is caused by witchcraft. Malema (2008:36) also contends that people in rural areas of Limpopo province of South Africa believe that HIV is caused by witchcraft and they view HIV and AIDS as '*Isidliso*' or 'black poison'. People who accept that AIDS exist believe that it has been sent by witches, which means that a person has been bewitched (Ashforth, 2001:03; Malema, 2008:36). According to Malema (2008:36) black people in South Africa consult traditional or faith healers who believe other people bewitched them, the consultation of traditional healers is prior consulting medical practitioners. Witchcraft is blamed for the HIV positive status and full-blown AIDS (Ashforth, 2001:03).

2.4.12 Faith healing

People's spirituality significantly influences what they think and believe. Spirituality is associated with positive health outcomes for people, from improved perception of health status and increased rates of mammography to the ability to withstand poverty or the diagnosis of HIV. The relationship between spirituality and health provides an important perspective for public health intervention. Spirituality is difficult to define. On one hand, it may mean an inner quality that facilitates connectedness with the self, other people, and nature, a relative quality that each person defines uniquely. On the other hand, the traditional definition involves one's acknowledgement of and relationship with a Supreme Being.

Traditionally, Miller (1995:257) states that "spirituality is often defined as a basic or inherent quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life." Malema (2008:43) contends that irrespective

of available information proven scientifically the AIDS is not cured; there are some people in Africa who believe that it can be cured. For instance, Malema (2008:43) notes that in Nigeria, a faith healer called Joshua claimed that he could cure AIDS and many people flocked to his church hoping that they would be healed. Pitman (2001:02) stipulates Joshua was financially exploiting the poor who are HIV positive due to the fact that during the prayer services large sums of money could be collected.

2.4.13 Traditional healing

Malema (2008:43) argues that a traditional healer in Kwazulu-Natal was selling a traditional herb called *Ubejane* which was claimed to cure AIDS and a number of patients ceased from taking the ARV's. Peltzer *et al.*, (2006:608) notes that some traditional healers claims to heal HIV and AIDS. The findings shows that most healers had poorer knowledge on other transmission routes and believed that there is a cure for AIDS. According to Peltzer *et al.*, (2006:610) traditional healers mentioned the common conditions they usually treat, amongst the stipulated diseases was sexually transmitted diseases, Arthritis, stroke, headaches, sores, children's problems, ancestral problems, sharp pains, spirit illness and stomach problems, and 6% of the traditional healers mentioned HIV and AIDS.

The traditional healers labeled HIV and AIDS as "*Isandulelangculazi/ingculazi*" (Peltzer *et al.*, 2006:610). According to Leclerc-Madlala (2002:8) the Zulu term '*ukwelapha*' is a term that refers broadly to treatment of disease and it might be used as therapeutic procedures that could encompass any and all efforts to prevent, treat or cure an illness. Claims by traditional medical practitioners that they can 'cure' an illness, whether AIDS, brain tumors, or chronic fatigue, are ethno medical interpretations that can be understood as claims of their abilities to treat disease (Leclerc-Madlala, 2002:8). It has been indicated that some traditional healers believe that AIDS is fictitious (Green, 1994:76).

2.5 SOCIAL WORK INTERVENTION IN THE FIELD OF HIV AND AIDS

The context of social work is changing rapidly. However, one fundamental element remains the same, namely that social work is located within some of the most complex problems and perplexing areas of human experience such as HIV and AIDS, and for this reason, social work is, and has to be, a highly skilled activity (Trevithick, 2000:1). Illness is an inevitable fact of human life. Man does not live in a vacuum. Therefore, like all other events of his life, illness is influenced by socio-cultural as well as biological factors. Illness refers to biological, psychological or social conditions that are often understandable in a social or cultural context (Habib & Rahman, 2010:79).

According to Kleinman (1988) as cited in Habib and Rahman, (2010:79) "illness refers to how the sick person and the members of the family or wider social network perceive, live with and respond to symptoms and disability." Disease, on the other hand, is the problem from a practitioner's perspective. In the biomedical model, disease refers to an alteration in biological structure or functioning. The HIV and AIDS pandemic has evoked a wide range of reactions from individuals, communities, and even nations, from sympathy and caring to silence, denial, fear, anger, and even violence. Social workers have been at the forefront of this issue since it first became a major public health crisis in the early 1980s. The ensuing three decades have produced not only new models of care, but also a major re-focus from raising awareness in the gay community to concentrating on prevention within a range of cultural and age-specific populations. Likewise, attention has broadened from managing end-of-life issues to learning to live with a chronic illness for ever-increasing periods of time, and promoting awareness of the impact of this illness throughout the world.

According to NASW (2005:5), health care social workers provide services across the continuum of care and in various settings. Social workers are present in public health, acute and chronic care settings providing a range of services including health education, crisis intervention, supportive counseling, and case management. Among the specific fields of social work intervention, HIV and AIDS are amongst others. Professional social workers are well equipped to practice in the health care field,

because of their broad perspective on the range of physical, emotional, and environmental factors that have an effect on the well-being of individuals and communities (NASW, 2005:6).

Social work's experience and expertise with co-morbidities and interventions that address families and communities struggling with multiple issues have produced a system-oriented approach to care. The constant growth, demands, and changes in health care have had a serious impact on the viability and need for social workers in all areas and settings of health care (NASW, 2005:5). Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and affirms, the worth and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation, and other diverse features found in individuals (NASW, 2001:6).

The current HIV and AIDS epidemic in South Africa poses major challenges to all professions and, in particular, to the social work profession. The focus of social workers falls on the improvement of the social functioning of people in interaction with their environment. Social work deals with the needs and problems that people experience in their effort to cope with the demands of their environment. Social workers look at the person-in-environment, including all of the factors that influence the total health care experience. Social workers practice at the macro and micro level of health care and thus have the ability to influence policy change and development at local, state, and federal levels and within systems of care (Potgieter, 1998:27).

2.5.1 A Right-Based Approach to service delivery with people infected and affected by HIV and AIDS

Social work intervention on HIV and AIDS uses the right-based approach which enshrines the social rights and justice to the people. Social work intervention on HIV and AIDS is also advocating on these rights, the rights are as follows according to (Patel, 2005:98):

- The right to a standard of living adequate for the health and well-being of an individual and his family,
- The right to security in the event of loss of income due to circumstances beyond the individual's control such as unemployment, sickness, disability, age, or lack of livelihood,
- The right to services and benefits should benefit the least advantaged, securing basic welfare human rights and active citizen participation in promoting human well-being, and
- The right to achievement of minimum social status in society

The right-based approach is guided by the Bill of Rights which makes provision for legally enforceable economic and social rights such as right to housing (section 26), the right to health care, food, water and social security (section 27), and the right to education (section 29) (Patel, 2005:98). This approach takes into consideration the values enshrined in the constitution of the Republic of South Africa, Act 108 of 1996; values contemplated in section 1 of the constitution are as follows: human dignity, the achievement of equality and advancement of human rights and freedoms, non-sexism and non-racialism (Davis, Cheadle & Haysom, 1997:73; Patel, 2005:98). Social workers use the right based approach to assist people who are HIV positive to enjoy the abovementioned rights. The researcher will divide the social worker's role into two parts: Psychosocial assessment and counseling. However, these two parts should not be performed lineally. Rather, the assessment is an ongoing and dynamic process that allows for the changes and adaptations throughout the helping process.

2.5.2 Psychosocial assessment

Assessment is the cornerstone of social work practice (Wright, 2000:12). Cowles (2000:46) identifies some areas of core knowledge essential for social work interventions and these include human behavior and social environment, as well as social work practice theory concerning the social work helping process, skills, techniques and modalities. Assessment forms part of this basic knowledge. By thorough assessment, a social worker will gather information about the socio-cultural

values, and practices around HIV and AIDS as well as people living with HIV and AIDS (PLWHA) physical and psychological functioning and about the social environment in which the person lives. According to Wright (2000:12) there are four areas that are essential to an effective and practical assessment of a PLWHA psychosocial functioning, which will be briefly discussed below.

- ***A thorough evaluation of the context***

It is very critical for a thorough assessment process to consider the context or environment where PLWHA lives in. As HIV and AIDS is a socially constructed disease, it depends on the environment/context that how a PLWHA will be accepted in the society and how will be his quality of life after being diagnosed with HIV. Social workers should assess the socioeconomic status of the PLWHA, his cultural background, geographic location and most importantly the availability of social support which includes interpersonal support, institutional support and also the community sentiment regarding HIV and AIDS. Interpersonal support includes family, friends and significant others in the community. Institutional support includes available, accessible, and affordable resources or services in the community such as medical or other health care services, home-based care services.

Social workers need to develop and create connections with the social services to get appropriate help for the PLWHA. The partnership of different institutions in the community is very much recommended as it is in line with social development partnerships at community level as contended by Patel (2005:284). The community partnerships bring the formal and informal organisations from communities, social service, and development organizations, religious organizations, universities, research bodies, government and the private sector. These structures are assets and using asset approach to people infected and affected by HIV and AIDS, social workers make use of community capacities, skills and assets.

The most paramount assets of a community are its organisations and institutions such as community-based organisations, civic associations, faith-based Organisations, clubs, societies and social, neighborhoods, and friendship networks, schools, clinics and businesses Patel (2005:284). The collaboration which is from the

community and its existing assets or resources enable the community to have support groups which increase the climate of psychosocial and spiritual caring and support among community members; and also deliver practical assistance in the form of home-based care for HIV and AIDS infected community members (Ebersohn & Eloff, 2006:99). Social worker could use his/her status and professional expertise to advocate with the service providers in order to arrange a comprehensive care for the PLWHA.

- ***The PLWHA knowledge about HIV and AIDS***

To help PLWHA alleviate their sufferings and stress, it is important to assess the level of knowledge that the PLWHA have about HIV and AIDS, because, the social worker wants to make the PLWHA to be able to help them, and for this the PLWHA should be aware of their medical conditions. The PLWHA may not have up-to-date and accurate information about HIV and inaccurate information or biased knowledge about the illness being very dangerous. Therefore, the social worker needs to assess the level of knowledge of the PLWHA and if necessary he/she will provide them with general information about the HIV and AIDS and particularly about the mode of transmission. Social workers will assess the risk behaviours and provide information on safer sexual practices. This will help the PLWHA to reduce the risk behaviours. Being able to reduce the unsafe sexual practices or risk behaviours will help the PLWHA have a sense of control over their lives and also increase their self-esteem. Thus, a social worker will provide information, support and intervene with resources that will enhance the PLWHA's overall functioning.

- ***Determine socio-cultural norms, beliefs, values and attitudes of the PLWHA***

The behavioural and attitudinal factors of the PLWHA's are primary in the prevention, intervention and treatment of HIV and AIDS. Wright (2000:12) provides some area that should be explored which include attitudes and beliefs related to HIV transmission, barriers to risk reduction and sexual self-efficacy. To assess these areas, social worker will ask about the sexual history of the PLWHA or about the substance use in relation to sexual behaviour.

- ***Determine beliefs about sickness and health***

The social worker needs to know the PLWHA's belief about illness and health, particularly how the PLWHA define sickness because this will influence the process to approach the PLWHA. The social worker needs to know how the PLWHA feels about being HIV positive. The social worker also needs to know what being HIV positive means to the PLWHA. The social worker needs to know what it means to be HIV-positive to the PLWHA, what the person believes to be the cause of his illness (that is, a natural cause, a curse or punishment?) and what is the PLWHA fear about being HIV-positive. These beliefs are important because they influence the coping process of the PLWHA. In addition, the understanding of a person's spiritual beliefs, including death and dying, and how these beliefs stimulate the PLWHA coping styles and behaviour will expand the resources for support to be explored. Considering the spiritual beliefs of PLWHA is important for assessment and intervention. For instance, PLWHA may feel anger, shame, guilt, depression and loss of control as a response to the diagnosis of HIV. To cope with these negative feelings, a powerful coping strategy could be to strengthen the faith in their spiritual beliefs. To that end, social workers could see that in order to help a PLWHA, they need to do a thorough assessment to gather information about the psychosocial function of PLWHA, their medical status, financial condition, coping style, beliefs about illness and death which will be useful in counseling and intervention.

2.5.3 Family functioning and cultural assessment

The families have various patterns of relating, deciding, rules, values and divisions of roles to be assigned to the family members. The manner in which these functions are taken into reality may be influenced by the cultural or racial preferences, socioeconomic status and available resources; meaning the cultural traditions are influential to the people and family functioning (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2010:228; 2006:240).

The social workers should assess risks in families through the use of Clinical Assessment Package for Assessing Risks and Strengths (CASPARS) developed by Gilgun (1994, 2001 as cited in Hepworth et al., 2006:245) for families receiving

mental health services. Specifically, CASPARS measures both risks and protective factors related to family relationships, peer relationships and sexuality (Hepworth et al., 2006:246). The social worker should assist families to maintain balance or the status quo in response to the family transitions in the life cycle or stressors, for instance, HIV and AIDS in association with cultural differences and environmental events, this is in line with the consideration of family homeostasis (Hepworth *et al.*, 2006:246; 2010:238).

- ***Family variant and family power structure***

The families have different subsystems to be considered in the assessment by the professionals, the subsystems has grandparents and the grandchildren; the other subsystem comprises of parents and their children; whilst the other subsystem involves the adult relative or non-relative and the child (Hepworth et al., 2006:264; 2010:254). It is important for social workers to assess how this type of subsystems influences individuals within the family system. The power is a socially constructed dynamic that varies in terms of factors like culture and preferences within the family system, meaning all families develop power structure (Hepworth et al., 2006:266; 2010:257).

The distribution of power wherein the male figure is the central family figure also instills influence over the subordinates for instance, women and children (Hepworth et al., 2006:246; 2010:238). In this kind of family power structure women are marginalised to such an extent that they fail to decide in the negotiation of condom use, men only dictate how sexual pleasure should be enjoyed which also jeopardises women. It is very much important for the social worker to consider social work value which is as thus: social workers respect the individual's right to make independent decisions and to participate actively in the helping process (Hepworth et al., 2006:09; 2010:07).

- ***Cultural variant and multicultural perspectives***

Cultural differences play a crucial role in many family subsystems. Cultural variants however, is that children may be attached to more than one caretaker. Adolescents

gradually from parent-child subsystem, as they move toward independence and perhaps prepare to leave home. It is true that each of these notions have a cultural variant and may not be a relevant expectation in some cultures (Hepworth et al., 2006:264; 2010:255). For instance, in some cultures adolescents may be married, although they will live in their own families. In other cultures young adults live with their families until they are married. Social workers should assess relationships in a cultural context, considering culturally derived subsystems or coalitions between family members and patterns of relating (Okun, Fried & Okun, 1999 as cited in Hepworth et al., 2010:255).

Cross-generational coalitions that are based on gender can in fact influence cultural solutions (McGoldrick, 1998 as cited in Hepworth et al., 2010:255). Although almost all cultures tend to view males as a central power figures, generalisations about power may be based on limited knowledge of the power nuances in different cultures. Many cultures are male oriented, so that females may appear to lack power in the traditional sense (Hepworth et al., 2010:258). Although almost all cultures tend to view males as central power figures as mentioned above, social workers should refrain from making this generalisation (Hepworth et al., 2006:267). The social workers should also consider the value to demonstrate respect for and acceptance of the unique characteristics of diverse populations (Hepworth et al., 2006:11; 2010:08).

2.5.4 Counseling a Person living with HIV and AIDS (PLWHA)

Along with the initial assessment, the social worker can do supportive counseling in order to help a PLWHA alleviate stress and sufferings. The counseling focuses on physical, psychological, social and spiritual aspects of the PLWHA. It involves the discussion of disease progression, discrimination and stigma related to HIV and AIDS, death and bereavement issues, life style, safer sexual practices and living positively with HIV and AIDS. Through the counseling, the social worker will help the PLWHA to identify concerns like disclosure of HIV-positive status, identify risk behaviours, practice safer sex and substance abuse; will enable PLWHA to identify and express their feelings and to develop coping strategies to adjust with the current situation. Some important aspects of counseling PLWHA are discussed below.

- ***Living with HIV/AIDS versus dying from AIDS***

Due to the advancement of medical technology, people are familiar with the concepts 'long term non-progressors' or 'long-term survivors'. Therefore, while offering counseling to PLWHA, the social worker can capitalize on strengths, build on resilience of people. He/she can help the clients balance a realistic sense of hope with practical issues inherent in learning to live with HIV and AIDS. When a newly diagnosed PLWHA will hear from the social worker that there is usually a period that increasingly last up to ten or more years where people remain asymptomatic, that will help the client and his/her family to internalize and revive some hope in adjusting to the diagnosis of HIV. Hearing from the professional that the diagnosis is not a death sentence, could be a very empowering experience for the PLWHA. Thus, when a social worker will tell the client that he/she is currently living with HIV, not dying from AIDS; it will be beneficial for the PLWHA and their families.

- ***Supportive denial***

Supportive denial means that the client will not keep an awareness of his/her condition in the forefront of his/her thoughts at all times (Shernoff, 1998:46). Denial itself is neither bad nor good. If the client's denial is so pervasive and intense that it impairs the PLWHA's reality testing, then the worker needs to challenge their denial. As for example, when the PLWHA denies that that he is, in fact at risk of contracting or transmitting HIV and therefore refuses to change either sexual or drug taking behaviours in order to protect others. Denial should be assessed according to its outcome. If the denial contributes to an adaptive mode of living with HIV and AIDS, then the worker should not challenge it.

- ***Mobilizing the family***

In the case of HIV and AIDS, an illness that is so emotionally laden, family conflict and stress often run high. Families of the PLWHA need encouragement and support to express hurt, anger and fear. Hence, the social worker needs to help families identify their conflicting emotions and help them make sense of their reality and begin to establish some control over their situation. A family genogram could be a useful tool to assess the personality and attitude of each member and understand

the conflict and relationship among them. Social workers can also help families negotiate with care providers in order to receive accurate information about medical care, treatment options, nutrition and other available social services.

- ***HIV disclosure and dealing with ethical issues***

In the process of helping a PLWHA, the social worker may face some ethical dilemmas, as for example, whether to reveal a client's HIV status to his/her partner(s) particularly when the client refuses to do so. This type of situation leads to conflict with the social workers value of self-determination and client confidentiality. To deal with this kind of situation the social worker can review the pros and cons of the options (that is., to disclose or not) and should make a reasonable decision (Giddens, *et al.*, 2006:18).

In the researcher's opinion, here the partner's need to be informed about potential risks outweighed by the client's need for self-protection. So the reasonable decision would be to disclose the HIV-positive status to other partner in order to reduce the risk of transmission. However, before making this decision, the social worker should motivate the client towards the decision and help him/her to achieve a sense of control and increase his/her self-esteem. The social worker can apply behavioural interventions to reduce risk behaviour of PLWHA which includes condom use and communication skills training and development of a personal risk reduction plan (Woditski *et al.*, 2006:29).

- ***Improve adherence to treatment***

The old adage that says prevention is better than is very important. However, if people are already infected, prevention for re-infection and treatment becomes the focus of intervention. The successful treatment of HIV infection is heavily dependent upon medical adherence. Poor adherence contributes to the development of drug-resistant HIV, and high levels of medical adherence are associate with sustained reduction in viral load, decreased risk of developing AIDS, and enhanced survival (Natasha *et al.*, 2002, cited in Woditski *et al.*, 2006:29). If the PLWHA have poor adherence, the social worker would encourage them, provide support and information about the needs of the medication. He/She can help the PLWHA communicate with physicians and other health care staff by bridging the gap

between them. This could ultimately be helpful in increasing the treatment adherence of the PLWHA.

- ***Preparing for serious illness***

Though it is assumed that the client who is newly diagnosed with HIV, counseling and preparing him for serious illness would be useful in overcoming the unforeseen but inevitable health crisis. AIDS-related illness can have an astonishing sudden onset. Often clients and their families are ill-prepared to cope with decision that could have been discussed prior to the onset of a medical emergency. Therefore, it is good to discuss some issues, though difficult and painful, long before there is any apparent need for them. The social worker could discuss the issues like which hospital the client wants to be taken to in case of an emergency, who will be contacted in crisis and the sensitive issues like advanced medical directives (AMD) and about a health care proxy (Shernoff, 1998:46). In fact, when the client is well, he/she is more likely to have the necessary energy for planning these difficult realities. The social worker could introduce these issues by stating that although it is too early to start thinking about these difficult realities, addressing these issues now will ensure that the client will have a control over what will happens to him/her. This will help the client feel better.

In view of the above discussion, it could be said that social workers can help a person with HIV and AIDS to learn to adjust and live with this life threatening illness and to deal with issues that have emerged with the diagnosis of HIV. To be able to help a PLWHA, the social worker should be well-educated about HIV and AIDS. As HIV and AIDS is a socially constructed disease, the social worker should be aware of cultural norms, values and stigma related to HIV and AIDS and should also be prepared to deal with issues like death and dying as HIV and AIDS is a fatal disease. One of the most important roles of the social worker will be as liaison between the PLWHA and his/her family, between the PLWHA and physician or other health care providers and between social service agencies.

Last but not least, in working with a stigmatized disease like HIV and AIDS, the social worker should always apply the basic social work values: respect the dignity and worth of each individual and uphold to non-judgmental attitude. Persons living

with HIV and AIDS must adapt to a disease that promises multiple changes in every aspect of their lives. HIV and AIDS not only brings health complications and inevitable death, it also brings enormous psychosocial stress and stigma that can shatter one's life. At the twenty-first century, when people have tremendous medical advancement in treating this disease, people hope that HIV and AIDS should be treated like any other illness. Social workers have the responsibility to respond to the person with HIV and AIDS who are in need of comfort, reassurance, compassion, and love. Working with persons with life threatening illness and engaging in issues as psychosocial functioning, sexuality, spirituality, dying and death, which are all inherent in AIDS, are invaluable clinical skills that are relevant to all aspect of social work practice with any client population.

2.6 CONCLUSION

This chapter presented on the literature review of the study undertaken. It presents the socio-cultural values and practices compounding to the escalation of HIV and AIDS amongst the youth. It also incorporates the following: background information on HIV and AIDS; the socio-cultural values and practices which were discussed in detail; and the social work intervention in the field of HIV and AIDS.

CHAPTER THREE

Data Presentation, Analysis and Interpretation

3.1 INTRODUCTION

The focus of this chapter will be on data presentation, analysis and interpretation of the empirical findings. The data to be presented was collected through focus groups and individual interviews. The total number of focus groups involved in the study was nine (9) consisting of 7 members each. The researcher uses qualitative data analysis in the study except for demographic factors of the respondents which are presented quantitatively. Qualitative data analysis is the process which allows the researcher to interpret and generalize the findings from the sample used in the research, to the larger population in which the researcher is interested (Bless, Higson-Smith & Kagee, 2006:163). Qualitative data analysis is the interaction which is presented in a linear form and has steps which move in circles (De Vos, Strydom, Fouche & Delpont, 2005:334).

There are specific steps followed in the qualitative data analysis (De Vos et al., 2005:334). They are: planning for recording of data; data collection and preliminary analyses; organizing data; reading and writing memos; generating categories, themes and patterns; coding the data; testing the emergent understandings; searching for alternative explanations; representing, and visualizing (writing the report). In this study, the researcher used simple random sampling and the reason for using simple random sampling was because the learners were known and had equal chances of being selected. The researcher interviewed Grade 10 learners which consist of three classes (Grade A, B and C) and the total number of learners were 240, but the researcher interviewed 120 learners. The researcher interviewed 40 learners from each class (19 learners through interview schedule and 21 learners through focus groups discussion).

In this study, the respondents were not required to write their names and to attach their signatures. They were requested to give answers freely and provide information

to the best of their abilities. It was indicated that confidentiality will be preserved; and there were no wrong and right answers. This chapter also presents the demographic factors of the respondents' participated in this study. The social, cultural and religious beliefs, values and conventions of learners that compound on the escalation of HIV and AIDS will be presented qualitatively.

3.2 DEMOGRAPHIC FACTORS OF THE RESPONDENTS

The demographic factors include age range of the respondents, gender, religious affiliation and Christian denominations of the respondents.

3.2.1 Age range of the respondents

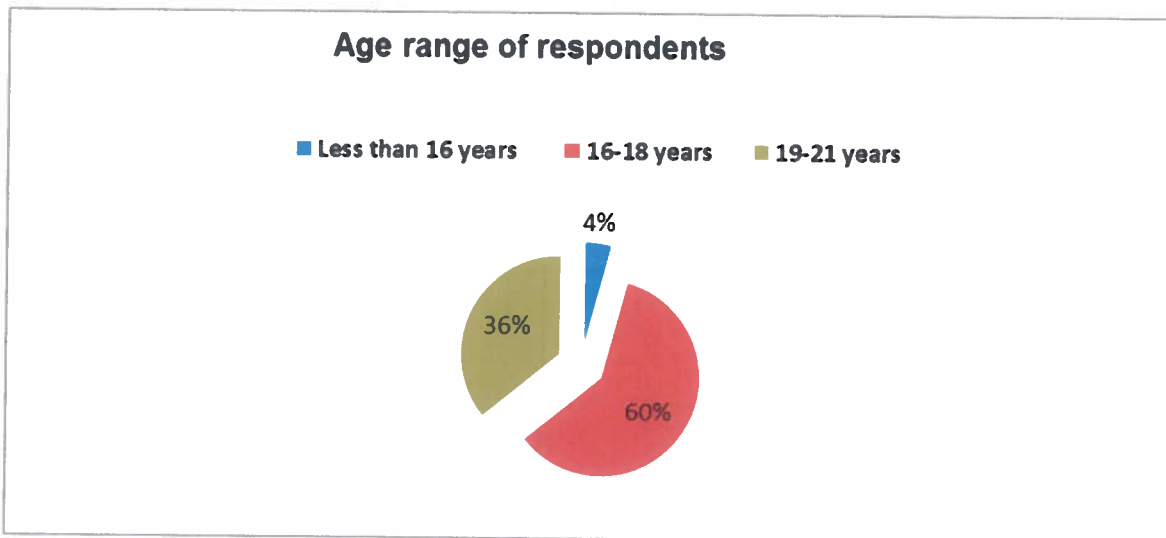


Figure 1: Age range of the respondents

The respondents who were less than 16 years constituted 4% in the study; those who range from 16-18 constitute 60% and 36% of those who ranges from age 19-21 years. The researcher uses the word "youth" to refer to young people between the ages of 16 and 21 years. According to Eric Erickson, those respondents who fell between age range of 16 and 21 falls under the fifth stage of eight major life stages, which is identity versus confusion (Erickson, 1968 as cited in Weiten, 2007:446). Louw, Van Ede and Louw (1998:24) states that the virtue of this stage is fidelity whereby adolescents must determine the sense of self. According to Weiten

(2007:446), the views of Erickson, is that adolescents ask questions such as “who am I and where am I going in life?”.

3.2.2 Gender of the respondents

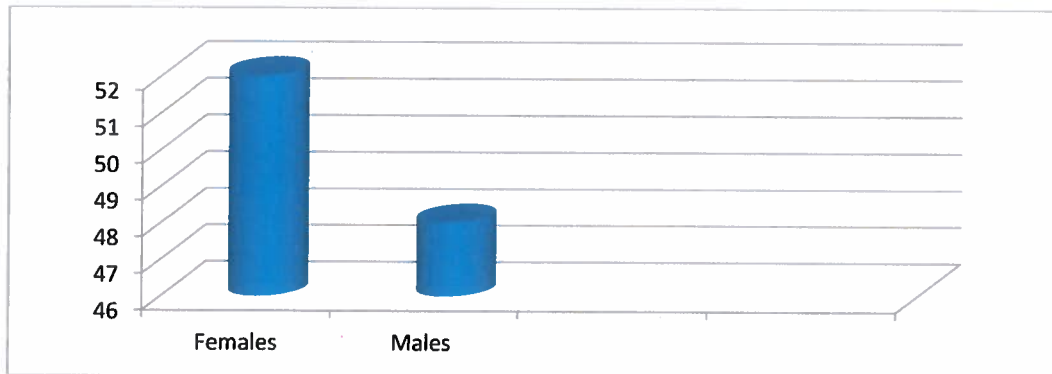


Figure 2: Gender of the respondents

In the sample, there were more females than males as females constituted 52% and males constituted 48% of the respondents. This implies that there are more females than males in the school and perhaps in the community.

3.2.3 Religious affiliations of the respondents

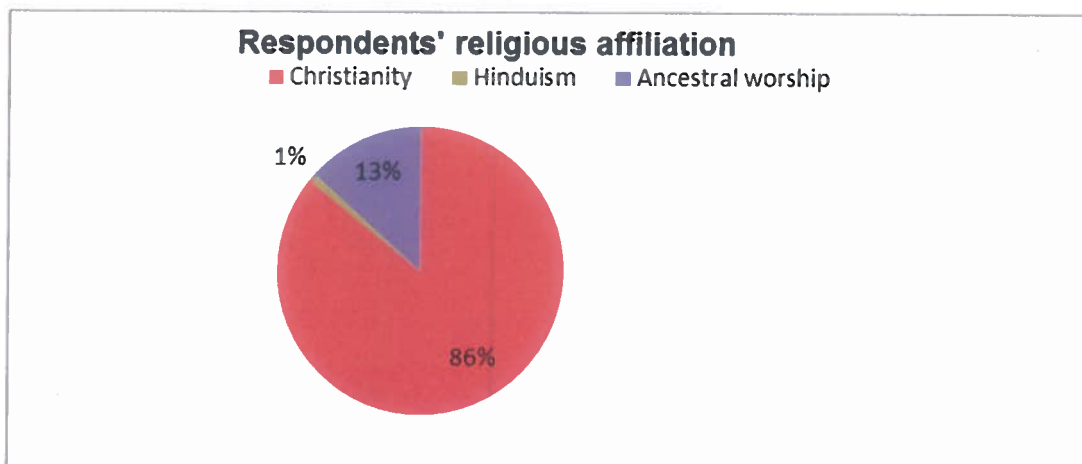


Figure 3: Religious affiliation of the respondents

Christianity constituted 86%, whilst ancestral worship and Hinduism constituted 13% and 1% of the respondents respectively. The abovementioned figures means that the most dominating religious affiliation from the research area is Christianity, followed by ancestral worship, and the last one is Hinduism.

3.2.4 Response on Christian denominations

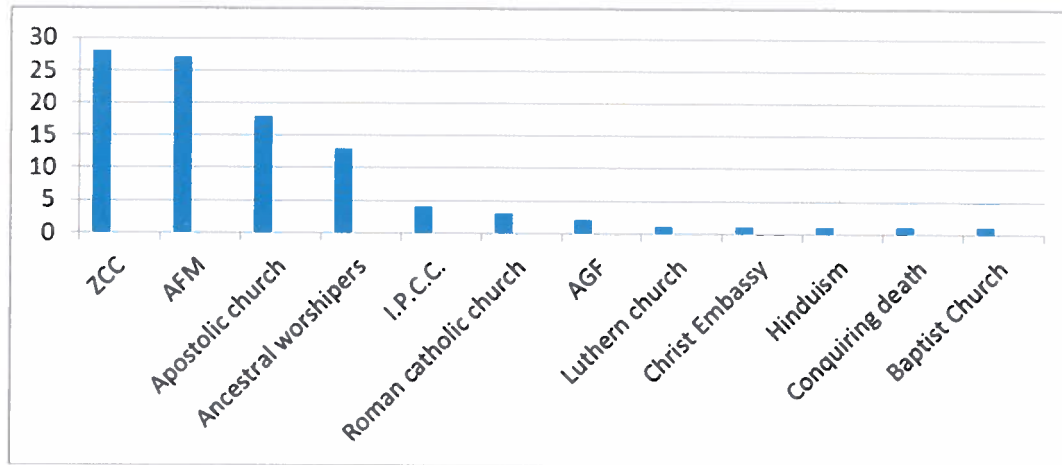


Figure 4: Christian Affiliations

The Christian denominations of the respondents were as follows in this study: Apostolic Faith Mission (AFM) constituted 27% respondents, Roman Catholic Church constituted 3% of respondents, whilst I.P.C.C constituted 4% of the respondents. Zion Christian Church (Z.C.C) constituted 28% of the respondents; Apostolic Church constituted 18% of the respondents, whilst Lutheran Church constituted 1% of the respondents. Ancestral worshipers constituted 13% of the respondents, whilst Christ Embassy constituted 1% of the respondents and Hinduism constituted 1% of the respondents. The members of Assemblies of God Fellowship (AGF) constituted 2% of the respondents, whereas Conquering Death members constituted 1% of the sample and members of Baptist church formed 1% of the sample.

3.3 SOCIO-CULTURAL VALUES AND PRACTICES THAT COMPOUND ON THE ESCALATION OF HIV AND AIDS AMONGST THE YOUTH

Qualitative responses are hereunder presented, analyzed and interpreted with quantitative indicators in some instances.

3.3.1 Respondents' understanding of HIV and AIDS

During the interview, respondents were asked to give their understanding of HIV and AIDS. Only 29.16% of the respondents indicated that HIV and AIDS is foreign disease brought by white people to annihilate the African race. The majority of the respondents which constituted 71.84 responded that it is a serial killer virus which weakens the immune system when a person does not follow a treatment. They have said that a person gets the virus or disease through unprotected sexual intercourse with a person who is HIV positive and it is not curable.

3.3.2 Responses on the transmission of HIV

Unanimously, respondents stated that HIV can be transmitted through contact with the infected blood, sharing of needles and/or syringes with a person who is HIV infected, use same injection and having unprotected sex with an HIV infected person. Others have mentioned breastfeeding and transmission during child birth. It was clear that respondents knew how HIV is transmitted. This is confirmed by other studies which indicates that the essential other mechanism for HIV infection is the so-called "vertical" transmission from a pregnant woman to her unborn child (Van Niekerk & Prins, 2001:4). Also, Zastrow (2004:515) states that breastfeeding is a contributing factor capable of transmitting the AIDS virus. AIDS virus can be transmitted through having unprotected sexual intercourse with someone who is HIV positive (Zastrow, 2004:514). Zastrow (2004:516) also contends that someone can get infected with HIV by using hypodermic needles that were also used by someone who has the virus, and by also reviving contaminated blood transfusions or other products derived from contaminated blood.

3.3.3 Responses on the symptoms of HIV and AIDS

The respondents indicated that people who are infected may suffer from various health symptoms such as rash, loss of weight, developing grayish hair and sores on their mouth. They sweat a lot when they are asleep. Again they experience problems of running stomach, coughing and always vomiting whenever they eat.

3.3.4 Responses on early sexual debut

It was found that 61% of the respondents had sexual intercourse experience whilst 39% had not had sexual debut. Tabane (2009:23) contends that girls and boys are socialized to go for circumcision where they are taught about sex. Socio-cultural practices and customs such as circumcision schools for both males and females teach people morals and sexual behaviour. Tabane (2009:36) further asserts that cultural practices articulated in the rules and norms which govern such basic activities and social relations as how, where, when and whom one makes love.

Furthermore, respondents were asked to give the number of people they had sexual intercourse with. Out of the 61% above which had sexual intercourse, 22% of the respondents had sexual intercourse with one person, 19% of the respondents had sexual intercourse with two people, whilst 11% of the respondents had sexual intercourse with three people and 9% of the respondents had sexual intercourse with more than 4 people.

With regard to the age of those people, respondents had sex with, 13% of the respondents indicated that persons they had sexual intercourse with were between 20 - 21 years old, 18% of the respondents indicated that persons they had sex with were 19 - 20 years old, whilst 19% of the respondents indicated that persons they had sex with were 18 - 19 years old. Only 3% of the respondents had sexual intercourse with persons between 17 - 18 years old. The first 4% had sexual intercourse with people between 16 - 17 years old, and the other 4% of the respondents indicated that they had sex with people more than 25 years old.

3.3.5 Use of substances and types of substances before sexual intercourse

The respondents were asked to provide data as to whether they use substances and what types of substances they use before indulging in sexual activities. 61% of the respondents agreed that they use substances and 39% of the respondents agreed that they do not use substances. The respondents indicated that they use the following substances such as: dagga, alcohol mixed with spirit and ice cream, tobacco, concoction of coffee with brake fluids, aloe plant. Some indicated that they use sexual tablets obtainable at pharmacies. The rationale for using all these substances was to boost and improve their sexual prowess.

3.3.6 Responses on the believe that babies and children cannot get infection with HIV

A substantial majority of respondents (100%) responded positively that babies and children can get infected with HIV. They stated that it is moral wrong to sleep with babies and children with the hope of curing HIV and AIDS. They have indicated that this is impossible that a man can cleanse his blood of HIV by having sex with a virgin and the virgin not get infected. A virgin or young girl will contract HIV. It has been also indicated by the respondents that this socio-cultural value and practice can also lead to the spate of the rape of babies and children.

Leclerc-Madlala, (2002:87) indicated that according to the virgin cleansing socio-cultural value and practice, a man can 'cleanse' his blood of HIV and AIDS through intercourse with a virgin, but the girl herself would not be infected in the process. She further said the socio-cultural value and practice that having sex with a virgin cures AIDS has been identified as the contributing factor to the rape of babies and children in South Africa. Whereas the prevalence of this socio-cultural value and practice has been a concern in local communities for some time, there have been recent attempts to discern the extent to which this belief is exacerbating perceived increases in child rape and the rate of new HIV infections nationwide. She further contends that closer attention has to be paid to the structural influence of cultural schemas as is critical to better understand the linkages between beliefs and behaviour in the context of rape

and AIDS. Van Niekerk *et al.*, (2001:4) contended that HIV is transmitted through the exchange of bodily fluids during homosexual and heterosexual intercourse and whoever who is HIV positive sleeps with babies and children, they may get infected.

3.3.7 Responses on the believe that one cannot get infected when he sleeps with an elderly woman

The respondents advanced their views on whether having sex with a elderly woman, could not lead to HIV infection. The majority of the respondents, 95% stated that the issue of age does not play a role on whether a person cannot be infected with HIV. If a man has sex with an elderly person who is positive the virus will be transmitted as long they have unprotected sex, due to the fact that the virus is transmitted through sexual intercourse irrespective of age. The virus does not discriminate due to age, colour, sexual orientation, or creed. Surprisingly, 5% of the respondents said the opposite that elderly women no longer have feelings; elderly women cannot have the virus because they had sexual intercourse with their partners before this virus came to be known.

3.3.8 Responses on who are vulnerable between men and women to HIV infection

It was indicated that (14% of the respondents) men are most vulnerable because of having several sexual partners and having unprotected sex with several women. Men contract the HIV infection and transmit it to their innocent wives. Another factor stated was that HIV infection is fuelled by commercial sex practices as most men would prefer to buy sex from commercial sex workers mainly when they are denied conjugal rights by their spouses. This validates what Zastrow (2004:516) has found that the high risk factor of contracting HIV is through having sexual intercourse with multiple partners without using safe sex practices, such as condoms.

However, 27% of the respondents stated that women are most vulnerable to HIV infection than men because women also have also several sexual partners whom they call "*bo makgwapeng*" meaning out-of-wedlock sexual partners. They said woman vagina is too soft compared to a man hard penis and also men have more

strong veins than women. They said that vagina is a big hole unlike a man's penis with a small opening. They advanced several reasons which predispose women to high infection with HIV than men. They said that women are prostitutes, whilst some are raped almost every day. Another reason mentioned was that since women are subordinates to men, and because of being unemployed and depend on their men and women are less likely to take decision on the use of condoms due to the respect of culture.

A substantial number of respondents (59%) indicated that both genders are most vulnerable because HIV infection does not discriminate against gender or sex of an individual. Any sex is equally vulnerable, provided he or she indulges in unprotected sex particularly with the infected person. Emah (2008:5) pronounces that the epidemic spread of HIV would tend to occur in populations that have high rates of several partners.

3.3.9 Responses on the views about what makes older men view young women as being negative from HIV

The respondents were requested to provide their views on what makes older men view young women as being negative from HIV. 100% of the respondents mentioned that young women are fresh and have not experienced a lot about sexual intercourse hence older people run after them. They play safe and most of them are still virgins. Unexpectedly, respondents indicated that young women are nice and hot during sexual intercourse. They have good looks. Because they are seen with fresh breast and considered safe partners, older men believes that they will be cured when they sleep with young women who are virgins in particular. Leclerc-Madlala (2008:12) contends that older men desire for 'clean partners', socio-cultural value and practice that having sex with a virgin can cure HIV and other sexually transmitted infections, and the belief that older men can be sexually rejuvenated (or having 'his blood move again') by a young woman, all contribute to men seeking younger women.

3.3.10 Responses on views about what makes young women view older men as safe partners, responsible and less likely to take risks than young men

The respondents were asked to give view points on what makes younger women view older men as safe partners, responsible and less likely to take risks than young men. Respondents during the interviews stated that older men are employed and have money to afford luxury goods, they drive fancy cars and as a result they are called ministers of finance as they buy clothes, cell phones and can afford to maintain these young women and their families. Older men have grown up and are respectful. Interestingly, their appointments are held in the restaurants. Comparing them to young men, older men are stable and tend to be serious in a relationship. Another point was that young women consider the size of older men's penis for satisfaction.

The above peroration is supported by the findings of Leclerc-Madlala (2008:12) who contends that older men are more likely to be employed and able to provide greater economic security than younger men. Young girls from poor backgrounds would see wealthier older men as 'meal tickets', providing them with basic needs such as food, housing, cell phones, luxury cars and clothing.

3.3.11 Responses on the traditional healers' believe that virgin cleansing with a virgin is a way in which a man could obtain measure of strength against HIV infection

All, which is 100% of the respondents conflicted with traditional healers, who believe that virgin cleansing with a virgin is a way in which a man could obtain a measure of strength against HIV infection. The respondents indicated that traditional healers need customers and it is a well known fact that they reckon to cure everything including HIV and AIDS.

3.3.12 Responses on the treatment of HIV and AIDS

The respondents were asked as to whether HIV and AIDS can be cured and/or treated. Only 12% of the respondents indicated that HIV and AIDS can be treated but treated through the use of ARV's to prolong the life of an infected person. It has been indicated that the ARV's strengthen the immune system of an infected patient. However, 88% of the respondents indicated, HIV cannot be cured. Nonetheless, they have said there is only one way of reducing the multiplication of the virus through ARV's. So this means that all the respondents know that there is no cure for HIV and AIDS but the use of ARV's is the only way to strengthen the infected person's immune system which lengthen the life span of the patient.

3.3.13 Responses on the use of condoms and whether condoms can prevent HIV transmission

The respondents were asked whether they have used condoms the last time they had sex. The majority of the respondents which constituted 53% indicated that they used a condom the last time they had sex whilst the substantial 47% of respondents said that they did not use a condom the last time they had sex. It is a worrisome issue and a concern for such a huge percentage for not using protection means against the sexually transmitted infections including HIV.

With regard to whether condoms can prevent HIV transmission, 52% of the respondents indicated that condoms do prevent HIV transmission. It has been indicated that the sexual partners should utilize the condom with care. Whilst 48% of the respondents indicated that a condom is not guaranteed to prevent HIV transmission due to the fact that they burst. As a motivation of their responses, they indicated that if a person drinks "Mageu" too much, and have sex a condom will always burst because the penis will be hard. Others indicated that free condoms (choice) are soft than the ones which people buy. An example given was that, one respondent had two condoms from different manufactures and brands, he once poured water inside choice condom and lovers plus condom, he threw them to the

ground, and immediately the choice busted, and to him choice is not strong enough and good to protect HIV infection.

3.3.14 Responses on whether condom use causes high blood pressure

With regard to whether condoms use causes high blood pressure or not, only 17.5% of the respondents indicated that a condom causes high blood pressure. They motivated their response by saying that a person will always think about being HIV positive. The majority of the respondents which constituted 82.5% indicated that there is no way a condom can cause high blood pressure. To them, high blood pressure can be caused by always thinking, stressed due to problems of life and poor nutrition.

3.3.15 Responses on whether condoms are unnatural and interfere with natural fetal development

The response to whether condoms are unnatural and interfere with natural fetal development, 22.5% of the respondents indicated that condoms are unnatural and interfere with natural fetal development. The majority of the respondents (77.5%) indicated that condoms inhibit the sexual pleasure between sexual partners, the issue of condoms being natural or unnatural is of less significance and that a condom plays no role on a woman who is pregnant and does not interfere with the natural fetal development. For those who believed that condoms are unnatural, they indicated that condoms interfere with fetal development because of oil in the condom and to that end the baby will be born abnormal with physical defects. Again the advanced the reasons that condoms prevent the sperm cell needed to nourish and boost the baby in the womb with nutrients.

This is supported by the findings by Schoepf, (1992:33), that "there is a widespread belief in many parts of Africa (East Africa, DRC and among the Zulu speaking people in South Africa) that repeated contributions of semen are needed to form or 'ripen' the growing fetus in the womb and the use of condoms solely prevent that". One of the objections often raised against condoms is that condoms are not natural as they

inhibit sexual pleasure. It was also mentioned that semen contains important nutrients necessary for the continued physical and mental health, beauty and future fertility of women.

3.3.16 Responses on whether the use of condoms means unfaithfulness or hiding STD's

Regarding whether the use of condoms during sexual intercourse means being unfaithful or hiding STD's, 43% of the respondents indicated that condoms are meant to prevent people from HIV infection and transmission of other sexual transmitted diseases, whilst 57% of the respondents indicated that the use of condoms means unfaithful, hiding STD's, and fear of unplanned pregnancy. Ackermann and De Klerk (2002:170) argue that the denial of men toward condoms arises from two issues. The first is physical, men claim that condoms reduce sexual pleasure and the second is attitudinal, which is the perception that exists that only prostitutes use condoms. If a woman suggests the use of a condom, she may be accused of being unfaithful; prostitute or hiding an STD and the use of a condom is an insult to males

3.3.17 Responses on whether in VaTsonga culture, women should take a decision with regard to condom use

The majority of the respondents (82.5%) indicated that women should not take a decision with regard to sex, when to have sex and how. That remains the man's territory to decide. Condom use should be initiated by a man as he is the head in a relationship. Culturally, among the Vatsonga cultural group, women are subordinates' to men and they should not make decisions which impact on men, theirs is to bear children. Whilst only 17.5% of the respondents indicated that women should take decision with regard to condom use because the use of a condom is an agreement between the two people who are in a relationship.

3.3.18 Responses on whether learners' religious values discussed with their friends would influence whether or not they decide to have sex

Of the respondents, 30% indicated that not at all to have sex due to their religious values and practices whilst 23% of the respondents indicated that they might slightly to decide to have sex. The reason advanced was that being a religious person does not stop them from having sexual feelings and that indicated that they were not sure, only the circumstances can determine what needed to happen with regard to having sex. The substantial number of respondents which constituted 47% stated that in spite of their religious values and practices, they would still indulge in sexual activities.

3.3.19 Responses on religious views about HIV and AIDS

Of all the respondents, 86% who subscribe to Christianity stated that the bible stipulates that when the world is nearing the end, there will be an incurable disease such as HIV and AIDS due to people's sins and God will be punishing people by such illnesses. For those who subscribe to Ancestral Worship constituted 6% and the emergence of HIV and AIDS is a punishment from ancestors for not obeying and practicing cultural rituals. They further state that witchcraft contributes to these pestilences which are ravaging the society. This concurs with what Malema (2008:36) stated that people who believe in ancestral worship mostly accept AIDS as the work of witches. According to Coleman (1996:3); McGeary (2001:48) and Van Niekerk *et al.*, (2001:334), sexually transmitted diseases come through sex and also when a person offends the ancestors, HIV and AIDS is punishment from God, and the person who is HIV positive is not appealing to the spirits of his/her ancestors, and they have cursed him/her with the disease.

3.3.20 Response on whether HIV and AIDS is a black poison or "isidliso" used by witches

On this issue, some respondents which constituted 47% believed that HIV and AIDS is a black poison or "isidliso". It is a work of those who practice witchcraft and have the ability to bewitch a person with "isidliso" pretending taking a form of an HIV and AIDS. Whereas 53% of the respondents indicated that HIV and AIDS is not a black poison or "isidliso" but caused by, amongst others, promiscuous behaviour. It was

found also by Malema (2008:36) that people in rural areas of the Limpopo province in South Africa believe that HIV is caused by witchcraft and they view HIV and AIDS as "*Isidliso*" or 'black poison'.

3.3.21 Response on whether having multiple sexual partners is culturally approved or not

Of the total respondents, 40% stipulated that to have multiple sexual partners is culturally approved and motivated. There are cultural idiomatic expressions which in one way or another influence people to have multiple-sexual relationships. For instance, "*Nwanuna i nhwembe wa nava*", in Xitsonga and "*Monna ke taka oa naba*", "*Monna ke selepe o lala a adimilwe*" and "*Monna ke phoka o wa boshego*" in Sepedi give and raise the confidence and ego of a man who practices such promiscuous behaviour. However, women are abhorred in having several sexual partners because it is regarded as a taboo. For a man to have multiple sexual partners proves manhood.

According to Matoane (2008:20) the practice of multiple sex partners is still prevalent amongst African people, particularly in rural areas. He also contends that some of the ethnic groups in South Africa, such as the Vatsonga and Vhavenda groups practice multiple sexual relationships. Multiple sex partnerships are also practiced among the Swazi speaking people (Buseh, Glass & McElmurry, 2002:53). Sithole (2001:24) points out that within the Swazi culture, being in multiple sexual partnership for a man is strongly supported, and that a man who has a multiplicity of sexual partners is called "*Ingwanwa*". This positive word is widely accepted, whereas the female correlates to the derogatory term called "*Ingwandla*". This practice of multiple sexual partners is also socialized into the young generation as they grow up. However, since a multiple sexual relationship is to more than one sexual partner, on the same breath, the prominent aspect that drives the HIV/AIDS pandemic is having multiple partners (HSRC, 2002:19).

Nonetheless, 60% of the respondents indicated that having several sexual partners is approved but has dire consequences such as sexually transmitted infections and the escalation of HIV and AIDS. Baxen & Breidlid, (2004:16) stated that cultural

practices such as polygamy, the encouragement of multiple sexual partners, traditional medicine, repressive customary law and culturally defined control over women all contribute to making efficient HIV protection more difficult. The prominent aspect that drives the HIV and AIDS pandemic is having multiple partners (HSRC, 2002:19; Hunter, 2005:123).

3.3.4 CONCLUSION

This chapter was on data presentation, analysis and interpretation which incorporate precise issues arising from the structured interview schedule in accordance with the preliminary literature review. Demographic factors of the respondents as well as social, cultural and religious beliefs, values and conventions of learners that compound to the escalation of HIV and AIDS were presented, analyzed and interpreted. The following chapter will focus on the findings, conclusions and recommendations

CHAPTER FOUR

Summary of the Major Findings, Conclusions and Recommendations

4.1 INTRODUCTION

This chapter presents the summary of the major findings drawn from the study conducted on the socio-cultural values and practices that give rise to the escalation of HIV and AIDS amongst the youth, conclusions and finally recommendations. Furthermore, re-statements of the problem, aim and objectives of the study and assumptions of the study are presented too.

4.2 RE-STATEMENT OF THE AIM, OBJECTIVES AND ASSUMPTIONS OF THE STUDY

4.2.1 Aim of the study

The aim of the study was to explore the socio-cultural values and practices that give rise to the escalation of HIV and AIDS in a rural community - Mapapila village in Vhembe District. The aim has been achieved as the researcher found that some socio-cultural values and practices like multiple sexual relationships, gendered power relations, promiscuous behaviour due to economic factors, age-disparate relationships, wife inheritance, virgin cleansing myth, having sex with girls and babies, virginity test, HIV as a foreign disease and un-Africanness of condoms, witchcraft as a cause of HIV and AIDS, faith healing and traditional healing contribute to the escalation of HIV infection in a rural environment.

4.2.2 Objectives and assumptions of the study

Objectives and assumptions of the study are synthesized so as to confirm or dispute the findings

- To describe the people's views and practices regarding HIV and AIDS as a foreign disease

This objective and the assumption were achieved positively as it was found that people in rural communities believed that HIV was introduced by foreigners, who intended to stop black people from having sex and reduce the black population.

- To establish people's values and practices regarding condoms and condom use:

This objective and assumption were achieved positively as it was revealed that condoms inhibit sexual pleasure. It was also found that condoms mean unfaithfulness and hiding STD's and women should not take a decision with regard condom use during sexual intercourse must should remain the territory of men (cf. 2.3.10; 3.3.13, 3.3.114, 3.3.15, 3.3.16, 3.3.17).

- To investigate people's values and practices into sex with girls and virgin cleansing:

The objective was achieved and assumption positively confirmed as it was revealed that girls are given to older men and women by their own parents in exchange for money. It is indicated that this exchange takes place in the young females' lives, which puts them on the risk of contracting HIV and AIDS (cf. 2.3.8; 3.3.9 and 3.3.10). It was found that infected person can actually be cured if he or she can have sex with virgins, with girls younger than 12 years. It is also indicated that this can cause abhorrent criminal behaviour, rape and can also cause HIV infection to spread like wildlife (cf. 2.3.7). The objective on virgin cleansing myth was not positively correlated as all learners objected the virgin cleansing myth as in the literature review findings and it was indicated that babies and children can get infected with HIV if one can have sex with an infected patient (cf. 2.3.7 and 3.3.6). This confirms the ecosystems theory which argues that people are living in environments which differ, meaning the virgin cleansing myth exists in other areas and not the same in the studied and sampled area.

- To establish how people relate HIV infection to witchcraft:

The objective was achieved and the assumption was positively confirmed as the literature review findings shows that there are some people who believe that AIDS is caused by witchcraft in Sub-Saharan Africa. AIDS is the work of "Ukuthakatha" which literally means AIDS is caused by witchcraft. People in rural areas of Limpopo province of South Africa believe that HIV is caused by witchcraft and they view HIV and AIDS as 'Isidliso' or 'black poison' (cf. 2.3.11). This was confirmed as 47% of the respondents believed that HIV and AIDS is a black poison or "isidliso". It is a work of those who practice witchcraft and have the ability to bewitch a person with "isidliso" pretending taking a form of an HIV and AIDS (cf. 3.3.20).

- Having multiple sexual partners is regarded as an indication of African virility:

This was not an objective but the researcher's assumption which was positively confirmed as such. Men cannot resist attractive women, men cannot control their sexual urges, young women cause married men to have affairs, there is nothing that a woman can do if her partner is having other affairs, it is the fault of a woman that influences a man to have multiple affairs, and all men have affairs. Concurrency is increasingly being contended to be an element of sexual partnerships that plays an important part in HIV transmission dynamics. Encouragement of multiple sexual partners contributes to making efficient HIV protection more difficult. Tabane (2009:30) asserts that in Botswana, it is believed that "a man is like a bull and should not be confined to one pasture". Kalipeni, Cradock, Oppong and Ghosh (2004:52) contend that most Africans do not judge having multiple sexual partners as immoral and being unfaithful (cf. 2.3.2). This was confirmed by the respondents as asked whether having multiple sexual partners is culturally approved or not was answered as such.

40% stipulated that to have multiple sexual partners is culturally approved and motivated. There are cultural idiomatic expressions which in one way or another influence people to have multiple-sexual relationships. For instance, "*Nwanuna i nhwembe wa nava*", in Xitsonga and "*Monna ke taka oa naba*", "*Monna ke selepe*

o lala a adimilwe" and "*Monna ke phoka o wa boshego*" in Sepedi give and rises the confidence and ego of a man who practices such promiscuous behaviour. However, women are abhorred in having several sexual partners because it is regarded as a taboo. For a man to have multiple sexual partners proves manhood.

According to Matoane (2008:20) the practice of multiple sex partners is still prevalent amongst African people, particularly in rural areas. Multiple sex partnerships are also practiced among the Swazi speaking people (Buseh, Glass & McElmurry, 2002:53). Sithole (2001:24) points out that within the Swazi culture, being in multiple sexual partnership for a man is strongly supported, and that a man who has a multiplicity of sexual partners is called "*Ingwanwa*". This positive word is widely accepted, whereas the female correlates to the derogatory term called "*Ingwandla*". This practice of multiple sexual partners is also socialized into the young generation as they grow up (3.3.21).

4.4 SUMMARY OF THE MAJOR FINDINGS

Hereunder, are the summary of the major findings of the study emanating from the literature review and the participants:

- The respondents revealed that condoms inhibit sexual pleasure and that condoms mean unfaithfulness and hiding STD's and women should not take a decision with regard to condom use during sexual intercourse and this should remain the territory of men. The findings from the study conducted in Swaziland on attitude towards condoms (Green, 1994:77) revealed how un-African contraceptives and condoms in particular are. The following are some of the reasons advanced about condoms. As one way of family planning, condom use will make Swazi nation and culture diminish, whereas white culture will predominate. Condom use and oral contraceptives weaken or kill babies in the womb.
- It is also believed that condoms burst and can threaten women lives. Adolescents believe that the use of condoms during the sexual intercourse inhibit the sexual

pleasure (Sherr, 1993:130; Klepp, Flisher & Kaaya, 2008:41). If a woman suggests the use of a condom, she may be accused of being unfaithful or hiding an STD. In addition, it appears that men feel insulted if a condom is suggested, as it casts doubts on their faithfulness (Ackermann et al., 2002:170). Sub-Saharan African women are disempowered to negotiate the use of condoms with their sexual partners who disadvantage their lives and this compound to women susceptibility to HIV (Ackermann & De Klerk, 2002:170).

- There are some people who believe that AIDS is caused by witchcraft in Sub-Saharan Africa. AIDS is the work of "*Ukuthakatha*" which literally means AIDS is caused by witchcraft. Some people in rural areas of Limpopo province of South Africa believe that HIV is caused by witchcraft and they view HIV and AIDS as '*Isidliso*' or 'black poison'. This was confirmed as 47% of the respondents believed that HIV and AIDS is a black poison or "*isidliso*". It is a work of those who practice witchcraft and have the ability to bewitch a person with "*isidliso*" pretending taking a form of an HIV and AIDS. The narrative approach is still effective in the narration of the socio-cultural values and practices knowledge of HIV and AIDS amongst some Africans.
- Whereas the findings from the previous literature review cite that an infected patient or person can actually be cured if he or she can have sex with virgins, or with girls younger than 12 years and with very young boys (Van Dyk, 2008:47; 2001:33; Leclerc-Madlala, 2002:87). "According to the virgin cleansing socio-cultural value and practice, a man can 'cleanse' his blood of HIV and AIDS through intercourse with a virgin, but the girl herself would not be infected in the process" (Leclerc-Madlala, 2002:87). Van Dyk (2001:33; 2008:47) support that beliefs like these can be the cause of abhorrent criminal behavior and can also cause HIV infection to spread like wildlife.
- According to Leclerc-Madlala (2002:87) the socio-cultural value and practice that to have sex with a virgin cures AIDS has been identified as the contributing factor to the rape of babies and children in South Africa. The respondents objected the virgin cleansing myth as in the literature review findings but indicated that babies and children can get infected with HIV if one can have sex with an infected patient. It was found that it is moral wrong to sleep with babies and children with the hope of curing HIV and AIDS. It is impossible that a man can cleanse his

blood of HIV by having sex with a virgin and the virgin not get infected. A virgin or young girl will contract HIV.

- It is also found that that this socio-cultural value and practice can also lead to the spate of rape of babies and children. This confirms the ecosystems theory which argues that people are living in environments which differs, meaning the virgin cleansing myth exists in other areas and not the same in the studied and sampled area.
- It was found that HIV was introduced by foreigners, who intend to stop black people from having sex and reduce the black population.
- Most Africans do not judge having multiple sexual partners as immoral and being unfaithful. There are cultural idiomatic expressions which in one way or another influence people to have multiple-sexual relationships. For a man to have multiple sexual partners proves manhood. The practice of multiple sex partners is still prevalent amongst African people, particularly in rural areas. Concurrency is increasingly an element of sexual partnerships that plays an important part in HIV transmission dynamics. Encouragement of multiple sexual partners contributes to making efficient HIV protection more difficult.

4.5 CONCLUSIONS

From the findings of the study, the following conclusions are drawn that:

- The socio-cultural values and practices give rise to the escalation of HIV and AIDS amongst the youth.
- There are socio-cultural values and practices still influencing that HIV and AIDS is caused by witchcraft and also that condoms inhibits sexual pleasure, as they interfere with natural fetal development.
- Some youth believe that condoms causes high blood pressure, condoms means being unfaithful and hiding of STD's.
- It is believed that a woman should not take part with regard to condom use and men are culturally allowed to have multiple partners.

4.6 RECOMMENDATIONS

Huber (1999:2) argues that one philosophy behind some of these changes is a commitment to reduce health and social inequalities through the establishment of national standards and objectives in relation to health and social services and a framework for assessing performance and effectiveness. Based on the findings and conclusions of this study, the researcher recommends the following:

- The HIV and AIDS preventative and intervention measures should incorporate cultural beliefs and practices.
- A paradigm shift from expert professionalism presentation to community emancipation approach needs to be considered. Meaning professionals should stop being experts and listen to the communities on how prevention of HIV and AIDS can be done within the communities considering cultural values, norms, beliefs and practices.
- A move from bio-medical model to social model as HIV and AIDS is now a social issue.
- The ecosystems theory and narrative approach to be taken into consideration on preventative strategies.
- Further research still need to be undertaken on how sub-systems culturally influence youth towards having multiple sexual partners and the escalation of HIV and AIDS.
- A study to be conducted on how cultural values and practices could protect people from the spread of HIV and AIDS or could reduce the escalation of HIV and AIDS.

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ADDENDUM A

Interview Schedule

SECTION A

Demographic factors

1. Age:

Less than 16 years
16-18
19-21

2. GENDER:

Male
Female

3. RELIGIOUS AFFILIATION:

Christianity
Muslim
Hinduism
Ancestral worship

Other [specify] _____

4. CHRISTIAN DENOMINATIONS:

Apostolic Faith Mission

Roman Catholic

I.P.C.C

Lutheran

U. R. C.

Z.C.C

Other [specify] _____

SECTION B

Social, cultural and religious beliefs, values and conventions that compound on the escalation of HIV and AIDS

5. What do you understand by HIV and AIDS?

Please explain _____

6. What symptoms indicate that a person has HIV and AIDS?

Please explain _____

7. Have you ever had sexual intercourse?

YES

NO

Please explain _____

8. Have you ever had sexual intercourse with both heterosexual and homosexual individuals?

Yes

No

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

YES

NO

Please explain _____

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

YES

NO

Please explain _____

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

Men
Women
Both genders

Please explain _____

12. According to your understanding, how is HIV transmitted?

Please explain _____

13. What makes older men to view young women as being negative from HIV? ___

14. What makes young women to view older men as safe partners, responsible and less likely to take risks than young men? _____

15. Is it a fact that a man can cleanse his blood of HIV and AIDS through having sexual intercourse with a virgin, and a girl would not be infected in the process?

Yes

No

Please explain _____

16. Is it a known fact that traditional healers believe that virgin cleansing with a virgin is a way in which a man could obtain measure of strength against HIV infection?

Please explain _____

17. Is it true that having sex with a virgin cures AIDS and do you think it is a contributing factor to the rape of babies and children in South Africa?

Please explain _____

18. Is it true that an infected patient can be cured if he or she has sex with virgins or girls younger than the age of 12 or with very young boys?

Please explain _____

19. Can HIV/AIDS be treated?

YES
NO

Please explain _____

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

21. How many times in the past month have you had sexual intercourse with a boy/girl _____ times.

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

YES

NO

23. Do you believe that condoms can prevent HIV transmission?

YES

NO

Please explain _____

24. Do you agree that a condom causes high blood pressure? _____

25. What is your view that condoms are unnatural and interfere with natural fetal development?

Please explain _____

26. What are your views on the use of condoms means unfaithfulness or hiding STD's?

Please explain _____

27. What is your view that the use of a condom is an insult to males? _____

28. Would you use a condom with your partner?

Yes	
No	

Please explain _____

29. Do you think according to your culture women should take decision with regard to condom use?

Please explain _____

30. How many people have you had sexual intercourse with?

One person	
Two people	
Three people	
More than four people	

31. How old was the oldest person you had sex with? _____ years old

32. Do you use any substances?

YES	<input type="checkbox"/>
NO	<input type="checkbox"/>

33. Name the substances you use:

34. 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.

34.1 Would you have sex?

Yes	NO

Please explain _____

34.2 "Fool around" [kiss and pet], but stop before having sex?

Yes	NO

Please explain _____

34.3 Go ahead and have sex?

Yes	NO

Please explain _____

34.4 How much would your social and cultural values and practices discussed with your friends would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

34.5 How much would your religious values and practices discussed with your friends would influence whether or not you decide to have sex?

Not at all	
Slightly	
Some	
A lot	
Very much	

35. What are your religious views about HIV/AIDS? _____

36. Do you agree that HIV/AIDS is caused by witchcraft? _____

37. Do you agree that HIV/AIDS is a black poison or "isidliso" used by witches? ___

38. Having several sexual partners is it culturally approved or not?

Please explain

Mabasa MA

MA (SW) Candidate

ADDENDUM B

Interview Guide

1. What do you understand by HIV and AIDS?
2. What symptoms indicate that a person has HIV and AIDS?
3. Mention and explain
4. Have you ever had sexual intercourse?
5. Have you ever had sexual intercourse with both heterosexual and homosexual individuals?
6. Do you believe that babies and children can get infected with HIV?
7. Do you believe that one cannot get infected with HIV if he sleeps with an elderly woman?
8. According to your understanding, what is the most vulnerable group to HIV infection between men and women?
9. According to your understanding, how is HIV transmitted?
10. What makes older men to view young women as being negative from HIV?
11. What makes young women to view older men as safe partners, responsible and less likely to take risks than young men?
12. Is it a fact that a man can cleanse his blood of HIV and AIDS through having sexual intercourse with a virgin, and a girl would not be infected in the process?
13. Is it a known fact that Traditional healers believe that virgin cleansing with a virgin is a way in which a man could obtain measure of strength against HIV infection?
14. What are your views on the myth that to have sex with a virgin cures AIDS has been identified as the contributing factor to the rape of babies and children in South Africa?
15. Is it true that an infected patient can be cured if he or she has sex with virgins or girls younger than the age of 12 or with very young boys?
16. Can HIV/AIDS be treated?
17. How many times in the past twelve months have you had sexual intercourse with a girl/boy?
18. How many times in the past month have you had sexual intercourse with a boy/girl

19. The last time you had sex, did you use a condom?
20. Do you believe that condoms can prevent HIV transmission?
21. Do you agree that a condom causes high blood pressure?
22. What is your view that condoms are unnatural and interfere with natural fetal development?
23. The use of condoms means unfaithfulness or hiding STD's.
24. What is your view that the use of a condom is an insult to males?
25. Would you use a condom with your partner?
26. Do you think according to your culture women should take decision with regard to condom use?
27. How many people have you had sexual intercourse with?
28. How old was the oldest person you had sex with? _____ years old
29. Do you use any substances?
30. Name the substances you use:
31. 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.
 - 32.1 Would you have sex?
 - 32.2 "Fool around" [kiss and pet], but stop before having sex?
 - 32.3 Go ahead and have sex?
 - 32.4 How much would your social and cultural values and practices discussed with your friends would influence whether or not you decide to have sex?
 - 32.5 How much would your religious values and practices discussed with your friends would influence whether or not you decide to have sex?
32. What are your religious views about HIV/AIDS?
33. Do you agree that HIV/AIDS is caused by witchcraft
34. Do you agree that HIV/AIDS is a black poison or "isidliso" used by witches?
35. Having several sexual partners is it culturally approved or not?

Mabasa MA

MA (SW) Candidate

ADDENDUM C

LETTER OF CONSENT FOR PARENTS OF LEARNERS UNDER THE AGE OF 16

Dear Parent,

My name is Mabasa Matimba Allan. I am a Masters' student (M.A.) in social work at the University of Limpopo – Turfloop Campus. The research study is part of my MA (SW) degree programme. As part of the study, I am expected to collect data from identified learners and that includes your child. I am studying the socio-cultural values and practices that influence the escalation of HIV and AIDS in a rural community giving it a social work perspective. During the interview, the researcher will make use of a schedule, as a guide.

You are kindly requested to allow your child to be a participant in this study. The session will take approximately one (1) hour. You are also kindly requested to read and sign the informed consent provided to you.

Thanking you in anticipation.

Mabasa Matimba Allan
M.A. Social Work Candidate
University of Limpopo- Turfloop Campus

Date

TOPIC OF THE STUDY

The study of socio-cultural values and practices that influence the escalation of HIV and AIDS in a rural community: A Social Work Perspective

Declaration of Consent (Parent)

I, the parent of the participant, out of my free will, hereby agree to that my child voluntarily participate in this research study with the following understanding:

The Nature of the Research

- The Social Worker, Mr. Mabasa Matimba Allan, from the University of Limpopo (Turfloop Campus) is conducting the research.
- The research forms part of the requirements for Mr. Mabasa Matimba Allan Master's degree programme.
- Information will be collected by means of interviews.

Rights of my child as a participant:

- He/she will not be forced to participate in this study.
- He/she will have the right to withdraw from the study at any given time.
- He/she will have the right to decline to answer any question (s) he/she is not comfortable with.
- He/she will remain anonymous and his/her name and identity will be kept from public knowledge.
- Any information he/she reveals during the process of this study will remain confidential, and will only be used for the purposes of this research and for publication in Mr. Mabasa Matimba Allan's dissertation or appropriate publications.
- I grant permission for any information he/she will reveal during the interview process, with the understanding that data collected will remain in possession of the interviewer, Mr. Mabasa Matimba Allan and his supervisor.

- The identification particulars such as surnames and names will be kept securely safe in Mr. Mabasa Matimba Allan's room and thereafter the list will be destroyed.
- I,..... (the parent of the participant), agree that my child participate in this study.

Signature

Parent

ADDENDUM D

LETTER OF CONSENT FOR LEARNERS UNDER THE AGE OF 16

Dear Learner,

My name is Mr. Mabasa Matimba Allan. I am a Masters' student (M.A.) in social work at the University of Limpopo –Turfloop Campus. The research study is part of my MA (SW) degree programme. As part of the study, I am expected to collect data from identified participants and that includes you. I am studying the impact of substance abuse on learners, families and the school. During the interview, the researcher will make use of a schedule, as a guide.

You are kindly invited to be a participant in this study. The session will take approximately one (1) hour. You are requested to be open and honest in answering the questions. You are also kindly requested to read and sign the informed consent provided to you.

Thanking you in anticipation

Mr. Mabasa Matimba Allan
M.A. Social Work Candidate
University of Limpopo- Turfloop Campus

Date

TOPIC

The study of socio-cultural values and practices that influence the escalation of HIV and AIDS in a rural community: A Social Work Perspective

Declaration of Consent (Learner)

I, the participant, hereby give permission to voluntarily participate in this research study with the following understanding:

The Nature of the Research

- The Social Worker, Mr. Mabasa Matimba Allan, from University of Limpopo (Turfloop Campus) is conducting the research.
- The research forms part of the requirements for Mr. Mabasa Matimba Allan's Master's degree in Social Work.
- Information will be collected by means of interviews.

My rights as the participant:

- I cannot be forced to participate in this study.
- I have the right to withdraw from the study at any given time.
- I have the right to decline to answer any question(s) I am not comfortable with.
- I will remain anonymous and my name and identity will be kept from public knowledge.
- Any information I reveal during the process of this study shall remain confidential, shall only be used for the purposes of this research and for publication in Mr. Mabasa Matimba Allan's dissertation, and relevant or appropriate publications.
- I grant permission for any information I reveal during the interview process, with the understanding that data collected will remain in possession of the interviewer, Mr. Mabasa Matimba Allan and his supervisor.

- The identification particulars such as surnames and names will be kept securely safe in Mr. Mabasa Matimba Allan's office and thereafter the list will be destroyed.
- I, (the learner), agree that I should participate in this study.

Signature

Learner