SEXUAL MISCONCEPTIONS THAT PREDISPOSE AFRICAN ADOLESCENT GIRLS TO HIV INFECTION IN UMLAZI TOWNSHIP, DURBAN

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DECLARATION

I hereby declare that this dissertation, unless otherwise indicated in the text, is my own original work. This research has also not previously been submitted to any other institution for degree purposes.

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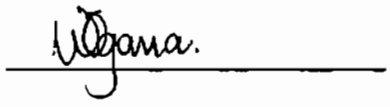
Signature: 

ABSTRACT

This dissertation elicits focuses on sexual misconceptions which pose challenges to HIV/AIDS prevention and control among African adolescent girls in Umlazi Township, Durban. The study springs from the realisation that mere misconceptions related to sexuality could instigate risky behaviour resulting in HIV infection, and ultimately, result in premature death related to AIDS-related illnesses. Due to their physiological vulnerability, adolescent women are among a group at highest risk for contracting HIV in South Africa The study seeks, therefore, to understand how sexual misconceptions predispose girls to HIV infection against the context of gender, sexuality and reproductive health. The latter three issues are shaped by myriad forces working against the adolescent group. The study concludes with recommendations focused on challenging and removing sexual misconceptions with gender-sensitive interventions.

Keywords:

Sexual misconceptions; gender; inequality; HIV/AIDS; sexuality; adolescents

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DEDICATION

This study is dedicated to two special people. One is my daughter, nine-year old Katherine, who prayed that God would help me complete my 'homework' (MA dissertation). The other is my mother, who for over a year rose daily at dawn to pray for the same.

TERMINOLOGY

I use the terms HIV, HIV/AIDS, and AIDS to refer to three conceptually distinct dimensions and collective and individual experiences of the crisis. *HIV* refers to the virus that damages an infected individual's immune system and renders her vulnerable to a variety of diseases and ultimately to death. *HIV/AIDS* is used to describe the total disease experience of people who are infected with HIV and those who are ill from the diseases that result from such infection. *AIDS* refers to the social constructions or representations of the collective experience of HIV infection and related illnesses.

CONTENTS

CHAPTER 1

INTRODUCTION AND PROBLEM FORMULATION

1.1 Introduction

There is little doubt that we are currently in the midst of a global HIV/AIDS emergency: children, women and men are all caught in the crossfire of this relentless epidemic. The sobering fact is that this epidemic (now a pandemic) is far from over. Sub-Saharan Africa, the world's poorest and most underdeveloped region, accounts for only 10% of the world's population, but has 85% of all AIDS deaths (World Bank, 2000). The number of people living with HIV worldwide in 2005 is estimated at 40.3 million, with Sub-Saharan Africa remaining the hardest hit by the HIV/AIDS epidemic. It is home to an estimated total of between 25.8 to 28.9 million people living with HIV (UNAIDS/WHO, 2005). South Africa, which falls under this sub region, is considered not only the global epicentre of the pandemic, but also as having the "fastest-growing epidemic in the world" (Walker *et al*, 2004:12). With an estimated 5.6 million infected people, South Africa is officially recognised as having the world's highest population of people living with HIV/AIDS (Dorrington and Johnson, 2002). Against this backdrop, South Africa's youth have attained the status of being among the world's highest risk groups for contracting HIV. (Department of Health, 1999). In this region, infant mortality is escalating while life expectancy is plummeting.

This pandemic is characterised by common sexual misconceptions held by the youth. My motivation for researching these fallacies arose when I read a newspaper article that pointed out how the incorrect beliefs held by adolescents could ultimately lead to their contracting HIV. I was shaken by the realisation that mere misconceptions related to sexuality could instigate risky behaviour, which may in turn result in HIV infection, and possibly end in developing AIDS.

According to UNICEF *et al* (2002), epidemiological studies in Eastern and Southern Africa have shown that between 17% to 22% of girls aged between 15 and 19 are already infected with HIV, compared with between 3% to 7% of boys of a similar age. Faced with such a catastrophe, it is of vital importance to counter the misinformation and misunderstanding that HIV and AIDS continue to generate (Van Dyk, 2001). Surveys conducted in 40 countries, South Africa included, indicate that over 50% of young people aged between 15 to 24 harbour serious misconceptions about how HIV and AIDS are transmitted, an issue which has not been handled with the gravity it deserves (UNICEF *et al*, 2002).

Worldwide, young people aged between 15 and 24 comprise the group most vulnerable to HIV infection, with adolescent girls being the most susceptible to contracting the virus. Even if the current HIV infection rates were to decrease, it is projected that half of all 15-year-olds today will eventually die of AIDS in the next few years in countries worst affected by AIDS (UNICEF *et al*, 2002).

In addition, increasing numbers of HIV-positive girls transmit the virus to their children during pregnancy, at childbirth or through breastfeeding (Chin, 1990; Jackson, 2002; Whiteside and Sunter, 2000). These facts prompted me to explore the link between such misconceptions and adolescent girls, in particular; a group with higher vulnerability to HIV infection than their male counterparts.

This study employs a gender perspective in order to examine sexual misconceptions as understood by African adolescent's girls of the Umlazi Township. Closely linked to these misconceptions is the accuracy of sexual education, which is widely recognised as being the cornerstone of HIV prevention (Shisana and Simbayi, 2002). The 1998 Demographic and Health Survey (1998) regrettably points out that although over 97% of women know about the nature and transmission of HIV and AIDS, this knowledge has had little effect on altering their behaviour. One explanation for this anomaly is the existence of many knowledge gaps between what they know and what they practise. This study hypothesises

that the anomaly is linked to sexual misconceptions, which may predispose HIV infection.

This study on sexual misconceptions was conducted at Ogwini Comprehensive Technical School, which is located in the Umlazi Township on the outskirts of Durban in KwaZulu-Natal (hereafter KZN). Umlazi Township was selected as the study site because of its positioning in KZN. The province is a strategic choice because of the following reasons. Umlazi lies within KZN, the province with the highest HIV prevalence in South Africa. According to the 2004 annual antenatal survey on HIV prevalence among pregnant women aged between 15 to 49 nationwide, the highest prevalence (by province) was 40% in KZN. Preliminary research confirms that HIV prevalence has reached 40 % in KwaZulu-Natal, while it remained exceptionally high – between 27 to 31% – in the Eastern Cape, Free State, Gauteng, Mpumalanga and North West Provinces (UNAIDS/WHO, 2005). Among women in their late teens (15 to 19), HIV infection levels have remained at 15 to 16% since 2000. A recent study of death registration data gathered from 2.9 million death notification certificates, has shown that deaths among people 15 years of age and older increased by 62% from 1997 to 2002 (Statistics South Africa, 2005). These statistics lend urgency to the plight of KZN's youth. Half the population is below the age of 19, and most of the newly infected are between the ages of 15 and 24 as this group is mostly engaged in unprotected sex (Varga, 1997). Stats = youth cultur

KwaZulu-Natal is situated along South Africa's east coast, which borders the Indian Ocean. With a population of 8.4 million, KZN holds a fifth of the nation's populace, with about 25% of the country's black population inhabiting the province (Rutenberg *et al,* 2001). The breakdown of the province's population is as follows: Africans (mainly Zulu-speakers) comprise 76 %; Indians 14 %; Whites 7 % and Coloureds 3 %. In keeping with these figures, Durban has a predominantly African population, which makes it relevant to this study as its focus is adolescent African girls.

Durban, the third largest city in the country, hosts Africa's largest and busiest port. Besides being a tourist attraction, the city also has an international airport and conference

centre, plus numerous industries that attract job seekers from far and wide. Durban is also a hub of trucker routes that fan out of the port to distant destinations throughout Southern Africa. Furthermore, the city, which has excellent rail links, also attracts migrant workers from the entire sub region. Due to all these factors, Durban serves as a magnet and attracts both South Africans and foreigners, urbanites and rural dwellers. This influx of large numbers of diverse people into Durban creates an extensive sexual network that poses a high HIV risk, if unprotected sex occurs.

1.2 Problem statement

As adolescent females between the ages of 15 and 19 are among those worst affected by the epidemic, this study focuses on misconceptions related to their sexual and reproductive health. The study aims to identify, problematise and challenge the most common misconceptions of this kind in a South African township setting. Ultimately, the study is geared to deepen an understanding of HIV/AIDS, with a view to improving intervention and prevention strategies. To be effective, intervention requires a deeper insight into the social, economic, political, structural and cultural contexts within which young people live. In keeping with this approach, this study focuses on the social context to demonstrate how sexual misconceptions are associated directly with gender, class, culture, race, age and location.

For the purposes of this dissertation, the study will restrict its scope to the misconceptions associated with adolescent sexuality, rather than the misconceptions associated with HIV transmission through normal, daily, social contact. The latter category includes beliefs that the virus can be contracted in the following ways: toilet seats, swimming pools, food, through contact with certain animals and insects, through contact with infected friends, which includes playing, hugging, shaking hands, social kissing, breathing the same air or sharing eating utensils, combs and clothes with them (Van Dyk, 2001; Jackson, 2002).

In the context of this study, the word 'misconception' is used to include misperceptions; erroneous assumptions; half truths; false notions; heresy and myths. All of these

negatively influence adolescent knowledge, attitudes, values and behaviour as they relate to sexuality. Some misconceptions that predispose adolescents to HIV infection are often closely associated with false beliefs and popular myths that are widely circulated. Kruger (2003) defines the contemporary meaning of 'myth' to mean something that is widely believed, but is not true. Kruger argues that myths, which are often linked to people's socio-cultural environment, are often stronger than scientific knowledge in driving people's behaviour. Offering an anthropological interpretation, Leclerc-Madlala (1999) points out that myths exist to explain the unexplainable, giving meaning to realities that are beyond our control. She posits, for example, that in times of desperation, myths – and the behaviour they prescribe – are more likely to come to the fore as people frantically search for answers, meanings and solutions to the baffling or disturbing aspects of HIV and AIDS.

From a public health perspective, it is regrettable that in view of the early sexual debut of adolescents, such misconceptions prevail, despite an onslaught of knowledge on HIV/AIDS. By 'public health' I refer to a branch of medicine concerned with prevention of disease and the promotion of health by organising efficient systems of control (Youngson, 2005: 519). Today's adolescent is becoming sexually active progressively earlier than past generations, with at least half of young people engaging in sex before reaching 18 (Dickson, 2003; Manzini, 2001). According to a survey conducted among 269 705 school pupils, aged between 10 and 19 in Grades 6 to 11 in South African schools (CIET, 2004), 1 out of 3 have had sex by the age of 10. Sexual activity and unprotected sexual intercourse among adolescents are related to the high levels of HIV infection in South Africa, with girls being more likely than boys to contract the virus. Though sexually active, many adolescent girls lack the knowledge to prevent pregnancy, which suggests they are engaging in unprotected penetrative intercourse; a high-risk practice for HIV infection.

Other key factors fuelling the high prevalence of adolescent sex include family and cultural breakdown; urbanisation; globalisation and media influence (Kelly and Ntlabati, 2002). The entertainment and advertising media, for example, often exploit the rapid

physical and psychological changes taking place in adolescents by constantly bombarding them with sexual images, which imply that everybody is 'doing it' (having sex). Adolescents, who are generally impressionable, believe this is the norm rather than the exception. Consequently, they emulate the fantasies they see on the screen during their transition into adulthood.

Other sources of information valued by young people include film, video, the Internet, magazines, romance literature and popular music. These sources fuel some of the misconceptions influencing sexual practices that are counter-productive to HIV and AIDS intervention. For example, many soap operas do not present their viewers with scenes that demonstrate the sexual negotiation between potential lovers. Instead, they offer a snapshot of a scene that cuts directly to the actual act of sex. Such visual stimuli shape, influence and construct ideas about sex that impact on impressionable youth.

Other key sources of knowledge on sexuality include churches and other religious institutions, the State, schools, medicine and public health. However, these institutions all too often fail to grasp the complexity of young people's sexual culture; a concept that recognises different systems of sexual behaviour among any group of people (Dowsell and Aggleton, 1999). Inherent in this culture are misconceptions that may predispose adolescents to HIV infection.

Despite the prevalence of adolescent sexual activity and the availability of information on HIV/AIDS, this age group's knowledge of reproduction and sexuality is generally inadequate. To some extent, it is due to this paucity of the relevant knowledge that many adolescents indicate they need information on such matters such as pregnancy, sexually transmitted infections (STIs), sexual intercourse and relationships (Rutenberg *et al*, 2002; Dickson, 2003). The study hypothesises that by gaining an understanding of misconceptions related to such matters, we could make a contribution towards curbing HIV infection among African adolescent girls not only in the Umlazi Township, but also in other places where similar socio-economic factors exist.

1.3 Study objectives

As mentioned earlier, a key objective of this study is to examine the effects sexual misconceptions have on the reproductive and sexual health of adolescent girls in relation to HIV/AIDS. In so doing, the project highlights the plight of these girls, who feature among the groups at highest risk of contracting HIV, with a view to improving our understanding of how misconceptions fuel the spread of HIV.

Sexual misconceptions proliferate among adolescents largely due to ignorance, naiveté and reliance on peer networks, rather than on adult sources of information (Jacobsen, n.d.; and Grayson, 2003). Van Dyk (2001) underscores this information gap when she observes that "the main source of information is usually their peer group – which often contains considerable misinformation and distortion". I maintain that though older children often have good general knowledge about HIV/AIDS, they are often the source of misinformation and half-truths about sex, HIV/AIDS.

Misconceptions generated by a lack of awareness or having limited knowledge about HIV/AIDS are common among adolescents. A nationwide survey involving 2000 adolescents in South Africa shows that 7% of respondents believed AIDS could be cured by having sex with a virgin, while 12% believed they could contract HIV from condoms (Kaiser Family Foundation, 2001d). In addition to this, 13% said traditional African medicine had an AIDS cure. It is important, therefore, to counter the misinformation and misunderstanding that HIV/AIDS continues to generate. But, before this can be done, another challenge needs to be faced:

> Determining the reasons behind certain beliefs is vitally important for AIDS educators because they cannot attempt to rectify what they don't properly understand (Van Dyk, 2001:122).

MacPhail (1998) develops the abovementioned issue further by pointing out that although South African youth have relatively good knowledge of HIV transmission and AIDS, but very little is known about how sexuality is constructed among adolescents, nor the

implications of high risk behaviour. Viewing the subject of sex and sexuality from a behavioural change perspective, MacPhail pinpoints research issues on adolescent sexuality that require addressing. These include female and male sexuality, gendered power imbalances and normative beliefs of peers that hamper safer sex. These issues feature in my study since they are critical in AIDS prevention and control. To this end, I highlight the complexities entrenched in adolescents' formative beliefs and values about HIV/AIDS. As indicated earlier, the study will focus on Umlazi's adolescent girls: their perspectives on how they live their gendered lives against the backdrop of their sexuality, and the impact of HIV/AIDS.

This study will also focus on how feminine and masculine identities play out in the HIV/AIDS epidemic; how significant adults such as parents, teachers or health workers' attitudes obstruct or enhance AIDS intervention' and how the media over-glamourises sex to the detriment of vulnerable adolescents' sexual and reproductive health. Cultural factors that go beyond the level of the individual to the realm of wider society in predisposing girls to HIV infection will also be examined.

Among the pertinent issues I address, is to what extent women in a patriarchal world (and the younger ones in particular) have a measure of control over their sexual and reproductive health. I believe that this path charts forward a more progressive mode of thinking, instead of narrowing the scope to the sterile confines of reproductive health. Despite being a taboo subject for many, sexuality cannot be omitted when discussing the complexities of HIV/AIDS.

In order to motivate the argument put forth in this dissertation, I borrow an idea from a population policy that originated from the International Conference on Population and Development (ICPD, 1994) held in Cairo in 1994. This policy represented a paradigm shift because it ventured beyond family planning as the centre of reproductive health. Besides attempting to enhance women's reproductive health, the ICPD extended the recognition that sex is not merely about procreation, but also about pleasure. My study

takes a similar stance by viewing these potentially contentious issues through the eyes of adolescent girls.

When discussing 'sexuality' there is a need to define the concept, since it covers a broad field, and means different things to different people. This study will adopt Varga's (1997) conceptualisation, which describes sexuality in a broad context. Varga takes into account the following aspects: feelings; desire; socially accepted attitudes; norms and meaning imbued through interaction with members of the same or the opposite sex; sexual decision-making and negotiation, as well as the formation of sexual and gender identities. Viewed from an even broader spectrum, I link Varga's definition of sexuality in the context of HIV and AIDS, to notions of shame, sin, and disease that arise from the sexual mode of HIV transmission. These issues will become evident as the arguments unfold in this dissertation.

1.4 Significance of the study

Apart from my personal concern for the health and survival of people who are affected by HIV/AIDS, I have a deep-seated interest in contributing to the development of proactive public health responses to the current epidemic. My motivation for undertaking this study is to underline, motivate and reinforce the urgency of limiting the spread of HIV through prevention and control measures that target adolescent girls in an African township setting. I concur with Campbell (2003: 4-5) concerning the need to take action *now*, when she points out:

> The dangers of the epidemic are now unavoidably clear. There is also a growing awareness that the suffering and damage already sustained are only minor compared to the devastation that lies ahead if nothing is done.

The catastrophic impact of the spread of AIDS on the youth cannot be overstated. An estimated 40% of South Africa's population is under the age of 15, but unless action is taken urgently, half of this age group could contract HIV (Africa Strategic Research Corporation, 2001). Currently, about 50% of HIV infections occur before the age of 20.

Research shows that the course of the country's HIV/AIDS epidemic can be changed by carefully targeting reductions in high-risk sexual behaviour among young people: If anything can stop the AIDS epidemic in South Africa, it will have to be the teenagers. Deeply entrenched patterns of behaviour are better addressed early, if there can be any hope towards successful intervention programmes for ameliorating the problem (Okonofua, 2001). Young people provide a window of opportunity for targeted prevention interventions, since the vast majority of those under 15 are not yet HIV-positive (loveLife, 2002).

South African adolescent girls are becoming infected younger and dying earlier than boys their age, following the same trend as girls of similar age in the rest of Sub-Saharan Africa (UNAIDS, June 2000a). The quest for objectivity, however, demands that we scratch below the surface by focusing on the relationship between what has become a pandemic, its spread, and the conditions under which the African majority live.

According to *Statistics South Africa, 2002* (Department of Health, 2003), the AIDS epidemic is most severe among this nation's African population; their mortality rate is almost 10 times higher nationwide than that of their Indian, White or Coloured counterparts. Black girls' and women's vulnerability to HIV infection is relatively higher than among males, which stems from a wide range of factors, including biological, social, cultural, economic, political and legal reasons (Campbell, 2003; Whelan, 1999). Willocks *et al* (2003) point out that the extensive disparities that occur in infection rates in South Africa follow geographic, age, race, social class and gender lines, with young, black females from economically depressed communities being worst affected than any other group in the country.

1.5 Structure of the study

In order to gain a better understanding of the girls' plight, this study analyses misconceptions rooted in these factors and how these interface with gender, sexuality and AIDS as they affect the African adolescent girls. In the process, the study will investigate

knowledge, attitudes, beliefs and values that support these misconceptions under the assumption that they predispose adolescents to HIV infection. The overall argument is structured as follows. **Chapter 1** motivates the overall project by identifying the central problem to be investigated in relation to the broader historical context of the current HIV/AIDS pandemic; its relevance to South Africa, and – more specifically – for my data sample. **Chapter 2** engages a literature review by focusing only on selected empirical studies that reinforce and accentuate my motivation in respect of sexual misconceptions and their relevance to my participant sample. **Chapter 3** identifies the significant theoretical concepts and issues that underpin my interpretation of the data. **Chapter 4** explains the methodological procedure with regard to the data gathering process in this study. **Chapter 5** profiles my participants with reference to an analysis of the data, and provides an interpretation of the data in understanding sexual misconceptions. **Chapter 6** returns to the overall project by revisiting my hypothesis. Here consideration is given to what the data discloses, in addition to questions that arise in the current study and for future research. In this section a few recommendations are also provided. I now turn to a discussion that considers a selected literature review in relation to the empirical context of HIV/AIDS.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Unlike previous generations, today's adolescents do not rely solely on their parents, extended family and other community members for information on sexuality and related social expectations. UNFPA (2003) identifies some of the key sources adolescents rely on for information on their sexual and reproductive health. In many settings, a large proportion of young people seem to rely on the least reliable sources such as their peers or the entertainment media. The net result is widespread ignorance, partial information and mistaken beliefs or myths. According to the aforementioned UNAIDS body, studies of young people's knowledge, attitudes and practices reveal either over-confidence (that they know it all) or, on the other hand, ignorance (since they know too little). Either way, such extremes spawn sexual misconceptions, which may result in risky behaviour, thus predisposing the adolescents to HIV infection. This chapter establishes a link between the misconceptions about HIV/AIDS, and the high rate of infection with regard to adolescent girls.

As adolescents make the transition to puberty and prepare to enter adulthood in a rapidly changing world, they face the threat of accidental pregnancy and sexually transmitted infections (STIs) including HIV. Worldwide, half of all new infections occur among young people aged between 15 to 24. Ignorance about the consequences of early sexual debut, unsafe abortion, unplanned or unwanted pregnancy and sexually transmitted infection is especially critical since these may have long-term consequences on an adolescent girl's future. Lack of awareness in the abovementioned four areas may even ruin an adolescent girl's entire future by preventing her from completing her education; finding employment; securing a good economic position once she has found a job; forming secure relationships or starting a family of her own (UNFPA, 2003). Despite the

possibility of such dire consequences, adolescent women fear that asking questions about sexual and reproductive health may result in them being labelled as promiscuous (Jackson, 2002; Skinner, 2001). Adolescent men, on the contrary, are afraid to inquire about these two concerns for fear of appearing ignorant. Due to both peer and social pressure, this male age group is expected to be relatively more conversant than their female counterparts about issues related to sexual activity. These fears may hamper adolescents from seeking information from the most reliable sources possible, and they may search for the information they need from peers with limited knowledge, and subsequently end up being misinformed.

It is crucial, therefore, for stakeholders who work in AIDS-related fields to make informed decisions, which partly necessitates probing below the surface to uncover the beliefs and attitudes that lead to risky sexual behaviour in the first place. In order to develop meaningful intervention strategies, stakeholders need to go even further to identify the context within which adolescents operate. To this end, further research is required to document the contribution of both socialisation and gendered patterns of behaviour to adolescent sexual and reproductive health in Africa. Okonofua (2001) observes that, whereas gender features prominently in research on sexual and reproductive health in adults, relatively little effort has been made to document its importance among adolescents. He suggests this could be done through adopting a holistic framework to uncover the underlying social, cultural, political, economic and developmental factors that negatively impact on the gendered patterns of risky sexual behaviour.

By categorising information under specific themes, this chapter will examine gendered factors that relate to misconceptions about HIV/AIDS. The following themes will be discussed: the biological aspects of reproductive and sexual health; culture in general and youth culture in particular; girls' sexual agency; the roles that significant adults play in the lives of the youth in terms of the information they give them and how this can fuel the spread of HIV, and the economics of sex.

2.2 'Ignorance ain't bliss' in reproductive health

Many misconceptions have been implicated in the spread of HIV, some of which are linked to biological factors relating to reproductive health. While writing the proposal for this study, I conducted a rapid appraisal by holding informal interviews or focus group discussions with female university undergraduates. They drew my attention primarily to misconceptions affecting adolescent females. Most of the mistaken beliefs they mentioned were associated with pregnancy, which again implies unprotected sex. Pregnancy, it appears, poses the risk for contracting HIV if a girl's sexual partner is infected. Below are some of the fallacies in circulation.

The abovementioned undergraduates cited sexual encounters in which adolescent girls drink Coca-Cola (before having sex), and then somersault after having sex in the erroneous conviction that they will not fall pregnant. The 'somersaulting' is believed to dislodge semen from the vagina, and the notion that drinking a lot (sometimes even six glasses of water) before engaging in sex serves as an effective form of contraception. Another misperception is that injectable contraception renders women barren. Girls would rather engage in unprotected sex than face the possibility of a childless future.

A further inaccurate belief is that laxatives taken after sex could serve as a form of emergency contraception. The laxatives are believed to flush out the stomach's contents. This misconception is based on the non-scientific assumption that the female genitals and the stomach are synonymous. But, seeing as though these are two separate organs, drinking liquid through the mouth to flush the virus from the women's genitals is not physically possible.

Another fallacy being advanced by the undergraduates is that anal sex, which is increasingly employed by girls to steer clear of being deflowered or falling pregnant, poses no risk for HIV infection. This worrying new trend is gaining currency with increasing numbers of girls who choose to engage in anal sex as an alternative to vaginal penetration to keep the hymen intact. Anal sex, through which these girls circumvent the

public shame of falling pregnant outside wedlock, has grave implications for the spread of HIV. It poses a higher risk of contracting HIV than vaginal penetrative sex. According to the Centre for the AIDS Programme Research in Southern Africa (hereafter CAPRISA), anal sex is a high risk practice since the delicate, anal wall tissue is relatively more prone to rupture than the vaginal walls during penetrative sex (CAPRISA, 2003). Tearing provides an entry point for HIV, if the sexual partner is infected. The CAPRISA study, conducted in Vulindlela (a rural KZN community near Pietermaritzburg), indicates that anal sex, which has received little attention to date, is not an uncommon practice. About one in five girls has practiced anal sex, which they perceive to be 'safe sex'.

The undergraduates also cited what has been dubbed the 'virgin myth'. Leclerc-Madlala (2002) points out that according to the virgin cleansing myth, a man can 'cleanse' his blood of HIV/AIDS through intercourse with a virgin. Sexual intercourse with a virgin is also thought to provide inoculation against future HIV infection. Leclerc-Madlala deduces that the escalation of rape of young girls in South Africa could be partially attributed to this myth.

Reviewing literature for the purpose of this dissertation revealed a proliferation of misconceptions that thwart condom use. For example, some people believe that the lubricant in condoms contains HIV; that condoms can get stuck in the vagina; that condoms are not 100 % safe; and that insisting a sexual partner uses a condom is either a sign of distrust or infidelity (see Jackson, 2002; Maurice Webb Race Relations Unit, 2004). In addition to this it is believed a condom does not have to be used if the woman is on contraception such as the Pill or the injection: either is mistakenly assumed to guarantee *safer* sex.

For example, a national survey of 2 204 South African youth, aged between 12 and 17, illustrates the level of awareness among people in this youth group (Africa Strategic Research Corporation, 2001). Even though a majority of youth featured in the study had a clear understanding about what "safe sex" means, one third (32%) say the term 'safe sex' refers to sex with no clothes on. When asked the question in reverse, as to what "unsafe

sex" means, one in five (20%) tick sex with an uncircumcised man, while 18% reply it is sex with your clothes on. About one in 10 indicate that the term refers to anal sex.

Findings from another study conducted in South Africa by the international research body Centro de Investigación de Enfermedades Tropicales (CIET, 2004), reveal a high prevalence of misconceptions about sexual violence as it relates to the risk of HIV infection. The national study, which linked sexual violence and HIV, found that at 18, one out of two respondents mistakenly believe that condoms do not prevent pregnancy, HIV or other sexually transmitted infections (STIs). The study comprised 269 705 learners aged between 10 and 19.

Women in general, but more so younger girls suffer more than men from asymptomatic sexually transmitted infections (STIs), which often remain undiagnosed for long periods of time. This compounds the risk of contracting HIV through sores or lacerations in the underdeveloped lining of the vagina, in the event that unprotected sex occurs. As they progress, STIs cause sores in the reproductive organs that provide an entry point for HIV into the bloodstream during unprotected sex. Many of the STI cases in South Africa never get treated. Over 50% of the ante-natal clinic attendees have been found to be infected with at least one STI, while up to 15% are diagnosed with syphilis (Whiteside and Sunter, 2000).

The STIs spread rapidly due to the fact that the majority of infections are either asymptomatic (especially in girls), or are so mild that they are often disregarded (UNICEF *et al*, 2002). Some symptoms may disappear over time, creating the false impression that the disease has been cured. Often, adolescents cannot distinguish between normal and abnormal genital states, and do not seek medical care as a matter of urgency. In many instances youngsters do not request treatment because they feel guilt or embarrassment due to the widely held assumption that adolescents are sexually innocent.

In my attempts to fully understand and reflect on my research topic, I also watched and listened to audio and visuals that included drama, film, video and television. Among the

most informative of these that I came across was Jill Kruger's *Deadly Myths* (2003), a documentary film that raises awareness about HIV/AIDS-related misconceptions. The latter were elicited from interviews with predominantly African subjects, but included a few White and Indian interviewees. In the film Kruger (2003) catalogues beliefs, attitudes and practices that contribute to the spread of HIV by barring people from practicing safer sex. In the documentary, refusal to use condoms is embedded in myths. The myths associated with condom use are numerous and include: the presence of worms; the fact they are believed to be too small to fit onto the male member; that they can be recycled once, as long as they are washed first; that the simultaneous use of two condoms provides double protection, and that condom use should be avoided as direct contact with semen is healthy for women.

All these myths are contrary to HIV/AIDS prevention messages. Condoms do not contain worms; if this were the case, the South African Bureau of Standards (SABS) would have taken the correct measures. On the issue of condom size, some AIDS counsellors have demonstrated that a condom can stretch to fit over the head of a human adult. For example, Garey Davis of the Campus Aids Support Unit (University of KwaZulu-Natal), illustrated the elasticity of the condom for peer educators by pulling a condom over his head. Condoms cannot be sterilised satisfactorily merely by washing them with water and re-use can render the condom useless. In the instances where two condoms are used one on top of the other, friction between the delicate rubber surfaces is likely to cause a tear in one of the condoms. This defeats the purpose of condom use in the first place, which is to prevent contraception and the spread of STIs. And, finally, there is no scientific basis for the belief that semen *per se* enhances women's health, yet women who believe this make a deliberate choice to have unprotected sex in order to enjoy the dubious benefits they hope to get (Skinner, 2001).

2.3 Youth culture backing AIDS

Youth culture is fast evolving in a bid to adapt to a post-apartheid South Africa in which transition is occurring at a whirlwind pace. Young people are bombarded with sex

messages mainly through television, movies, Internet, newspapers, magazines, advertising, popular music, school, church, the street, governmental organisations and non-governmental organisations. The evocative visual dimension of media images is significant: they are intended in my view to manage, control and effectively modify sexual behaviour in the era of HIV/AIDS. However, some of the messages are conflicting, and youngsters are torn apart in the process of having to determine how best to manage their sexuality (Kelly and Ntlabati, 2002). The electronic media, for example, only serves to intensify the confusion by linking glamorised sex with guaranteed ecstasy, success and satisfaction (Ferguson, 2004: 90).

Misconceptions related to HIV/AIDS are common among youth in their adolescent or pre-adolescent stages, as they grapple with rapid bodily changes while also experimenting with their sexuality. The misconceptions include equating love with sex; seeing sex as the only way of expressing love; assuming a girl cannot get pregnant the first time she has sex; boys engaging in sex as proof of manhood, or that saying 'no' to sex is not an option. De Rosset (2004) provides a variation of the last point when he zeroes in on the assumption that when a girl says "no" to sex, she actually means "yes". Such a view for example foregrounds the gendered response to sex.

Men have used the last two assumptions to force girls who are unwilling or unprepared into having, often unprotected, sex. Coy behaviour in females within boy/girl relationships sometimes results in the male partner coercing, forcing or tricking his girlfriends into having sex on the pretext that when a girl says "no" she really means "yes". A survey conducted in KwaZulu-Natal reveals that 36% of the girls were unwilling or coerced into their sexual debut (Manzini, 2001). A view held in both South Africa and Swaziland is that a boyfriend must use force in the first sexual encounter with a new girlfriend (Jackson, 2002).

A report by UNICEF *et al* (2002) points out that forced, first sex has been identified as one of the high risk factors for HIV infection among girls, coupled with the fact that their first sexual experience is often forced and coerced. And where forced or coerced to have

sex, young girls are more vulnerable to HIV infection than older females. The genital tracts of the former are underdeveloped and, therefore, more likely to permit entry of the virus should there be tearing or bruising of tissue during sex.

Misconceptions related to peer pressure are based on the assumption of the urgency and inevitability of adolescents engaging in sex. De Rosset (2004) illustrates this by listing some of the prevalent arguments circulating among this age group: sex is an expression of being in love; the sex drive cannot be controlled; sex is seen as an initiation rite into adulthood; and that sex is a test drive for sexual compatibility. Under such circumstances, abstinence or choosing not to have sex regularly, poses the social risk of being looked down upon by one's peers (Nzioka, 2001).

Peer pressure is the pivotal factor promoting this kind of thinking. With adolescents forging an identity in preparation for the adult world, peer pressure plays a significant role in influencing their thinking and actions. Through this form of pressure, boys are socialised to assume that sex is a necessary and an integral part of boy/girl relations. Not choosing to have sex poses the stigma of being despised by peers (Nzioka, 2001). Jackson (2002) points out that boys in some Southern African communities laud themselves as being heroic for being infected with STIs, which they regard as battle scars of sexual conquest.

Impregnating or fathering a baby may be seen as enhancing a boy's status by demonstrating further proof of his manhood, virility and sexual prowess (Nzioka, 2001). Some girls, for their part, view engaging in sex or falling pregnant as a way of cementing a relationship, or coercing sexual partners with a view to marriage (Nzioka, 2001). Conception implies unprotected sex, with its attendant risks of contracting HIV and other STIs. Many a boy has been known to blame an unplanned or unwanted pregnancy on the girl, whom he regards as 'stupid' for not taking the necessary precautions against conception. In such cases, boys do not accord high priority to wearing a condom since they place the burden of contraception squarely on the girl's shoulders. In this respect, girls often worry more about the obvious and immediate consequences of sexual activity

– pregnancy – rather than the silent entry and invisible multiplication of HIV in the body, thereby jeopardising her prospects of a healthy reproductive future.

A mindset of 'entitlement' prevails among the young men in some black townships, who see themselves as 'owning' girlfriends, despite not being married to them (Walker *et al*, 2004). Patriarchy, a system of social organisation in which the father is the head of the family, upholds the view that women and children are the property of their fathers and/or husbands. Cultural attitudes towards women and children as owned property may contribute to some cases of abuse, including sexual abuse that could lead to HIV infection.

A study conducted in Cape Town's Khayelitsha Township among pregnant adolescents aged between 14 to 18, illustrates sexual violence in boy/girl relationships, and how this is related to the entitlement mindset (Wood *et al*, 1996). The study findings reveal pervasive male control over almost every aspect of the participants' early sexual experience, gained through coercive and violent practices during sexual encounters. Resistance on the part of the girl often elicits verbal or physical assault.

The girls in this study observed that the act of forceful sex was painful because there was no preparatory foreplay to produce lubrication. (Forced intercourse is also a high-risk practice because, if a man is HIV-positive, his young partner may contract the virus through the resulting vaginal lacerations that occur in the absence of lubrication.) The risk is multiplied when a girl suspected of having other sexual partners is gang-raped by her partner's acquaintances in order to 'punish' her (Walker *et al*, 2004). Due to the hurried and often impromptu nature of rape cases, condoms are unlikely to be used in the sexual act.

Also, going against the grain of sexual and reproductive rights today is the pervasive belief that women and girls are mere objects of male sexual gratification (Ewing, 2003). In some instances, this view can be taken to extremes. For example, among young, black South Africans there is the widespread misperception that non-consensual sex (rape) is

not serious and is not a crime, but is rather considered part of normal sexual relations (Wood *et al*, 1996).

In cases where the girls do not provide sex on demand, it is a common practice for men to subject the young women to sexual violence. Such behaviour is a violation of the bodily integrity of the female. Yet a survey in 20 schools in KZN found a shared belief among schoolboys that women have no rights, or 'voice' (in other words, decision-making power) when it comes to determining sexual behaviour (Clarke, 2003).

Besides general ignorance about HIV/AIDS, complacency is a common factor that exposes adolescent girls to HIV infection. Disquieting findings stem from an HIV/AIDS impact assessment commissioned by the KZN Department of Health that appraised knowledge and modification of sexual behaviour in the province since 1997. This assessment covered a sample of 2662 respondents between the ages of 14 and 49 (Maurice Webb Race Relations Unit, 2004). From the total of 761 school children who were interviewed, a worrying response by some school children aged 14 and older was that there is no point to abstinence, or making efforts to retain virginity since rape is so common. Sexual activity among younger adolescents has implications for the spread of HIV since unprotected sex is often the rule, rather than the exception among them.

A cultural vestige of the past which persists today among many Zulus, is that boys are socialised to assume that pre-marital sex is a necessary and integral part of a boy/girl relationship. Non-penetrative premarital sex *ukusoma* (intercrural sex) among Zulu adolescents was socially condoned in the past, but today's sexually active adolescents of this ethnic group have dropped the age-old practice and instead engage mainly in penetrative sex. With *ukusoma*, the chances of contracting an STI were almost non-existent. But, in stark contrast, today's youngsters engage in unprotected penetrative sex of the vaginal, oral or anal kind, and have to reckon with the risk of contracting STIs.

Fieldwork conducted by (Wood and Jewkes, 2001) in Ngangelizwe, one of the oldest townships in Umtata (Eastern Cape), discloses that violent male practices such as

physical assault, forced sex and verbal threats are a common feature of sexual relationships. Due to poverty, boredom and the lack of opportuni for advancement, young people place a heavy premium in the few areas entertainment and success are achievable; notably their sexual relationships. For this reason, relationships become pivotal in gaining (or losing) respect and status among adolescent peers.

2.4 Regressing by way of culture

Culture, has also been associated with a significant number of misconceptions associated with the spread of HIV/AIDS. This subsection highlights how culture, in general, and youth culture, in particular, contributes to fuelling the spread of AIDS. The AIDS pandemic cannot be divorced from an understanding of gendered identities of masculinity and femininity, which are in fact largely propagated, instilled and shaped by culture, because it is becoming increasingly clear that existing masculinities and femininities are contributing to the spread of HIV infection. According to Morrell (2001) and Campbell (2003), constructions of masculinity are such that young African men in townships construct their manliness around sexual prowess. Three factors that form a significant link to this form of hegemonic masculinity and the spread of HIV/AIDS in South Africa are "insatiable sexuality, the need for multiple sex partners and a manly desire for the pleasure of flesh-to-flesh contact" (Campbell, 1997: 278). Such notions, as stated earlier, run counter to prevention measures, which hinge on protected, monogamous sex.

Another prevalent cultural belief is that men cannot do without sex. Shefer and Ruiters (1998: 39) encapsulate the sexual drive in what is considered a key aspect of essentialist hegemonic masculinity worldwide: "the notion that real men need sex; are focused on sex; are ever ready to have it; and that it is ultimately a biological urge outside their control". A survey that sampled 173 boys aged between 14 to 15 years of age in 20 schools in KZN, reinforced the existence of this misconception by uncovering the myth that a build-up of sperm could lead to 'madness' (Clarke, 2003). It is for this reason that some communities in the province hold the view that a boy's first wet dream signals the

need to indulge in his first sexual encounter. Among such communities, it is socially sanctioned that a boy only becomes a 'real man' at his sexual debut, which is deemed a rite of passage by his peers. However, crossing the line between childhood and manhood does not automatically go with the responsible sex attitudes attributed to adult thinking. Due to sexual inexperience the younger adolescents are less likely to use a condom and in the few cases where condoms are used, they are not always used correctly or consistently.

A major concern in the literature on AIDS is the double sexual standards that entitle men to have several sexual partners while women may not have more than one at a time (Jackson, 2002; and Walker *et al,* 2004). This draws attention to a global trend, where over 90% of women infected by HIV in developing countries are infected as a result of heterosexual transmission after sex with their one regular partner (Patz *et al*, 2002). The risk of getting infected with HIV increases with the number of sexual partners men keep and the number of unprotected sexual acts they participate in. Like Baylies and Bujra (2000), Patz *et al* (1999) advances that a woman's vulnerability to contracting HIV, is often the direct result of her partner's behaviour rather than her own. Besides having multiple partners, risky behaviour may include using alcohol or injectable drugs, or practising bisexuality. The primary HIV risk behaviour for both girls and women, therefore, is engaging in sexual activity. Wilton (1997), Doyal (1994) as well as Patz *et al* (1999) reinforce the following feminist motivation: that heterosexual intercourse has never been safe for women. According to these authors, the act of penile penetration puts women at risk of pregnancy, cervical cancer, and many sexually transmitted diseases, including HIV/AIDS.

Baylies and Bujra (2000) challenge this argument by advancing the view that heterosex (sex between men and women); with the men engaging in sex with multiple partners, is in fact the key driving force of the HIV/AIDS epidemic in Africa (see also Foreman, 1999).

Scorgie (2002: 65) highlights another aspect of sexual double standards reinforced by the practice of virginity testing which girls, and not boys, have to undergo:

> Where sexual responsibility for sexual abstinence is placed so unambigu shoulders of young girls, the implication that they are therefore also respo spread of the disease is only a short step away.

Cultural expectations of female submissiveness and male dominance i
and other areas of their lives limits many women's ability to exert control over their sexual and reproductive health. In a patriarchal society, women have either very little, or no control over their lives, their bodies, their reproduction or their destinies. This brings into sharp relief the issue of the lack of women's sexual and reproductive rights. In view of these shortcomings, some researchers highlight a common trend in patriarchal thinking that cuts across black Africa, in which women are often wrongfully blamed for being the source of STIs. In fact, HIV/AIDS can, in many African languages, be translated as "women's diseases" (Leclerc-Madlala, 1999; Smith, 2003; and Tallis, 1998). An unspoken, pervasive assumption that forges a recurrent theme concerning issues of reproductive health is that women are a "reservoir of disease" (Scorgie, 2002: 67). Ultimately, there is a stigma attached to an HIV/AIDS infection as well as feelings of guilt and secrecy.

Similarly, men have also been known to hold women responsible for mother-to-child transmission (MTCT) of HIV. Baylies and Bujra (2000) together with Jackson (2002) must be praised for going beyond the norm of blaming women for MTCT, to acknowledging the joint gendered possibility of infection through both maternity and paternity. According to Baylies and Bujra (2000: 3) the acronym 'MTCT':

> [...] turns a blind eye to the potential role men play in infecting women with the virus, yet the most significant mode of transmission in Africa is through heterosexual encounters. 'Parent-to-child-transmission' (PMTCT) is hardly acknowledged on the continent.

Meanwhile, in attempts to make sense out of the baffling, relatively new syndrome known as 'AIDS', people either blame it on witchcraft, or attribute it to disrespecting culture, rather than engaging in unprotected sex and other risky practices (Walker, *et al,* 2004). Lack of knowledge has contributed to the belief that AIDS does not exist, or that AIDS results from bewitching. Moreover, it is limited sexual education that brings about such beliefs as the notion that washing in Dettol disinfectant protects one against HIV.

2.5 Significant adults fuelling AIDS

Sexual misconceptions that predispose adolescent girls to HIV infection are not simply confined to misconceptions spread by young people, but also by adults. Within this context, 'significant adults' is defined as adults who play an important nurturing role in the lives of adolescents. A prevailing misconception is that adults and children should not discuss the taboo subject of sexuality. But, the price of adults' silence may be the premature deaths of young people through HIV infection. In this section, I extend the meaning to cover adults who either wittingly or unwittingly influence the young lives negatively through risky behaviour. For example, adults often choose to believe youngsters are sexually chaste, yet contradict themselves by strongly disapproving of pre-marital sex, which they consider to be inappropriate in adolescence. To keep them innocent, therefore, parents avoid advising youngsters about sex. Due to this gap in communication, children educate and misinform each other; in the process passing on myths or inaccurate information as facts (Ferguson, 2004).

On the other hand, adolescents find it difficult to raise the thorny topic of sex and sexuality with significant adults such as parents, teachers, religious leaders and health workers. There are also various reasons why adults offer either limited information or none at all on sexual and reproductive health to youngsters. A key reason for the knowledge gap is embarrassment, since the issues are shrouded in secrecy due to being associated with individual privacy and sexual intimacy among partners. The case of HIV and AIDS becomes even more awkward since these reasons are also associated with guilt, shame, sin, disease and death, and therefore have ominous moral undertones.

A second reason is that adults fear that talking to adolescents may encourage an early sexual debut, followed by continuous experimentation with sex, and possible promiscuity. Third, parents and other significant adults may themselves lack the relevant knowledge on the twin subjects of sexual and reproductive health, especially in relation to HIV/AIDS. Finally, adults may simply lack the adequate skills and training required to

impart information to young people effectively. These limitations could all distort the information passed onto the youth and have grave consequences for them.

Despite the reality that many adolescent girls are sexually active, which is evident through the occurrence of teenage pregnancies, parents and other adults cling to the illusion of this group's sexual innocence. Usually, a parent would like to imagine that his/her adolescent daughters will uphold the moral ideal of sexual purity (in other words maintaining 'virginity') until their wedding night. It might, therefore, come as a surprise to some adults that South African children engage in sexual intercourse at increasingly younger ages, with one out of every three having had sex by the age of 10 (CIET, 2004; Edward, 2000). However, it may come as a greater shock that young women aged between 15 and 24 are having more sex than their male counterparts, and that only a minority of all sexual encounters among this age group are unwanted (Pettifor *et al*, 2004).

An early sexual debut, however, poses multiple risks for HIV infection for young girls. For young women, their age at first sex is also a significant factor if early sex leads to pregnancy. Early sex also leads to a longer exposure to HIV in the event that the girls engage in unprotected sex. (Edward, 2000; Kelly and Ntlabati, 2002; Jackson, 2002). Moreover, adolescent girls engaging in early sexual initiation are more likely to have sex with older partners who pose a relatively higher risk of infection. And since young girls have limited negotiation skills, they are likely to be coerced into sex with multiple partners, and are unlikely to insist on condom use where partners choose not to.

2.6 Money and AIDS: inseparable bedfellows?

The imbalance of power and material resources between women and men may have adverse effects on the females' sexual and reproductive health, especially in situations of economic deprivation. Many poverty-stricken women in South African township settings, for example, do not have the social or economic power necessary to insist on condom use, or to determine their male sexual partner's fidelity, or to abandon partnerships that

places them at risk. In such circumstances adolescent girls, most of whom are usually unemployed or who are at the lower end of the economic ladder, are relatively more disadvantaged than their older female counterparts in their ability to negotiate safer sex.

At a global level, a prevalent myth associated with assigning guilt and blame to the spread of HIV in poor regions of the world, is because promiscuous, hedonistic or reckless people in these areas refuse to alter their lifestyles. Irwin *et al* (2003: 20) assert that the myth is based on the assumption that everyone can select from the same menu of options:

> The daily lives of affluent, educated people in wealthy countries do provide numerous opportunities to make choices [...] Yet while this model of personal choice may offer an appropriate lens for understanding middle-class behaviour in a consumer society, it distorts our view when projected into contexts of poverty, like those on the front lines of the AIDS crisis).

The above researchers emphasise that the language of sexual or lifestyle choices exaggerates the degree of agency that many people (especially women, and poor women in particular) are able to exercise. All too often the key factor hampering sexual choices is poverty, combined with other social factors such as inequality in the distribution of wealth and social power. The authors reiterate that poverty limits people's options for protecting themselves and forces them into situations of heightened risk. This means that if a girl receives money, clothes, food or other gifts from her partner, she is expected to reciprocate by being sexually available.

2.7 Conclusion

After reviewing empirical literature it is evident that women's disproportionate vulnerability to HIV infection, as compared to men, is compounded by social, cultural, economic, legal and political forms of inequality. This chapter explored the interface between sexual misconceptions and factors such as class, race, gender and age. In so doing, the chapter examined the following themes as they relate to sexual misconceptions: the biological aspects of reproductive and sexual health; culture in

general and youth culture in particular; girls' sexual agency; the roles significant adults play in fuelling the spread of HIV/AIDS; the economics of sex and the media. Though by no means exhaustive, an interrogation of the above themes could nevertheless make a significant contribution toward developing gender-sensitive interventions. I return to these themes in a little more details in **Chapter 5** in relation to my participants and their experiences within a gendered cultural context. In the following chapter, I examine a few theoretical concerns of gendered issues from a feminist viewpoint.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

For the purposes of this study a 'theory' is defined as a set of ideas or concepts designed to answer a question or explain a particular phenomenon. Frow (in Bennett *et al*, 2005: 348-349) explains that, in its contemporary usage, the term theory "designates less any particular set of systematic ideas than a politically contested attitude toward the use of abstract explanatory models in humanistic and social inquiry". The citation suggests that theory is integrally connected to making meaning in relation to a particular set of problems. Similarly, this chapter unpacks theoretical concepts through which sexual misconceptions are construed. The concepts include: power, gender, gender identity, gender roles and responsibilities, gender stereotypes, femininity and masculinity, patriarchy, age, class, race, ethnicity, sex, sexuality, reproductive health, HIV/AIDS . The argument in this chapter outlines how these concepts are associated with misconceptions likely to predispose African adolescent girls to HIV infection.

The theoretical framework, which is composed of two parts, focuses on feminist theory in relation to gender and power against the backdrop of behavioural change theories in the area of sexual and reproductive health. Gender differences are increasingly falling under sharp scrutiny as South Africa struggles to contain the alarming spread of HIV/AIDS. Given that gender permeates all aspects of social relations, an accurate analysis of personal and societal vulnerability to HIV/AIDS must take a gender perspective into account. This chapter demonstrates the significance of gender as a social, cultural and political category shaping the course of AIDS in the black township of Umlazi, where the respondents of this study are located.

3.2 A feminist framework

Feminism could be broadly understood to provide a theory, language and politics for making sense of gendered lives. The critical literature on feminism is vast, and rather than to restate and review the entire field in this study, I utilise the term here to refer to the context and knowledge of a particular group of people's experience of sexuality, reproduction, masculinity and femininity, all of which are underpinned by the question of power.[1] More specifically, the overall argument hinges on what is known as the *feminist standpoint theory*. This theory not only explores relationships between knowledge and power, but also the application of feminist epistemology that foregrounds stories (narrative aspects) that highlight the reality of gendered lives. Since the feminist standpoint theory is an overarching label for several feminist theories (with which this dissertation does not engage), I opt to focus on the feminist theory that addresses issues related to gender and power as espoused in Connell (1987). The theory will be motivated in relation to a behavioural change theory in order to reinforce the idea that theory and practice should ultimately lead to some form of agency.

By discussing the gender aspect of this framework, I proceed to define some of the key concepts, the first of which will be to delineate biological 'sex' from the social and cultural category of 'gender'. Helman (2000) points out that the binary division of humankind into 'male' or 'female' through biological attributes is simple since they can be verified empirically. Shefer (2004) on the other hand, employs the widely used definition to distinguish between sex and gender to point out that sex is a function of biology, while gender is a function of culture. She offers a broader definition of 'gender' as a concept referring to the social construction of intrinsic sexual differences between men and women. Shefer also infers that in the narrow sense, gender comprises the social roles and responsibilities assigned to men and women, coupled with their culturally construed feminine and masculine identities.

[1]Feminism is highly contested and may be broadly delineated in terms of liberal, radical, socialist, third world feminism, African feminism(s), and now in some instances, post-feminism. What is central to all of these strands of feminism (despite the cultural contexts in which they are framed), is the political, social, sexual, legal and cultural rights of women. By the latter I mean the oppression, subordination and discrimination that accrue to women based on patriarchal power.

Helman (2000), however, asserts that the gender constructs of 'masculinity' and 'femininity' are relatively more complex and vary from culture to culture. Shefer (2004) ventures a step further, claiming that though there is need to acknowledge that gender differences are culturally constructed, culture is not static. If anything, the differences are constantly changing.

The differences between gender identities and roles will become apparent in the argument through a number of factors which influence adolescent thinking. These include the generation gap between the young and the old; breaks with tradition; youth culture (through adaptation to modern trends such as the entertainment media and globalisation); legal changes that espouse gender equality under the current South African Constitution, and adolescent women's sexual agency. Holland *et al* (1992) maintain that the impact of the way in which sexual identities are constructed have important consequences for the negotiation of safe sex.

But where does feminist theory fit into all this? In order to answer this question, I define the term 'feminism' broadly as a conceptual framework to make sense of the unequal distribution of power between men and women. Feminist gender analysis plays an important role in examining the power relationship between men and women, and its consequences. In the areas of health, gender analysis questions and challenges how the social roles ascribed to males and females influence their sexual behaviour and their health (Cottington and Mynthi, 2002). Both gender roles and identities impact on sexual and reproductive health. Such analysis also illustrates how the social system, at the public and private levels, incorporates inequalities of power between men and women. Analysis at this level enables me to examine the Umlazi adolescent girl's socially defined roles and the relative powerlessness that determines her exposure to the risk of HIV infection. In addition to this, gender analysis will shine light on how boys and men are socialised in their outlook and behaviour towards women, and how related sexual misconceptions have an impact on sexual and reproductive health.

According to Shefer (2004), most gender theorists assume that the term 'gender' sums up a notion of power inequity as viewed through feminists' eyes. Shefer defines 'feminism' in a more comprehensive way to comprise a large and diverse body of work that broadly questions women's subordination in male-dominated societies, with a view to challenging gender inequality. My argument adopts this broader definition of feminism while focusing specifically on the area of sexual and reproductive health in relation to HIV/AIDS. Though adolescent women's bodies (from the ambit of reproductive health) remain central in this study, I simultaneously remain attentive to the influence and impact of men.

Similarly, this study calls into question how manhood, coupled with diverse masculinities, is in flux. The study, through descriptions and analysis of my respondents' views show how masculinities have implications for adolescent girls' sexual and reproductive health. In this regard my study demonstrates how such masculinities are acquired, developed, maintained, changed or abandoned altogether.

The concepts of 'femininity' and 'masculinity', however, cannot be divorced from people's ways of thinking, acting and interacting when it comes to the intricacies of sexual and reproductive issues. In the argument I investigate the impact of patriarchy in the lives of my respondents in Umlazi. In this setting, however, women's sexual and reproductive health can hardly be detached from a pervasive masculinity which could be defined as hegemonic. Deriving his concept of 'hegemony' from Antonio Gramci's analysis of class relations rooted in cultural dynamics, Connell (1995:7) explains:

> Hegemonic masculinity can be defined as the configuration of gender practice which embodies the legitimacy of patriarch, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women.

In this project I acknowledge, however, that men are not a homogenous group, a reality that is not always reflected in feminist writing that often lumps men and masculinities together as if they all fall into a hegemonic category. I will stay away from the kind of

feminism that makes blanket statements concerning not just masculinities, but femininities as well.

In addition to the issue of hegemonic masculinity, Connell (1995) points out that gender cannot be divorced from class and race, which makes gender politics one of the main determinants of the collective fate. This appraisal fittingly applies to the AIDS pandemic in Africa in particular, where the key mode of HIV transmission is through heterosexual sex, largely – but not solely – affecting people at the low end of the economic ladder, a majority of whom are people of African descent. All these determinants feature in the spread of HIV/AIDS in the Umlazi Township, and they become apparent in the chapters that follow.

In writing this chapter I found that attempts to identify a single theory to explain the intricacies of HIV/AIDS in relation to sexual misconceptions that predispose African adolescent girls to HIV infection, in a township setting, proves futile. An extensive literature search only underlined the impracticality of such an undertaking. An author who argued along the same lines is Berger (2004: 46) who observes that though the discourse of gender vulnerability provides a necessary starting point for developing intervention programmes, such analysis is incomplete due to the nuanced nature of the subject:

> By telling part of the story as if it were the entire story, the vulnerability picture often painted is inaccurate and misleading.

Such a discourse, Berger (2004) declares, contradicts the increasing recognition that there is no single explanation for the HIV/AIDS epidemic. According to Campbell (2003), various perspectives form an essential framework for the kaleidoscope of factors that are implicated in the development and persistence of the HIV epidemic in developing countries. Due to the complexity of factors, I have chosen to consider behavioural change theories in tandem with feminist theory in this study.

I acknowledge that though the contribution of gender as a conceptual framework in HIV/ AIDS is critical, other theories also have strengths and relevance that enhance understanding of the vulnerability of adolescent women to infection. Hence, my inclusion of behavioural change theories in the following section in this chapter.

3.3.1 Multi-faceted theoretical perspectives on AIDS

This section probes socio-psychological factors associated with sexual misconceptions that influence the spread of HIV/AIDS among African adolescent girls. The section offers a brief overview of several theories of behavioural change that are commonly used in intervention strategies. Among the key objectives of studying sexual misconceptions that predispose African adolescent girls to HIV infection, is how the findings could be incorporated in intervention. Intervention is geared to behavioural change through the prevention, control and management of HIV/AIDS. Understanding the root causes that influence behavioural change among this age group is critical in HIV prevention and control strategies. Many of today's behavioural change strategies in the context of HIV/ AIDS are based on social psychology theories or models (Airhihenbuwa and Obregon, 2000; Ross and Deverell, 2004; Skinner, 2001). With the realisation that no single theory can explain all the root causes of the existing sexual misconceptions related to AIDS, I have chosen to bring together the following theories considered to be among the most important models of behavioural change in the AIDS context: the Health Belief Model (HBM); The Theory of Reasoned Action (TRA) and the Social Inoculation Theory (SIM).

3.3.2 Health Belief Model (HBM)

The Health Belief Model views health behaviour as a function of an individual's beliefs and attitudes. The theory behind the HBM is the assumption that people fear disease and that the degree of fear or perceived threat motivates them to take the necessary action (Rosenstock, Stretcher and Becker, 1994). The model, which focuses largely on the individual's perceptions, was among the first to adapt theory from the behavioural

sciences for health problems. It remains one of the most widely recognised conceptual frameworks of health behaviour. The HBM predicts an individual's perceived seriousness of the disease; severity of the disease; perceived benefits of services, and barriers to accessing the services (Airhihenbuwa and Obregon, 2002). This model was introduced in the 1950s by psychologists to explain why people did not participate in health screening and prevention, with particular reference to tuberculosis screening and immunisations. More recently, the HBM is increasingly used to gain a better understanding of sexual risk behaviours and the spread of HIV/AIDS (Family Health International, 1999). In this study, the HBM points to the need to translate knowledge about the potential danger of exposure to HIV into recognising that one is at risk of infection.

3.3.3 Theory of Reasoned Action (TRA) Model

The Theory of Reasoned Action (Fishbein and Ajzen, 1975) assumes that individuals are rational and will, therefore, make systematic use of information available to them. Linking an individual's beliefs, attitudes and intentions to engage in a certain behaviour, the theory presupposes people will consider the implications of their actions before they decide to engage in a given behaviour. A key limitation of this theory, however, is the assumption that individuals are rational in their decision-making behaviour which, when it comes to sex and sexuality is driven by emotions. A number of researchers (see Campbell, 2003; Walker *et al,* 2004; Skinner, 2001) repeatedly ask the same question: why people knowingly engage in risky sex and gamble with the possibility of contracting HIV. The sexual misconceptions discussed in this dissertation offer perspectives on the numerous answers to this question.

The Theory of Planned Behaviour (TPB), which builds on the TRA, links attitudes to one's behaviour, rather than to the objects of the behaviour (Skinner, 2001). An example would be to ask an adolescent girl about her attitude to using a condom with her partner during sex, rather than her attitude towards condoms in general. Such an approach elicits greater precision in the research context. Another limitation of both TRA and TPB is that they are too individualistic when it comes to behavioural decision making: they fail to

take into account environmental factors that contextualise and ground sexual activity. In other words, the idea that sexuality is embedded in contexts of meaning is valuable when considering how sexuality is negotiated in sexual relationships.

3.3.4 Social Inoculation Model (SIM)

In recognition of the fact that an individual does not operate in a vacuum, my study goes beyond the individual by drawing on the Social Inoculation Model (SIM).This model explains how society and social groups affect and are influenced by the attitudes and behaviour of others. I select this model over one other traditional approach to prevention, namely the information model. Though the latter has been used extensively, it has nevertheless attained limited success. The information model is based on the assumption that providing people with factual information about a potentially risky behaviour will prevent them from engaging in it. It hinges fundamentally on fear arousal, and emphasises the negative aspects of an individual engaging in a particular behaviour. Recognising this limitation, Evans *et al* (1978) conducted a pilot study that supplemented fear arousal messages with information on how social influences or pressures push young adolescents into smoking. Based on the results of their study, the researchers introduced the Social Inoculation Model (SIM), and this model has since been used globally for the past two-and-a-half decades in behavioural health intervention.

The key strength of this model is that it recognises that peer influence plays a key role in influencing health behaviour. Research conducted by Nduati and Kiai (1997) in Eastern and Southern Africa shows that peers are an important source of information or misinformation. Therefore, in understanding issues of their sexual and reproductive health, we cannot ignore peer influence in relation to HIV and AIDS issues (Family Health International, 1999). The limitation of SIM is that it overemphasises the role of peer pressure and ignores the fact that individual attitude and intentions also influence behaviour. Criticism levelled against SIM is the assumption that individuals are passive; that their behaviour is influenced only by factors outside their control.

3.5 Conclusion

Though the HBM, TRA and SIM models provide explanations on behavioural change, the three, however, do not capture all the elements required for behavioural change in the context of AIDS. This study adopts the Merged Factor Model (MFM) for a better understanding of how behavioural change occurs. MFM combines the strengths of variables identifies in HBM, TRA/TBP, and SIM, and combines all of these to explain how behaviour change occurs (Family Health International, 1999). In addition to this, MFM includes other factors not identified by the theories, such as the influence of sexual partners in intimate relationships. The MFM emphasises that partners in such relationships have considerable influence on each other's health-related behaviour. The theories I have chosen to utilise in this study will reinforce a gendered approach to factors exacerbating the spread of HIV/AIDS. I examine the strengths and weaknesses of each since none provide all the answers.

This chapter reviewed only relevant theoretical perspectives and their application as to how sexual misconceptions that predispose girls to HIV infection may be interpreted and changed. Since my study also probes the thinking underlying sexual behaviour, I touch on behavioural change theories that influence cognitive learning, thoughts, emotions and personality linked to human sexuality. Each theory contributes unique insights into understanding the complex, multi-faceted nature of sexual and reproductive health in the era of HIV/AIDS. All the theories are connected by a feminist perspective on related gender issues.

CHAPTER 4

RESEARCH METHODS

4.1 Research design

In the previous chapter, the argument reiterated the hypothesis that the high prevalence of HIV infection could be partially attributed to subscribing to sexual misconceptions, which leads to people engaging in risky sexual activities (Walker *et al*, 2004; Nduati and Kiai, 1997). The research methodology employed is qualitative in design. This methodology goes beyond a focus on description to look for causes and reasons related to the subject under investigation. Rather than to simply apply quantitative research, which employs hard facts and statistical analysis for the purposes of generalisation, the methodology used in this study is an in-depth understanding of individuals' experiences.

A qualitative approach is also utilised to identify the social processes that need to be understood when considering HIV intervention. In so doing, my overall argument makes a link between adolescent girls in the African township of Umlazi, their immediate environment, and the broader social, economic, cultural and political forces at work in their lives. This approach acknowledges that the functioning of society is best understood when observed in the context of how individuals interact with each other – be it in immediate groups such as families and peers – with the community, with organisations, or with institutions such as schools or churches.

The methodology I employ is geared to explore a range of meanings about sexuality and culture in relation to the construction of identities, with a view to interpret factors that would be difficult to capture in a quantitative survey. Though numbers in surveys have the advantage of being more 'exact', some kinds of responses cannot be elicited using quantitative data alone. Subjective factors such as opinion, attitude, personality, emotion, motivation, interest, personal problems, mood, drive and frustration are relatively more

complex, and hence more difficult to capture quantitatively than variables that can be empirically verified (Baumgartner and Strong, 1998). The expressive language used in qualitative research provides a far more sensitive and meaningful way of recording human experience by using words and sentences to qualify and record information about the world (Babbie and Mouton, 1998; Bless and Higson-Smith, 2000). Such language, which this study so heavily relies on, prioritises more than just the facts and figures predominantly used in quantitative research.

Critics of the qualitative approach to data collection point out that the findings are of limited use since they cannot be generalised, due to the small sample size involved. While it is true that, to some extent, the findings of qualitative research cannot be generalised in the same way as in quantitative research, I would argue that the findings can nevertheless be used to generalise – to some degree – without relying on the statistical analysis that is characteristic of quantitative surveys. One way qualitative data could be used to generalise, is by identifying the forces that underlie individual and group behaviour (UNAIDS, 1999a), for example. The UNAIDS also points out that generalisation could be applied in qualitative research, citing the importance of the contribution of cultural and historical forces to patterns of behaviour. Another way qualitative findings could be generalised is by revealing institutional imperatives in a community such as school rules or religious prohibitions. If this kind of definition for generalisation is used, then it lends my study the capacity for wider application. It does so by enhancing the understanding of the circumstances likely to predispose adolescent girls to the risk of HIV infection in other African townships since the youngsters have a similar cultural background.

4.2 Project area

As mentioned earlier, the study was conducted at Ogwini Comprehensive Technical School and its environs, which is located in Umlazi Township on the outskirts of Durban. I repeat some necessary facts about this location. Umlazi is a predominantly Zulu-speaking, peri-urban, low-income community. The township is based in South Africa's

epicentre for the HIV/AIDS pandemic: KwaZulu-Natal has the highest HIV prevalence (40%) of all the country's nine provinces (Department of Health, 2005).

4.3 Study sample

The study focuses on adolescent girls at Ogwini Comprehensive Technical School aged between 15 and 19, with the exceptions of two young women aged 20 and 21 respectively, who are still at school. The older girls had a valuable contribution to make to the subject under discussion since, in their narratives (to be explained later), they focus largely on their sexual experiences spanning the years between the ages of 15 and 19. This is a period in which most girls have made their sexual debut. As pointed out earlier in this dissertation, adolescent girls aged between 15 and 19 comprise a special interest group because they are among South Africa's fastest growing high risk group for HIV infection.

The sample was identified based on the 15 to 19 age group's vulnerability to HIV infection. In South Africa, as in the rest of Sub-Saharan Africa, more women than men are HIV-infected, of which women contract the virus at a younger age than men, and die younger (UNAIDS, 2000a). In contrast, AIDS deaths among women in the Sub-Sahara peak in their 20s, while peaking in men in their 30s or early 40s (Jackson, 2002). Studies conducted in this region indicate that girls aged between 15 and 19 are five or six times more likely to be HIV-positive than boys their own age (UNAIDS/WHO, 1999). UNAIDS (2004) reports that a possible explanation as to why 75% of HIV-infected youths in Sub-Saharan Africa aged between 15 and 24 are girls and young women, is because females – more than males – are relatively more vulnerable to poverty, sexual exploitation and sexual violence. These factors, as the literature review in the last chapter demonstrated, are common in a township setting, of which Umlazi is a part.

I employed the snowball sampling technique to recruit interviewees, with high school students identifying fellow students they believed were sexually active. Snowball sampling, a non-probability sampling procedure, permits the investigator to identify

eligible participants by relying on previously identified eligible particip
However, due to stigmatisation founded on moral judgment that deci
adolescent girls should not be sexually active, several participants identified were a
to stress they were still virgins.

The choice of Ogwini Comprehensive Technical School as the base of my field research was partially because the school was among others participating in a provincial quantitative survey I was working on at the time, as a research intern, while studying for my Masters. Originally, I had planned for this study to piggy-back on the survey: an impact assessment of programmes of the HIV/AIDS Unit under the KZN's Department of Health. Initially, my aim was to conduct both quantitative and qualitative research under the umbrella of 'Youth in Schools', which is among the Unit's 11 programmes. However, due to budgetary and time constraints, I scaled down my fieldwork to a qualitative study focussing specifically on Ogwini.

4.4 Data collection methods

This study of sexual misconceptions employs methodological triangulation, in which multiple methods are used to study a single problem by searching for similar evidence from different sources (Terre Blanche and Durrheim, 1999). The study employs three qualitative data collection methods, the main two being the focus group discussion and in-depth interviews of individuals. I conducted five focus group discussions comprising an average of six girls each, and in-depth interviews with 25 girls. I also used the observation method, but only to a small extent since working full time did not permit me to be away from the office for unlimited periods.

To improve the quality of my information I initially intended to spend many hours in Umlazi Township to observe some of the interviewees as they engaged in activities beyond the school setting in particular, and youth culture in general. I had planned to conduct unobtrusive participant observation in venues where youngsters hang out, such as the home, places of worship, market places, shopping areas, community halls, sporting

events and other venues of entertainment. Again, due to budgetary and time constraints, I was unable to do so. Instead, I had to be content with face-to-face observation, and studying respondents' body language to determine how they felt about the sensitive topic under discussion, and how they prompted me to re-phrase certain questions to make them more user-friendly when they were either uncomfortable, or reluctant to answer a question.

Negative indicators included a grimace, frown, change in tone of voice, nervous body movements and sitting uncomfortably at the edge of the seat, all which called for caution in handling the questions. Positive indicators, such as a smile, chuckle, laughter, friendly or a very relaxed tone of voice, joking, and sitting back comfortably and enjoying the interview, were all signs that the respondent and I as an investigator had established a rapport. The latter was vital since the quality of data gathered, largely depends on how the subject being interviewed feels about the interviewer.

When considering what research methods would be most appropriate for exploring the highly taboo topic of adolescent sex and sexuality in relation to HIV/AIDS, I settled for the qualitative approach rather than the quantitative approach for a number of reasons. While quantitative research readily allows the researcher to establish relationships among variables, it may often be inadequate to explore the reasons for those relationships. Whereas quantitative research is concerned with large-scale data collection gathering aimed at drawing representative data sets, qualitative data focuses on exploring in detail smaller numbers aimed at achieving 'depth' rather than 'the breadth' characteristic of quantitative research (Punch, 1998).

I chose to capitalise on the social dynamics guiding focus group discussions to generate a rich understanding of participants' beliefs and experiences. Qualitative methods provide context and depth; offer opportunities for exploration and discovery, and facilitate interpretation of hard facts (Krueger and Casey, 2000). Since certain disclosures will not be made in a group discussion for fear of public censure, I also employed individual in-depth accounts in the study. The focus group discussions took up approximately an hour

and-a-half each, while individual interviews ran from between 45 minutes to an hour and 15 minutes in length. Both the discussions and the interviews were recorded on audio cassette.

Initially, the age difference between my research subjects and I was a source of concern. I wondered whether they would 'open up' to discuss sex-related matters with someone old enough to be their mother. The barrier was bridged fairly easily as I fell back on my journalistic training, which requires not only striking up a conversation with virtually anyone, but also the ability to elicit and uncover relevant and interesting information. Within each interview and focus group discussion I tried to establish friendly and non-judgmental relations with the young people I was researching, which created a good rapport between us. Consequently, in some of the in-depth interviews and focus group discussions, the interviews went over the scheduled times.

The fact that I was a foreigner (a stranger in some respects); someone who resided in another part of town, and a non-Zulu speaker, reinforced information gathering from respondents, because I was unlikely to know or communicate directly with their mothers, aunts and local health workers to whom I could divulge the intimate, personal details under discussion. Being female also proved to be advantageous as discussions on sex and sexuality would probably have been more uncomfortable had the interviewer been male.

I chose the qualitative approach, specifically from an interpretivist perspective. This paradigm holds that an individual's world is constructed, interpreted and experienced through their interactions with each other and with the wider social systems (Ulin *et al.* 2002). In this process qualitative research focuses not only on objectively verifiable facts, but also on many subjective meanings that people attach to them. Seen from different perspectives, reality is subjective and multiple, with meanings derived from perceptions and behaviour stemming from the social context in which individuals operate. Such thinking is fundamental to understanding how sexual misconceptions are constructed and circulated.

The interpretivist paradigm is one of three paradigms generally used for researching sexual and reproductive health. The other two are the positivist and the feminist approach. The positivist approach views the social world as comprised of observable facts, with reality being objective and independent of the researcher. On the other hand, the feminist paradigm conceives the social world as being governed by power relations that influences perceptions and behaviour. For the purposes of this study, I combine the interpretivist and feminist paradigms for discussions on sexual issues that largely hinge on gendered power relations. Here the feminist, interpretivist paradigm is instrumental in interventions designed to improve the quality of life for African adolescent girls as they negotiate their sexual experiences, which are fraught with the risk of HIV infection.

Babbie and Mouton (1998) quote Sandra Harding – an advocate of critical feminism – from the standpoint of epistemology to question the capacity of social science research to address the experiences of women adequately. Together with other feminists under this category, Harding challenges the assumptions that existing methodological approaches are adequate in eliminating or reducing the androcentric (or male-centred) bias in the bulk of current research. Harding takes issue with such research because it presumes the social identity of the observer is irrelevant to the quality of the results in the research process. The feminist paradigm has the additional element of amplifying the personal accounts of subjects to reflect their individual versions of reality. Through the subjectivity of this approach I am able to capture the distinct and discernable voices of adolescent girls as they discuss their lives. This is in keeping with one of feminism's key concerns: to give a voice to the voiceless. 'Giving voice' enables me as the researcher to remain attentive to my respondents' experiences.

I deliberately steered clear of the positivist paradigm for researching sexual and reproductive health since it centres on quantitative data collection methods such as surveys, clinical trials and rating scales, which are pre-structured. Under this approach facts are arrived at through standard scientific processes, and, therefore, too rigid to allow for probing further for clarification or additional information. Besides, this form of

scientific inquiry is largely context-free since it does not offer investigators the opportunity to study their subjects in natural settings.

Qualitative research goes beyond this to become an exercise of human interaction on a very personal level on the sides of both the research instigator and participant. In keeping with the qualitative research tradition, I attempt to study human action from the "emic" or insider's perspective (Babbie and Mouton, 1998). My interpretation of the Ogwini schoolgirls, their behaviour, and the words they use to express the realities of their lives form the basis of my approach to this methodological project.

To gather the data I had to carefully consider which tools would be most appropriate to elicit the information. For both the in-depth interviews and the focus group discussions I used a semi-structured questionnaire and divided it into themes (see Appendices: annex 1 and 2). The first section comprises standard typical questions on age, education level, and economic background. The second section consisted of exploring questions regarding specific themes geared to elicit sexual misconceptions that are rife among adolescents in particular, but also in the community at large. In an attempt to heighten understanding on gender, sexuality and the HIV/AIDS epidemic, the questions probe into human emotions, values, processes, relationships, behaviours, activities and trends. Questions include sexuality indices such as age at first intercourse, number of sexual partners and patterns of contraceptive use.

Other questions centre on gendered identities, for example, how masculinities are constructed in the areas of sex and sexuality. Some questions touch on how gender relations respond to increased awareness on STIs including HIV and AIDS, and the consequent behavioural change or lack thereof. Another set of questions dissect how gender relations that put girls at risk of HIV infection are perceived and played out in equity and equality issues. There are also questions dealing with communication and negotiation over sexual decision-making in safer sex.

All the in-depth interviews and focus group discussions were conducted in the medium of English, and those who could not find the appropriate words in English used Zulu instead. The use of English as the medium of communication has the additional advantage of possessing key terms used in discussing adolescent sexuality. Zulu terms relating to the taboo subjects of sex and sexuality are hardly ever spoken out aloud since, according to Zulu speakers, these terms sound vulgar in the vernacular. The semi-structured questionnaire used in the misconceptions study was piloted to assess the adequacy of the research design in relation to the data collection instrument. This allowed for corrections to the original instrument.

4.5 Data analysis

The sexual misconceptions are categorised according to themes in the analysis, and interpreted to show the link between belief in the misconceptions and the spread of HIV/AIDS. The units of analysis are the individual schoolgirls themselves, and groups of schoolgirls who comprised focus groups discussions. The data analysis affords me the opportunity to identify new themes that were not pertinent in the literature review, while exploring similarities and differences in adolescent girls' thinking about sexual misconceptions. The data analysis provides further opportunities to hone in on detail, elucidate arguments and draw up recommendations. The analysis interprets the data gathered for the purpose of drawing conclusions that reflect the interests, ideas and theories that initiated the inquiry. Validity of the information gathered, using the abovementioned three data collection instruments, will be verified by analysing available secondary and tertiary information sources.

4.6 Research ethics

The ethics of privacy, confidentiality and anonymity (Neuman, 2000) were strictly respected in both the approach to my research topic and the execution of the study. Each respondent, for example, was assured that their identities would be protected. This is reflected in the study's naming system for reporting purposes, where each girl chose a

pseudonym. Due to the sensitive nature of the research topic, some girls had to be repeatedly assured of anonymity and that the information they were providing would not be shared with their teachers. Extra effort was made to secure a private space to hold in-depth interviews in the township school setting, which hardly had available rooms during school hours. This was achieved through juggling the times of interviews with both students and the teachers who facilitated my research, and even then there were constant interruptions as students or teachers walked in, which resulted in the interviews being suspended temporarily.

The principles of informed consent were also applied to this study, and consequently I ensured all my research participants' ages did not fall below the legal limit of 15. The South African government requires that children aged 14 and under must have the approval of their parents or guardians before being interviewed.

Ethical concerns also have implications for the dissemination of data findings once a study is complete. A researcher owes it to respondents to give them feedback and the findings of data gathered from them. As a result, I pledged a copy of my dissertation to Ogwini Comprehensive Technical School where the research was conducted, and promised to do a follow-up presentation and workshop of the findings at the school. In the following chapter I return to an analysis of the data.

CHAPTER 5

DATA ANALYSIS AND DISCUSSION

5.1 Introduction

This chapter discusses the findings from my fieldwork that elicited data on misconceptions that predispose girls to HIV infection. The chapter draws largely from my focus group discussions and in-depth interviews conducted with pupils at Ogwini Comprehensive Technical School in Umlazi Township. To reflect the respondents' thinking, their quotations are cited verbatim as opposed to being edited for grammatical errors or logic.

An understanding of HIV infection in relation to adolescent girls' reproductive health begs an examination of the relationship between biological sex and socially constructed gender roles, which are often inextricably intertwined. Using a gender lens to interpret this relationship, this chapter focuses on misconceptions as they relate to various themes. The first section focuses on sexual misconceptions linked to biomedical aspects of reproductive health. The second section centres on culture in general, but youth culture in particular. The third explores the girls' sexual agency, while the fourth surveys the economic backdrop of HIV/AIDS and its possible impact on the lives of my respondents. The fifth investigates the role of significant adults in the spread of HIV/AIDS among adolescents. The sixth, seventh and eighth segments focus on the media and HIV/AIDS; sexual orientation, and gender-based violence respectively. Some of these themes overlap in the ensuing discussion.

5.2 Biomedical aspects of AIDS

The focus group discussions and in-depth interviews yielded several misconceptions related either directly or indirectly to the risk of HIV infection. Numerous misconceptions were rooted in the biomedical aspects of reproductive health. A number of misconceptions, for example, stemmed from a flood of responses over what the Umlazi Township adolescents think about pregnancy, which connotes unprotected sex.

Unprotected penetrative sex is a high risk practice for HIV infection and other STIs, unless sexual partners who are HIV-negative remain in a monogamous relationship. Where one partner is HIV-positive, the couple risks parent-to-child transmission of HIV, if they have any children. The first part of this section deals with pregnancy and related concerns.

In one focus group discussion, for example, uncertainty arose over the age at which a girl can fall pregnant:

> *Portia:* I don't really know the age. I'm not really sure, but I think it's from the age of 10 upwards. Some girls I know get pregnant at a very early age, say, 10-16 years. When I ask them why they get pregnant, they say: "I love my man so I have to keep him." That's not good.
>
> *Jessica:* A nine-year-old could have sex with a seven-year-old, but she can't get pregnant. Boys before puberty can have sex, but that is meaningless sex because a girl cannot get pregnant.
>
> *Cindy:* To them it's not sex, it's nothing serious, it's like something they see on TV. It is meaningless sex. I think she could get pregnant from 13 or 12 years and above, I'm not sure.
>
> *Desiree:* Sometimes they get pregnant at the age of nine.
>
> *Sarah:* I'm not really sure, but I think it's at the age of 10, when she gets the first [menstrual] period, which is the sign that she is ready to bear children.

It took the focus group members five attempts before the question was answered adequately, with more than half the respondents replying: "I'm not sure [...]". It is only Sarah, aged 15, who – despite acknowledging she "is not sure" – finally points out that menses are a sign that a girl has entered her child-bearing years. According to Portia, some girls as young as 10 mistakenly believe the only way to keep a man is to have sex with him. In a relationship, males demand sex as proof of love, and adolescent girls fall for this ploy frequently.

Jessica and Cindy talk of "meaningless" sex, which the latter believes is "not serious". However, seemingly "meaningless sex" could have negative short-term and long-term public health implications. An adolescent could contract STIs, which may include HIV

infection, in their adolescence, if they engage in unprotected sex with multiple sexual partners. This thinking emphasises a misconception that McDowell (2002: 127) labels as "no consequence sex". McDowell explains that "no consequence" applies when it is assumed no one pays the price for sex. Yet, in real life people pay dearly in terms of unwanted pregnancy, STIs and even AIDS-related deaths. People are deemed mere objects to use for personal gratification under "no consequence sex".

Girls also seek sexual gratification in secret, hoping not to fall pregnant. But, what was sex in secret becomes public, if conception occurs, and a fatherless child is born of the union. This matter will also involve family members for years to come. Daughters of unwed mothers are likely to follow in their mother's footsteps and have children out of wedlock. Likewise, sons are likely to imitate their fathers' behaviour, in the instances where their fathers are not present and had multiple sexual partners. A key informant in this study, 33-year-old Island Luthuli, who spent most of his life in Umlazi's P Section where my fieldwork was conducted, has this to say: mothers in Umlazi who have children by different fathers (at times up to four men) provide a negative role model to their children. Children in turn imitate the actions of their parents, who provide either positive or negative role models.

During this discussion on pregnancy, another respondent points out that thanks to being naïve or overly optimistic, girls mistakenly think that despite having unprotected sex, "it can't happen to me". This is especially the case during girls' sexual debut. Many girls bank on the assumption that one cannot fall pregnant the first time one engages in sex. According to a respondent:

> *Palesa:* Some girls say: "If I am doing sex one day, I do not get pregnant." But that is wrong. If you do sex [on only] one day, you can get pregnant.

However, there are occasions where girls can fall pregnant before having experienced their menses.

Arguments about contraceptives feature among respondents' discussions on pregnancy and STI prevention, as seen in the exchanges below:

> *Philile:* Some girls use preventing pills, like Morning-after Pill, and other pills, daily.
>
> *Cindy:* If there's a guy a girl really trusts – the ones she likes more than other guys and is really sure of– with this one she won't mind if she doesn't use protection.
>
> *Jessica:* Injections. But I wouldn't advice anybody to use injections. You know, a woman or a girl should have a strong (sic firm) body, rather than going around in a [flabby] old body, which is disgusting. The injection does something to your body so it gets to be jelly-like. It's so-o-o-o disgusting!

Like other respondents in the Ogwini study, Cindy observes that some girls are more likely to use condoms with secondary sexual partners than primary partners. In so doing, these girls place their primary partners at risk of contracting STIs, because they view trust and their confidence in their partner's love as a safeguard against contracting STIs. Or conversely, insistence on condom use could be interpreted either as a lack of trust of their sexual partner, or infidelity on the part of whoever insists a condom should be used.

Though different contraceptives offer a measure of protection against pregnancy, they do not generally protect against HIV and other STIs. In the above case, Jessica uses the word "disgusting", which she exercises repeatedly as though she cannot over-emphasise the abhorrence she feels for flabby bodies. Jessica believes that the bloated, prematurely ageing bodies of some females are among the pitfalls associated with the use of the injectable contraceptive, Depo Provera. A trim body, as is indicated by Jessica and other respondents in two different focus groups, is a prerequisite for many adolescent girls in the Umlazi township. This image consciousness is in keeping with modern ideals of what the female body should look like, which is promoted by both the mass media and the advertising industry. To keep trim, therefore, some girls are prepared to forgo using the contraceptive injection, and in the process chance pregnancy through unprotected sex. Girls making such a decision may unwittingly contract HIV. Likewise, some adolescent users of injectable and oral contraceptives hold the erroneous belief that, like condoms, these contraceptives will protect them against HIV. Though they play a key role in controlling fertility, injectables do not safeguard against HIV and other STIs at all.

A majority of girls in the focus groups endorse condom use as dual protection against pregnancy as well as STIs. Unless specified otherwise, the 'condom' referred to in this chapter and elsewhere in this study refers to the male condom as opposed to the female condom. Because the female condom is 10 times more costly than the male condom, and due to a lack of product awareness, relatively few couples use it:

> *Desiree:* Most girls I know, when they have sex, they use condoms.
>
> *Jessica:* Girls aged between 17 and 20 would actually prefer using a condom, or just abstain from sex.
>
> *Jessica:* Some guys believe that: "I can't have sex with a plastic; condoms are like plastics." They want to have that connection, like, skin-to-skin [flesh-to-flesh sex]. Some guys might say, "You can't eat a banana with its peel" or a "sweet with its cover."

The 'banana' and 'sweet' arguments, which sound plausible, nevertheless accord higher priority to sexual pleasure than a commitment to safer sex.

Asked about girls' attitude towards condoms, Penny – one of the respondents – offers a reply with a twist, in the process questioning the assumption that it is only men who insist on sex without condoms:

> *Interviewer:* Why do some girls not want to use condoms?
>
> *Penny:* They [girls] want "inyama inyameni" (flesh-to-flesh) sex.

Though condoms may minimise sexual pleasure to a certain extent, they do not eliminate pleasure completely, as suggested by those who insist rather on unprotected sex on the grounds mentioned by Penny.

Ogwini respondents point out situations in which adolescents misguidedly use two male condoms for double protection during penetrative intercourse. On the contrary, being this careful may actually achieve the exact opposite of the desired effect. Friction during penetrative sex may result in the condoms tearing. A similar effect occurs when heterosexual partners use both the male and female condoms simultaneously during sex.

Preserving one's virginity, another method of avoiding pregnancy, generates frenzied debate among respondents in various focus group discussions. For example:

> *Mandy:* I've heard from a friend of mine that virginity is not easily lost. They say if you put ice in your...[pause] your thingy...[pause] your private part, you become a virgin again.
>
> *Desiree:* I have to tell you gal, it's a myth. Your friend is just telling you lies.

When they were growing up, today's generation of African parents or grandparents probably did not own refrigerators, from which adolescent girls could use ice cubes creatively to re-create the illusion of vaginal tightness, which is characteristic of a virgin. The case above draws attention not only to a leap between age-old practices and modernity, but also an increasingly widening generation gap among the Zulu as well. This example of using ice cubes also highlights the modern adolescent's ingenuity in fooling either a boyfriend or virginity tester into believing she is sexually innocent.

The case below, on the other hand, exemplifies how valuable cultural practices can, with time, be corrupted through misconceptions while being handed down from generation to generation. The discussion below illustrates how indigenous knowledge borrowed from past generations underpinned and safeguarded sexual and reproductive health among Zulu-speaking adolescents:

> *Cindy:* I have a friend who says they [the friend and her boyfriend] kind of had sex, *but not really*, with her boyfriend and now she's scared that she's pregnant. She says that, um [...] I don't know whether you girls know the thing called *ukusoma*? [some girls chuckle knowingly]. Jah, she says they [the friend and her boyfriend) got ready to have sex and stuff, but instead of just doing it as usual, she had to squeeze her thighs together. So I don't know what happens, but that's it. The guy did not wear a condom, so you cannot really be 100 % sure that she was safe.

A number of the girls in the focus group giggle, some from ignorance, and others from recognising what appears to be an embarrassing practice for today's adolescents. Yet, like many other girls her age, Cindy has only sketchy information on a traditional practice that used to be common among the Zulu in the past. This case exemplifies how valuable traditions of the past are corrupted with time, giving rise to misconceptions while being

handed down from generation to generation. In the past, *ukusoma* (intercrural or thigh sex) was a socially regulated form of non-penetrative sex permitted among unmarried adolescents and young adults, through which pregnancies and STIs were avoided. Such a practice would prove appropriate today in keeping HIV/AIDS at bay.

Besides Cindy, some girls in the rest of the focus group do not seem to know much about this practice either. The erosion of culture is evident as in the case above where half-baked indigenous knowledge of *ukusoma* has backfired. This is suggested through Cindy's friend's apprehension that she is pregnant after what to her was a new sexual technique.

Like some of her peers in this focus group discussion, Cindy has total faith in the condom's safety, yet it is only 98% safe (McCammon, Knox and Schacht, 1998), and even less so if not used correctly or consistently. Due to sexual inexperience, adolescents do not always use the device correctly or consistently.

Meanwhile, Sarah is brave enough to display her ignorance in a group setting by insisting on asking what *ukusoma* is, since Cindy's sketchy explanation exemplifies her lack of knowledge of what used to be common knowledge among past generations:

> *Cindy:* I don't know what is that word *ukusoma*. Most people, when you ask that word, they just say "You don't know?" They then say, "You are lying!" Nobody want to face up [own up] and tell you what is *ukusoma*.
>
> Sarah repeats her question: What is *it?*
>
> *Rose: Ukusoma* is a kind of sex when a boy does not put his penis into your vagina. He could do it everywhere else on your body. In [between] your thighs. Breast [seeing the perplexed look on the faces of other focus group members, Rose adds] Yes, you should squeeze your breast, then he does it.
>
> *Cindy:* My friends in my previous school used to talk about 'thigh sex'; so that's what it is... [Cindy's voice trails off on hearing of the novelty of this act].

Rose speaks of a modernised form of *ukusoma* that their parents' generation might either frown upon, or feel uncomfortable discussing due to sexuality being a taboo subject. The young people, for their part, either build on what existed before in their own culture, or

borrow from what appears innovative from other cultures. In non-penetrative sex, the youngsters now also utilise breasts rather than confining themselves to the traditional use of thighs.

Other adolescents would choose to discard some practices altogether. Asked whether she has heard of teenagers practising the age-old Zulu tradition of *ukusoma*, Palesa offers an impatient reply:

> *Palesa:* Eish! At this time and this generation? No one, no one!
>
> *Interviewer:* Why are they not practicing it?
>
> *Palesa:* They say if the boy asks to "sisome" [verb derived from *ukusoma*], she say to him: "This is history: this is a history of uShaka."

Palesa relegates *ukusoma* to centuries' old history surrounding Shaka Zulu, a heroic king who lived between 1787 and 1828, and reigned in present-day KZN. Palesa and some fellow adolescents of her generation have no time for history, whether positive or negative. Her thinking reflects the trend that cultural values are fast-eroding among modern-day adolescents who choose instead to dismiss such values as antiquated, and, therefore, no longer relevant.

For her part, Penny (aged 17) confesses in a focus group discussion: "I don't know anything about Zulu culture." She represents a growing number of adolescents in urban South Africa who have not been schooled in 'morals' of the past and are consequently vulnerable to all sorts of influences. Generations no longer hand down values consistently to the next, due to factors such as migrant labour (parents do not live with their children); rural-urban migration; the generation gap and modernisation. As a result, the younger generations pick up values from an assortment of sources, and in the process often end up receiving a jumble of ideas (among them sexual misconceptions), which affects them adversely when it comes to their reproductive health. Cultural practices and taboos of the past that curbed pregnancies and STIs, such as *ukusoma* and abstinence for example, are no longer strictly observed by the younger generation.

The subsequent confusion is evident in the area of STIs, which are a major public health concern. Ignorance is not bliss when it comes to reproductive health, especially in the case of HIV and other STIs that might be asymptomatic. What the individual does not know or refuses to acknowledge is likely to ultimately affect his or her reproductive health adversely. The longer an STI goes undiagnosed or treated, the more likely it is to advance, with far-reaching, dire consequences. These include experiencing pain and discomfort, infertility, ovarian cancer, and in the event of developing AIDS, even death.

Responses with regard to STIs, elicited the following comments:

> *Interviewer:* What do girls who are sexually active do when they get sexually transmitted infections?
>
> *Cindy:* Some of them could be stubborn [*sic* reluctant] on the fact that they have to go to see a doctor, or see anybody who could help them in it (STI). Others just don't believe they have it. They say: "That's nonsense! No, I couldn't have that."
>
> *Jessica:* Some of them believe what they are told and take action to prevent it somehow.

As Cindy pointed out earlier, some girls do nothing, with the hope that an STI will heal on its own, while others take the denialist approach even when the symptoms are obvious. In both cases, either group of girls is likely to harbour the infection until it reaches an advanced stage. Should the condition end up as an ulcerating sore, it provides an entry point for the virus in cases where the sexual partner is HIV-positive.

In South Africa the prominence of HIV/AIDS in prevention and control strategies has largely camouflaged the "hidden epidemic" evident in the proliferation of STIs. Since only AIDS, rather than other STIs, is associated with death, the general public does not attach the same gravity to the latter when considering reproductive health. Despite a media blitz on AIDS, therefore, sexually active adolescents are not always able to make a link between STIs and HIV infection. Consequently, STIs pose major individual and public health concerns as many sexually active adolescents do not test for HIV/AIDS and other STIs. Indeed, many are unaware they are infected.

Many sexually active adolescents do not get tested for HIV/AIDS and other STIs because they assume they are not infected, because they do not have multiple partners or engage in prostitution. A number of STIs are asymptomatic, especially in women. An individual having an STI may not know it. Many such individuals do not get tested for HIV/AIDS or other STIs, fearing the results may indicate they are infected. Because of these fears, some adolescents get tested but never return to get the results, based on the misconception that HIV equals death. An infected individual can prolong his or her life by adopting a healthy lifestyle, practising safe sex and ultimately taking anti-retrovirals when the body's immunity is severely compromised by the virus.

Adolescents aged between 15 and 19, and young adults aged between 20 and 24, are the two groups currently facing the greatest risk of acquiring HIV and other STIs, with most of the infections acquired during adolescence (UNFPA, 2003). One reason for this is that individuals among the two groups are more likely to have multiple sexual partners. Given that experimentation and risk-taking characterise adolescence, this group is likely to engage in sexual intercourse without using condoms. Since they are young, some adolescents believe they are invincible, and therefore immune to contracting the virus.

According to one study, South African adolescents of both sexes hold disquieting misconceptions about sexual violence and the risk of HIV (CIET, 2004). Two out of 10 pupils featured in the study, for example, do not believe condoms prevent pregnancy, HIV and other STIs. The CIET (2004) findings concur with the Rutenberg *et al* (2001) survey that sexually active adolescents are oblivious to their risk of HIV. The survey entitled: "Transitions into Adulthood in the Context of AIDS in South Africa", reveals that despite the fact that 31% admitted to engaging in unprotected sex, only a small proportion interviewed felt that they were at risk of contracting HIV. The survey covered 3000 teenagers from urban and rural settings in KZN. Generally, young people feel invincible and believe that they are too young to contract life-threatening illnesses, including HIV/AIDS.

Another misconception fuelling the spread of HIV among adolescents, is the belief that one's libido is uncontrollable. The strong sexual drive unleashed and reinforced by a surge of hormones at puberty often leads to the assumption that pre-marital sex among adolescents is inevitable, especially among boys. The respondents' views ranged between either affirming or challenging beliefs hinging on the widely accepted sexual misconceptions that an uncontrollable hormonal urge for sex must be gratified. On the one hand, for example, males are assumed to be too testosterone charged to refrain from 'laying' girls. On the other hand, females are deemed as largely asexual until marriage gives them license to have sex. The focus group participants offer an array of conflicting responses in discussing whether females in general, and males in particular, can do without sex:

> *Cindy* (annunciates her words categorically for emphasis): Men use that [misconception] as an excuse to sleep around.
>
> *Jessica:* Everyone can live without sex; sex is just a matter of people making themselves happy through sexual satisfaction.
>
> *Desiree:* Some men live without sex, and some girls abstain from sex.
>
> *Rose:* I disagree because we have to do sex to express our feelings, so that's why I say I have to do sex.
>
> *Sarah:* I happen to be a strong believer of God. I believe God created Man to have sex only in marriage. He did not write in the Scriptures that men should have sex with little (*sic* young) girls in schools.

In this discussion, 16-year-old Rose supports one extreme of the argument by openly declaring what many adolescent girls would rather be reticent about. Speaking categorically as one who cannot do without sex, Rose publicly flaunts the fact that she, personally, is sexually active. Her dissenting voice differs sharply from the moderate position taken by Jessica, who insists that having sex is a matter of choice as opposed to being an uncontrollable biological urge. Desiree, for her part, logically points to the other extreme, underlining abstinence as an option for either sex. She categorically states that it is not uncommon for both boys and girls to desist from sex.

In the ensuing discussion Sarah digresses, veering to one extreme by pointing out a different misconception widely upheld by religious faiths worldwide that insist on pre-

marital abstinence. Sarah specifically bases her argument on the Christian belief that sex should be confined strictly to procreation within the boundaries of marriage. In so doing, she ignores the reality of sexual pleasure experienced by single people and married couples alike, as well as by the young and the old.

Sarah's position highlights a blind spot that disregards sexual biological urges ushered in by the rise in hormones at puberty. A strong libido may translate into unprotected sex, which could lead to pregnancy, or contracting STIs. Linked to this line of thinking are common misconceptions prevailing among adolescents that 'everybody's doing it' [i.e. having sex] and that there is 'something wrong' with those not having sex. Surrounded by peers who accept and even glorify casual sex, some adolescents plunge headlong into sex with little thought about the consequences.

The above-mentioned misconceptions are prevalent far beyond Umlazi. Caldwell (2002), for example, points out that belief systems are also a reason why people take sexual risks, under what he terms adherence to incorrect theories leading to HIV infection. Citing his earlier works, he observes two such theories, one of which is that most men see sexual relations as the result of a sudden biological need that must be assuaged (Caldwell *et al*, 1999). The second is that most men and women believe that men are biologically programmed to need more than one woman (Orubuloye, Caldwell and Caldwell, 1997). Though Caldwell in all three publications (2002, 1999, 1997) grounds the research in Nigeria, such theories are reflected in what the Ogwini respondents express concerning popular misconceptions in Umlazi Township in South Africa.

Further abroad in the United States, Josh McDowell (2002:82), an internationally acclaimed speaker and author on cultural issues facing youth, declares:

> Love is primarily an act of the will [...] And since sex is an act of love, not a primal response, our most important sex organ is not found below the belt; it is in the mind. It is here we make decisions. The brain takes in information, sifts through it, accepts some elements, rejects others, and arrives at conclusions. It is in the brain, not in some primal instinct that the choice is made to engage in sex or to say no to sex. Therefore to claim that sex is only an uncontrollable urge is to deny our ability to make choices.

While discussing misconceptions related to biomedical factors, an element not to be overlooked is substance abuse, which is associated with a heightened risk of acquiring HIV and other STIs. For example, using the catch phrase: "Get drunk, get high, get AIDS," media campaigns in the US have warned of the dangers of combining alcohol and drugs with sex (McCammon, Knox and Schacht, 1998). These three researchers explain that using alcohol and other recreational drugs not only clouds judgment and attitudes about sexual behaviour, but also damages the immune system, rendering individuals more vulnerable to infectious diseases in general.

Adolescents in South Africa, have similarly been known to resort to drawing false bravado through the use of hard drugs or alcohol before approaching girls for friendship or sex. Under the influence of these substances, sexual inhibitions are lost, and users are likely to report having a negative attitude towards condom use, for example. In South Africa, the use of alcohol and recreational drugs is a risk behaviour most frequently associated with STIs, and unplanned or unwanted pregnancy. Such cases may lead to a HIV-negative partner contracting HIV. Taking alcohol and hard drugs has become part of today's youth culture, a topic examined in the next section.

5.3 Youth culture and AIDS

Culture, as addressed earlier (cf. 2.3 and 2.4), is a central factor influencing how people think and act, and cannot be sidestepped in interpreting sexual misconceptions that predispose African adolescent girls to HIV infection. This section considers misconceptions related to socio-cultural factors that have a negative impact in the prevention and control of HIV/AIDS among adolescent girls in Umlazi. Culture is a problematic term. As Clifford (1988: 10) states, culture is a "deeply compromised idea". Culture could be defined as "a system of interrelated values active enough to influence and condition perception, judgment, communication and behaviour in a given society" (Mazrui, 1986:239).

Bates (2003) echoes this when he says that culture not only governs how people perceive and understand the world, but also motivates and justifies people's behaviour within it. In addition to this, culture provides the patterns of understanding that allow people to recognise and relate to what happens around them. Even though Bates addresses Catholic theologians and AIDS activists, his views could apply to the context of my study when he claims that the experience of illness is always cultural; based on an individual's resources of knowledge and previous experiences. In turn, these resources are conditioned by a culture that socialises the individual into their worldview, their sets of beliefs and value systems. The Ogwini girls' thinking and practices are heavily influenced by the cultural mores evident in Umlazi Township. Both sexes deem sex as a prerequisite in male-female relationships, as amplified by a respondent:

> *Happy:* Boys just think that sex has to be their daily bread: they can't do without it. They need someone to fulfil their needs, so they say: "If you don't have sex with me, I'm going to go crazy." He uses lame excuses. Men say if you are [real] a man, you must have sex. And he can tell you: "If you don't want to sleep with me, there are other girls who can sleep with me, you know."

Happy highlights two sexual misconceptions: first, that among the Zulu, men run the risk of mental insanity unless they have sex, and, second, that a man is less of a man if he does not engage in sex. When these prevalent coercive cultural beliefs do not work, boys resort to emotional blackmail. They threaten desertion to punish sexual non-compliance from their girlfriends. And where all else fails, boys seem to think that they are entitled to resort to verbal abuse, or to 'blacklist' the female culprit and spread the word that she is lacking in sexual appeal:

> *Zoë:* Some boys go to the extent of telling your friends you are 'un-cool'; you are not in fashion; you don't have 'style'; or pride yourself for abstaining since you have elevated yourself to being the 'other Mother Theresa.'
>
> *Glenda:* If you refuse to have sex with them they go around telling their [boy] friends: Ag, that girl, she's nothing. I've come from there; go see for yourself, there's nothing there!

As is evident above, it is difficult for adolescent girls under tremendous peer pressure not to succumb to coerced sex without condoms at times.

Probing for reasons why adolescent girls in Umlazi have sex, for example, elicits an array of responses. Mandy captures most with a five-pronged answer, with Sarah and Desiree giving additional reasons:

> *Mandy:* I think the girls, they enjoy having sex. It could be for love, because love does exist. But it could be pressure from her boyfriend, friends, or other girls. Or she just wants either to prove something to herself, or just to experiment.
>
> *Sarah:* I believe some girls do have sex at an early age coz they feel it's fine [to], but some because they are forced to, and some do it because they are trying to prove a point to their friends, like: "just because I have many boyfriends I can have sex any time I want."
>
> *Desiree*: Some girls do have sex coz they love their boyfriends too much to lose them.

Sarah also mentions forced or coerced sex, while Desiree speaks of emotional dependence on boyfriends as being among the reasons some girls engage in sex.

Another reason why girls have sex is to deliberately fall pregnant so that their partners may take a greater interest in them. Pregnancy could be interpreted as a catalyst to cement a relationship and secure marriage. However, many girls knowingly enter into unprotected sex, despite the health risks:

> *Rose:* Some girls say: "I will get pregnant so that he may love me and respect me, and guide me all he way, and [eventually] we'll get married."

Such girls pursue the illusive myth of blissful marriage. What they probably do not know is that 35% of all South African girls (as indicated earlier) become pregnant by the time they reach 19. A respondent explains the reality of similar cases:

> *Rose:* They get pregnant coz they think the boyfriend won't go away when they are already pregnant. But they are stupid since they (boyfriends) would still go away [anyway].
> *Cindy:* A sister of mine got pregnant. The child is turning three this year, but the father hasn't even been to see the baby once – to know that his child is ok.

Cindy points out the harsh reality of certain cases in which the father is not even remotely interested in getting a glimpse of the child he sired. In so doing, she draws attention to a

disturbing aspect of masculinity: a fatherless generation of children has become an increasingly common trend in the Umlazi Township.[2] In this case, it appears men are increasingly applying a care-free, individualistic and hedonistic approach geared to sexual gratification, often with multiple partners. They do what feels good, irrespective of the consequences of unprotected sex, be they pregnancy or STIs.

In a follow-up to Cindy's observation, Zoë comments on what she sees as another negative aspect of hegemonic masculinity, whose roots lie in culture. She maintains that the thinking behind sexual misconceptions that predispose adolescents to HIV infection is the preserve of men, and is inherited from older generations of males:

> *Zoë:* I think workshops should be [conducted] done for us. Most of the uninformed people are boys; they tend to talk a lot about sex. There are more myths in their conversation than facts.
>
> *Interviewer:* Where do the boys get their information?
>
> *Zoë:* From their brothers, and their fathers and their father's fathers.

Zoë rightly points out that culture, with sexual misconceptions included, is handed down through successive generations. Zoë, however, erroneously narrows down the source of misinformation when she emphasises it is passed down from male siblings, and two older generations comprising fathers and grandfathers. Moreover, she makes an over-generalisation when she insists boys are relatively more uninformed than girls about HIV/AIDS in relation to reproductive health. Girls are equally uninformed, as is evident in the focus of this study. A lack of knowledge; myths; half-baked knowledge; and erroneous

[2]The problem of fatherhood is increasingly being recognised in the context of HIV/AIDS in South Africa. Fatherhood is highly contested because either fathers are absent, neglectful, abusive and sometimes brutal. Often violence in relationships lead to the separation of parents and this does have a major effect on the children. In these circumstances, the process of child-rearing becomes the sole domain of mothers who usually have to work to support their children. The central ideas are directed towards promoting men's care and protection of children in the absence of fathers; to influence social expectations and perceptions about men and their care of children; and to raise consciousness about the important role of men in the positive development of the child. See also the recent publication by *Baba: Men and Fatherhood in South Africa* (edited by Richter and Morrell, 2005), that examines the above issues in the context of representation and roles, historical conceptions of fatherhood, and about being a father in South Africa today within the context of HIV/AIDS.

thinking, attitudes or values, are not simply a male preserve. In reality, however, such shortcomings are neither exclusively male or female by definition.

Zoë then goes on to contradict herself when she offers the following example, which illustrates a misconception that pervades the thinking of adolescents of both sexes:

> *Zoë:* Some girls say if you die from AIDS you are a warrior: a true warrior like Shaka. You are a hero when you die from AIDS. It's not a shameful or a sad thing for them; it is more a heroic and proud deed. I was surprised that young women and men like us – aged about 17 and 18 – thinks he who dies of AIDS is a hero [...]

According to Zoë, sexual conquest leading to HIV/AIDS forms an epic analogy with Shaka's military conquest through which he created the Zulu kingdom. The symbolism attached to an AIDS-related death, based on the above example, illustrates a cultural and historical comparison between 'death' from an incurable disease and a form of sacrifice or heroic act. In my view, this represents a misconception that impacts on the understanding of sexual agency.

5.4 Girls' sexual agency and AIDS

In this section, respondents voice their opinions about their sexual experiences, whether consensual, or as a result of coercion, force or deception. The sexual agency of Ogwini girls today, would dash the myth handed down either by conservative parents or grandparents that adolescent females are not sexually active, or even interested in sex. Granted, on the one hand, there are girls who would opt for abstinence according to morals handed down by their elders. This is in keeping with the universal ideal that girls should not engage in penetrative sex until marriage. An Ogwini respondent attests to this view. When asked what she would do if a man made unwanted sexual advances towards her, she replies:

> *Phlile:* I would say no, because my culture (refers to Zulu culture) does not allow me to have sex before marriage.

But, times are changing fast. Past generations of parents would be surprised to hear candid opinions about the early age at which girls experience their sexual debut, and how

they make their decisions regarding sex. In the focus group discussions, the respondents recounted all manner of personal sexual experiences and those their peers had encountered too. Their responses emphasise the misconceptions related to adolescent girls' sexual behaviour (or lack thereof), and how these misconceptions influence the extent to which girls are predisposed to HIV infection. The responses range from rape at one extreme, and at the other, instances in which pre-meditated sex [just] occurs:

> *Desiree:* Some girls in Umlazi become sexually active at the age of nine, while some of them start having sex between the age of 16 and 18. Other girls remain virgins until they get married.
>
> *Jessica:* I believe when people reach puberty, that's when they start to have sexual feelings. It's then they start wanting sex, so they have to get satisfied in that special way. That happens at the age of nine, upwards.
>
> *Mandy:* Some girls start having sex between the age of 17 and 18.
>
> *Sarah:* It happens between the age of 9 and 20 – that's the latest age.

However, as respondents pointed out, maintaining virginity until marriage appears to be the exception rather than the rule. Largely due to peer pressure, some adolescents believe abstinence before marriage is impossible. It would appear that abstinence is increasingly being promoted as a key strategy in curbing the spread of HIV/AIDS. In fact, some funders (such as USAID) with pressure from the Bush administration, are influencing local HIV/AIDS prevention programmes with regard to the abstinence campaign (Sengwana, 2004). The abstinence model has raised much debate and dissension about informed, individual decision-making with regard to sexual choices.

Findings from a nationwide survey conducted in South Africa by CIET (2004) corroborate the Ogwini girls' responses. The study involved 269 905 pupils from South Africa's nine provinces. It included participants of both sexes, aged between 10 and 19, and was representative of pupils of all races from Grades 6 to 11. This survey found that 1 out of every 3 children has had sex by the age of 10, and by the age of 18, 2 out of every 3 children has had sex. The findings of the CIET (2004) study were publicised as being 'shocking' to adults who do not expect such young children to be sexually active. This response suggests that adults underestimated the early age of sexual debut and the

prevalence of pre-pubertal and adolescent sex among children, whom they would rather have chosen to believe were not sexually active. Adults who adopt this view are unlikely to discuss risky sexual behaviour, in relation to the HIV/AIDS epidemic, with their children.

These adults would be even more shocked over the findings of a study conducted by Pettifor *et al* (2004). These researchers claim that young South African women aged between 15 and 24 are having more sex than their male counterparts, and that only a minority of all sexual encounters by this group are unwanted. Some of these women are having relatively more sex, not only over the previous 12 months, but also since their sexual debuts.

The Ogwini research participants give various, diverse reasons for having sex, which are evident in earlier responses. In other instances, girls either choose to have sex, or are coerced into having sex through emotional blackmail:

> *Rose:* Sometimes it's their choice, but at other times it's the boyfriends' choice. A boyfriend threatens: "If you don't have sex with me, we'll break up." So she thinks: "Oh no. I love this boy and don't want to lose him, so I'll have sex with him."

Peer pressure appears to be among the key reasons that girls engage in sex with boys. It appears that the label of 'virgin', also has negative connotations for girls, and implies that a girl who is still a virgin is considered 'unworthy' of being part of her peer group. Furthermore, when the label of 'virgin' is applied to a girl within the context of this peer group, it suggests that she is devoid of any fun and pleasure because she denies herself the opportunity to engage in recreational sex. Consequently, at the earliest opportunity, an adolescent girl may cast aside her virginity to avoid being seen as 'prissy' by her peers. Such an attempt to 'belong' or appear 'cool' could catapult a girl into a precocious sexual career, with the attendant risks of contracting HIV and other STIs through unprotected sex. A respondent sums it up as follows:

> *Jessica:* Sometimes it's more like a pressure thing: you find that all your friends have had sex before, and that it's a fun thing. And you are kind of the only one who's never had sex before. You have to be like all your friends.

One misconception that needs to be acknowledged in HIV/AIDS intervention is the assumption that girls are merely objects that males can act upon sexually. The reality is that girls' also have sexual desire; a taboo subject that is often skirted by the girls themselves and society at large. In a succinct response, one study participant, Mandy, emphasises what most parents of adolescent girls would be loath to hear, that "girls enjoy having sex".

When discussing female sexual agency, Berger (2004) goes against the grain when he challenges the beliefs that deny female sexuality. Instead, he maintains that many women actually enjoy sex for the sake of sex. He quotes Dowsett (2003: 25) in describing HIV/AIDS as 'an epidemic of desire' originating from both sexes. In a suggested intervention which he dubs 're-sexualising the epidemic', Berger (2004:45) advocates that greater attention be paid to sex and desire in the design of prevention and control campaigns. He argues that without such a measure, well-intentioned efforts would be meaningless.

Meanwhile, in the process of assuaging desire, girls may engage in unprotected sex, with adverse effects on their reproductive health. In no uncertain terms, one respondent pinpoints the consequences:

> *Cindy:* I must say there are a lot of teenagers fooling around; that's why there's a high rate of pregnancies, AIDS, and so on and so forth.

This response emphasises the fact that sleeping around is no longer a male prerogative, as it is normally perceived to be. The main difference today between men and women is that men are relatively more open about sex:

> *Jessica:* Whether the majority of girls here in Umlazi sleep around or not, well, you can't really tell. Girls don't go around exposing themselves by announcing: "I've had intercourse." It's personal. This underscores the contrasting double standards where boys, on the other hand, broadcast that they have multiple sexual partners – regardless of whether it is true or not.

Coerced or forced sex is quite common due to a 'culture of entitlement', which is related to the assumption that sex is a man's prerogative in a male-female relationship. In other

instances, some men impose sex on girls, cashing in on the misconception that has gained wide currency: when a woman says "no" to a man's sexual advances she means "yes". Another indicator of girls' sexual agency is not only knowing how to say "no" to sex, but also being prepared should a man try to force sex on them:

> *Desiree:* There's nobody who's going to force me to have sex with him. I don't say 'no' to mean 'yes'.

Some girls may be bulldozed into having sex against their will, but not the likes of Desiree. She enunciates *no* and *yes* to emphasise that she is not ambiguous. Men who refuse to take "no" for an answer, face possible consequences, such as the threat of prosecution or injury to their genitals:

> *Desiree:* I would definitely say 'no' because it's something I don't want to do.
>
> *Jessica:* I would say 'no', but if he forces himself on me, that would be rape. I would have to go to court and lay charges on him.
>
> *Cindy:* I'd say 'no', and tell him there's someone who would love me more than he does and appreciate me enough to wait for me. But if he keeps forcing himself on me, I will just kick his testicle, alright!

The focus group members laugh derisively, in agreement with the plan. Reiterating her point for emphasis, Cindy declares that if overpowered by a strong man, a strategy to confront such violence would entail the following:

> *Cindy:* If the guy is stronger than you, you should rather just lead him on, but not until he actually rapes you. At least tell him to just wait, or to do it slowly, to take it easy, or something. Then kick him [in his genitals], or whatever. At that stage it would be easy to run away.

After flattering him in the envisaged situation, Cindy would opt to 'kick' his testicles to paralyse him, before escaping. She would be prepared to make an attempt to escape rape, rather than to literally take it lying down. These various responses indicate the emergence of a new breed of girls who belong to a generation that refuses to be helpless victims, but rather to physically confront, challenge and even 'attack' their potential assailants.

The girls chuckle at what appears to them to be a new approach to handling unwanted sexual advances. The laughter may suggest that the girls have little sympathy for a man

who assumes he can have his way with a girl whenever he wants. This mindset overturns the stereotyped misconception generated by masculine hegemony; that a man must have sex on demand. Cindy is not prepared to keep a man at any cost by sleeping with him – on his terms – unlike some girls who act out of desperation and cannot bear to be seen as being 'undesirable' to men. Cindy is hopeful that there are other men out there who would be prepared to wait for her until she is ready for sex. Unlike some of the respondents, Cindy refuses to stereotype all men as being potential rapists.

5.5 How adults fuel HIV infection both directly and indirectly

Significant adults, previously defined as people who play an important role in adolescents' lives, cannot be left out of the equation of adolescent girls' sexual agency in relation to HIV/AIDS. This is because age difference could be a factor fuelling HIV infection in situations where adolescent girls have older sexual partners. Girls' sexual agency is illustrated by their strategic choice of older sexual partners. Consider the following observations:

> *Jessica:* Most girls want men who are older because they (men) will satisfy them more [better] sexually, and be able to protect them. Well as for age, it doesn't really matter. You could find an 18-year-old girl having an affair with a 45-year-old man – a man with his own family who has children her age.

> *Cindy:* Some girls I know don't want a young guy. They want a guy who is experienced sexually, but also on feelings and stuff; a guy who knows how to treat well. Even though the older guys turn out to be bad. A *playa* [playboy). These girls like the *bad* guys instead of the *good* ones.

From Jessica's comments, it can be inferred that girls prefer dating older, more sexually experienced men, rather than with groping boys their own age, even if it means risking serious health consequences. Under these circumstances, contracting HIV may be accorded low or no priority at all, in the pursuit of sexual gratification or acquisition of material goods. The young female strategists who opt for sugar daddies may ultimately contract HIV through intergenerational sex. Besides being sexually more experienced, older men are likely to have had more sexual partners, which increases their risk of HIV infection with each act of unprotected sex. A respondent points out the average age gap:

Sarah: I think that girls have older people as their boyfriends, and the age difference starts at about five years.

A nationwide survey indicates that, generally, older men are less likely than younger men to want to use condoms for protection, because they are more set in their ways. Young people are often more open to adopting new behaviour (Shisana and Simbayi, 2002). It is, therefore, ironic that when young girls such as Jessica seek protection by partnering with older men, they (girls) run a relatively higher risk of engaging in unprotected sex than they would with partners of their own age, who are more likely to heed HIV/AIDS prevention messages.

The system of patriarchy, which advocates gender inequality, endows men with more social power over women worldwide. The trend is even more evident when it comes to older men, who also wield the authority that comes with age. Conversely, the younger the adolescent girls are, the less likely they are to have adequate negotiation skills to insist on condom use during every sexual act. Cultural double standards advocate that unmarried adolescent girls abstain from, and remain uninformed about sex. Consequently, girls may be too embarrassed to even ask a man to use condoms to safeguard them against HIV.

A number of Ogwini respondents mention that in some instances, older men assume that young girls are virgins, and act in accordance with the virgin myth. Raping a virgin is believed to be a prophylaxis or cure for HIV/AIDS. Young people of both sexes, have also bought into this misconception by listening to their elders. At least 12% of the adolescent girls and 15% of the adolescent boys interviewed, believe having sex with a virgin could cure HIV/AIDS (CIET, 2004).

When it comes to intergenerational sex, sexual misconceptions are held by both partners. The young girl, for her part, may work on the assumption that because she is sexually active, she is mature enough to handle an older sexual partner. However, some girls succumb easily to sex since they are socialised culturally from a young age to be subservient to older men in general. Such a dynamic in intergenerational relationships is reinforced by the strictures of patriarchal power, which make it difficult for girls to insist

on safer sex, or simply to say "no" to sex. According to the CIET (2004) study, 22% of girls say they do not have the right to refuse their boyfriends sex, while 30% of the boys feel the same. This thinking is most pertinent among younger girls who may not know their rights or – despite knowing them – lack negotiation skills, or are too young to make moral decisions relating to sex. As one respondent explains:

> *Mandy:* Some girls have sex at an early age: they are too young to decide whether it is right or wrong to have sex. They can't choose.

Girls who are minors may agree to have sex, mostly due to peer pressure or through coercion. Out of a lack of awareness, girls unwittingly make decisions that might have a bearing on their entire lives. An abrasion in their genital tract resulting from sex, could provide an entry point for HIV, should they have unprotected sex with an older, infected man.

The older man, often assumes that the younger a girl is, the more likely she is to be a virgin, or that she has had very little sexual experience, if any. Other older men, often hold the same beliefs and approach the same eye-catching, young girls. The girls in turn exercise their sexual agency and end up with multiple partners. They then have to juggle the relationships in such a way that the men involved do not know of each other's existence.

What these men are not aware of, however, are the physiological factors that paradoxically predispose younger women more to HIV infection than their older female counterparts. For example, young adolescent girls have an increased presence of cervical ectopy (an outgrowth of membranous tissue from the cervix towards the vagina), which increases their risk of acquiring HIV (Hankins, 1996). In addition to this, young adolescent girls are also at an increased risk of HIV infection partly due to minimum vaginal mucus production, which provides less of a barrier to HIV than adult women with more mature reproductive organs (McCammon, Knox and Schacht, 1998). Due to limited mucous secretions, the adolescent girl may get lacerations in her genitals due to inadequate lubrication and vigorous penetrative intercourse.

The range of significant adults predisposing adolescent girls to HIV infection includes what appears to be unlikely groups of males. According to Hunter (2002: 110):

> Older male relatives, family friends and men in positions of power and influence such as teachers, often sexually abuse young women. 'Sugar daddies' may entice young girls into sexual relationships in exchange for necessities or 'treats'. These men are generally older and economically independent, and therefore have considerable power and access to girls.

The individuals who are supposed to be role models by virtue of their age, and who are expected to protect and care for the young girls, are implicated in fuelling the spread of HIV.

5.6 The economic backdrop of AIDS

This section analyses two main aspects related to monetary or material gain: gender inequality in the ownership of economic resources, and individuals exploiting the epidemic for personal gain. Men generally have more access to economic resources, and the consequent imbalance of power affects adolescent women's sexual and reproductive health. The respondents point out that girls have internalised the pervasive message that love can be measured in monetary terms, by selling their bodies. Consumerism far too often takes priority over maintaining reproductive health:

> *Interviewer:* I'm told some girls keep five boyfriends. Why would one want to keep so many boyfriends?
>
> *Palesa:* It's because one gives you money, but you don't love him. There's a boyfriend, he has a car. They say: "So-and-so, I want to go there" and he drives her there. And there is a boyfriend; he gives her money to buy clothes and junky [junk] food. And there's one [boyfriend] whom she loves, very, very, very hard [much]. The fifth one is the boy who tells you he loves you. He is talking and you say "Ok, ok", but in the end you fear to tell him you are not interested in him because you fear he will hit you.

Palesa observes that girls trade their attractive young bodies not only in exchange for money, but also for goods or services. The Ogwini girls explain the various reasons why the exchange occurs. Mostly, as Palesa mentions, poverty seems to be the primary factor motivating the exchange of sex for money, be it for commercial or transactional sex.

Pressure to engage in either form of sex is tremendous, considering that the majority of learners attending Umlazi Township schools are from poor homes and working class families (Rudwick, 2004).

According to Bates (2003:13), HIV is an illness that creates and feeds off poverty:

> It spreads with the ferocity of a bush fire amongst the poor who have no way to protect themselves, found as they are, only on the margins of a full human life, in their daily experience of limitation in knowledge and resources.

In comparison to men, women bear the brunt of poverty, and have the least access to resources (cf. Hunter, 2003; Walker *et al*, 2004). These researchers cite young women as being the poorest, most economically marginalised and the least educated sector of the South African population. Women who are in dire financial need sell sex to obtain basic necessities, while those better off also sell sex, but with the intent to acquire luxuries such as cell phones and clothing. Due to their low social status and economic dependence on men, selling their bodies renders young women vulnerable to HIV/AIDS.

While girls are in the process of sleeping with multiple partners for economic gain, they often have to comply with practices that may ultimately compromise their health. Take the example below:

> *Rose:* Sometimes when girls age going to sleep with a man and maybe yesterday they slept with another man, the following day they put a newspaper in their vagina to make it dry. To take [absorb] all the dirty things: discharge and stuff [Pause]. A lot of girls often do that. Every time a girl is going to sleep with another boyfriend, she should put a newspaper inside them and wait for 10 or 20 minutes, till she becomes dry.
>
> *Interviewer:* What other substances do they use apart from newsprint?
>
> *Rose:* They go to traditional doctors and get all kinds of things to drink in order to dry their vaginas.

Known as 'dry sex', this form of sex seems to be gaining currency among adolescent girls. 'Dry sex' is a practice whereby a taut and dry vagina is obtained using drying agents to ensure there are little or no vaginal secretions, which is contrary to a woman's natural physiological responses during sex. A girl with a wet or slack vagina is

considered a 'loose woman', and the vaginal secretions are mistaken for symptoms of an STI. This is done to create the impression that the woman is monogamous. In addition to this, men consider a tight vagina to be sexually desirable since it enhances sexual pleasure. Nonetheless, the practice has serious implications for the spread of HIV. Dry, tight vaginas are a major risk factor for HIV infection. The excessive trauma that occurs during penetrative 'dry sex', often results in pain, bleeding and even lacerations in the female genitalia that could provide an entry point for the virus. 'Dry sex' is practised mostly by adult women throughout Southern Africa. But, older adolescent girls in KZN are also known to practise 'dry sex' for the reasons above and to please their men by recreating the taut vagina of a virgin.

As the AIDS pandemic takes its toll on South Africans, a growing number of people living with HIV/AIDS (PLWAs) are seeking remedies. In Umlazi, alternative HIV/AIDS 'cures' proliferate among those who not aware that there is no cure for the illness, and thus a lucrative market is emerging for herbalists and other traditional healers. Some of the individuals, who know there is no cure, try to clutch at straws, as revealed below by several respondents. When asked whether she knows of a cure for HIV/AIDS, Palesa – aged 17 – offers a comparison between biomedical treatment and the role of traditional healers:

> *Palesa:* It [AIDS] cannot be treated. You go to clinic, they give you many tables, but very expensive. They don't cure AIDS, but they lengthen life. But some traditional healers say: "Come to me. I have medicine. If you have AIDS it can finish from your body." If you say: "How much?" he will tell you big price. R500. Or some say R200, R450, R300. If medicine finish, you go back to buy another bottle. You pay R500 again, and again and again.
>
> *Interviewer:* Young people your age, do they also go to these traditional medicine men? Palesa gives an example: Yes, she is going, if very, very sick.

Palesa observes that young people (who know there is no cure for HIV/AIDS) visit traditional healers for a cure only as a last resort. When asked how many healers she knows of in Umlazi Township who claim to heal HIV/AIDS, she mentions three in the township's Section C alone.

It is not just traditional healers who cash in on the remedies they sell for HIV/AIDS, but some faith healers also ask payment for their prayers. As the race for both a vaccine and a cure continues worldwide, Ogwini respondents reveal that HIV/AIDS patients in Umlazi join queues for 'miracle cures' for HIV/AIDS, or for prayers among *abathandazi* (faith healers):

> *Palesa:* I know one woman who is *umthandazi* (faith healer). Abathandazi (faith healers) pray for people and they get better. But such *abathandazi* are small [few] in number.
>
> *Mandy:* I don't think there is a cure for AIDS. It's just that some people in church – I believe, because I've seen it – that when a pastor or somebody prays for somebody in such a way that the person can feel that it [prayer] is working. When they go for a test, they test negative. I don't know how it happens, but it happens!

Other widely held misconceptions prevail concerning a cure for HIV/AIDS, as evident in another participant's response:

> *Jessica:* A cure for AIDS, I don't think there is. But I believe there are pills one can use to prevent themselves from getting AIDS.

An antiretroviral is not a vaccine, as Jessica mistakenly believes. According to respondents, some adolescents who knowingly engage in unprotected sex for material gain, rather than love, wrongly believe antiretrovirals are a cure to be taken should they contract the virus.

5.7 Sexual orientation and HIV/AIDS

Despite South Africa's 1996 Constitution being hailed as among the most liberal in the world, people often fail to grasp the fundamental principle of freedom and equality, which the constitution enshrines (Reddy and Louw, 2002). One such issue is sexual orientation and homosexuality in particular. Given that homosexuality is still perceived as 'unAfrican' and stigmatised as a European invasion into African culture, many African homosexuals are despised, derided and ostracised. In fact, the connection between HIV/AIDS and homosexuality is not co-incidental, given the fact that perceptions still

abound about the misconception that HIV/AIDS is to some extent still a gay, male disease.[3]

In a focus group discussion, Grade 12 participants of Ogwini pointed out that about 10% of the girls in their high school are lesbians. Moral judgments are often obvious during 'lesbian bashing'. In some instances the tongue-lashing does not stop there. A number of misogynistic, homophobic men interpret the act of a lesbian coming out of the closet as an open invitation to rape her, with the aim of helping 'straighten out' what they perceive to be an immoral sexual orientation. This factor is verified in several studies, most recently in Moothoo-Padayachie (2004). In such cases the rapists, who usually conduct sex hurriedly, do not use condoms during the assault. Due to the haste and force of the act, plus the fact that the girl is not psychologically primed for sex, the vaginal tract does not lubricate, and the girl could contract HIV through lacerations in her genitals.

Homosexuals often keep their sexuality a secret, due to the stigma associated with being gay, and for this reason relatively little is known about the demographic characteristics of those who identify themselves as gay, lesbian or bisexual. By the same token, relatively little research has been invested in the study of reproductive health issues affecting non-heterosexuals and bisexuals in South Africa. In other words, heteronormativity obscures issues of sexual orientation and does not take cognisance of homosexuals (gay men and lesbian women) and bisexuals in understanding reproductive health in the era of HIV/AIDS. Though the highest number of cases of HIV/AIDS in South Africa are found among the heterosexual population, lesbians are not immune from HIV and other STIs, as is often assumed. Women who have sexual relations only with women (and whose partners do likewise) have a substantially lower risk of contracting STIs than heterosexual women (McCammon, Knox and Schacht, 1998). Nonetheless, the three

[3]One theme that recurs in homophobic discourses is the question of homosexuality being a 'gay plague'. The latter was a popular term in the early days of HIV/AIDS in the United States because the virus was identified initially among gay men. Scientists called it GRID (Gay Related Immuno Deficiency). AIDS superseded this label in the mid-eighties, but the associations with HIV as a gay disease have remained and in many quarters in the African continent this belief is still held, despite the presence of the virus in a predominantly heterosexual population.

authors point out that lesbians could transmit vaginal infections between partners through direct vulva-to-vulva contact or hand-to-vulva contact.

One Ogwini respondent refers to the seldom talked about 'trend' of bisexuality among her fellow schoolgirls. In discussing anal sex between gay men, Cindy comments:

> *Cindy:* Naturally, that part of the body wasn't meant for you to have intercourse with, so I'm sure there would be some kind of bleeding. Then they would contract HIV from there. What if the men are bisexual, that is, having sex with women as well?

Failing to get a response from the rest of the focus group, Cindy replies:

> *Cindy:* Then that means spreading AIDS to the whole nation!

Homophobia underpins Cindy's language, implying that gay sex contributes to a moral panic whereby it is assumed – first – that all gay men practise unprotected anal sex, and – second – that such men are HIV-positive. Cindy does not mention that one of the sexual partners has to be HIV-positive in order to transmit the virus. She also assumes that this minority group could ultimately be responsible for spreading the virus nationally. These examples illustrate how individuals are apportioned blame for spreading HIV merely by being part of what is considered a high-risk group. Unprotected sex, rather than the group one belongs to, leads to the transmission of the virus. In some cases, as shown here, this is precipitated because some men wish to 'teach' lesbians about being 'proper women' by raping them. These violations against lesbians must also be seen within the broader context of gender-based violence against women.

5.8 Gender-based violence and AIDS

One cannot talk about sexual misconceptions that predispose Umlazi's adolescent girls to HIV infection without recognising the role of gender-based sexual violence. This form of violence is aptly illustrated in the prevalence of rape in South Africa. South Africa has the world's highest level of rape in a country not at war (Simpson and Kraak, 1998). According to Walker *et al* (2004), the deep-seated gender inequalities manifested in

sexual violence in this country have contributed to the rapid spread of HIV/AIDS in South Africa. The researchers point out that it is not possible to negotiate safe sex within abusive relationships, which are commonplace in the country. In addition, many women infected after being raped are unable to get to get the drugs they need to prevent HIV infection.

To establish the prevalence of rape in Umlazi from the respondents' point of view, focus group discussions framed the following questions:

> *Interviewer:* How prevalent is rape in Umlazi?
>
> *Jessica:* It's not easy to say that [specify how prevalent rape is]. If I were raped, for example, I wouldn't come and tell people. It's really hard to tell some of us here have been raped. Some of us sitting here could say: "I've never been in such a situation." Yet it's like three out of five, or something like that, have been raped.
> *Cindy:* It [rape] happens a lot, and it's something we have to protect ourselves from [pause]. Most people say girls should not wear a miniskirt, but you find old women who never wear a miniskirt getting raped.
>
> *Interviewer:* How do you protect yourself from getting raped?
>
> *Rose:* First of all, you cannot protect yourself from getting raped. A person can rape you when you are going to school.
>
> *Desiree:* I'd like to add to what Rose has said. You cannot prevent yourself from getting raped: even our fathers rape us. Some fathers rape us: *their daughters*! Even the uncles you trust; people you think you can rely on.

To emphasise the magnitude of incest, Desiree reinforces the point:

> *Desiree:* People you think are supposed to protect you – your own parents – are the ones that turn against you and rape you. Your father is supposed to be one person you value the most, but he turns out to be the one that is raping you, and your uncle. You can never really be sure you can ever be safe.

While trying to establish a link between rape and HIV infection, one respondent replied and the rest concurred:

> *Desiree:* Yes. If a person has HIV he can spread it to you. There are some rapists who have the virus and are looking to spread it to other people.

It is not just rapists who spread the virus. Below, two respondents point out how youngsters acting out of vengeance in sexual relationships know full well they are living with HIV/AIDS, yet spread the virus deliberately. This is another form of sexual violence:

> *Portia:* I think most of healthy looking person with HIV, they are most spreading HIV because, um... because they say: "I wasn't born with AIDS, so I must pass it on to someone".
>
> *Rose:* And healthy people, they spread AIDS, because they are the carriers. They have to spread AIDS before they die.

By deliberately attempting to pass on the virus, these adolescents are getting caught up in the misconception that all sexual partners should be unfairly punished through unprotected sex with an HIV-infected individual, who has not disclosed their status (see also Leclerc-Madlala, 1997). Death comes relatively faster to such individuals, who – while in the process of having sex with as many partners as possible – end up with drug-resistant HIV strains that do not respond to first-line antiretrovirals.

Should a man rape her, Sarah declares she would first resort to legal means to get him arrested, rather than suffering in silence in what seems to be a common trend:

> *Sarah:* I'd scream as loud as I can and try to leave the room. If he doesn't allow me to get out, I'll try every possible way to get him off my back and then run next door and tell them everything so that the man can be arrested or have something else done to him.

Some girls have been known to suffer in silence to avoid being branded as 'damaged goods' for losing their virginity. Other girls keep mum for fear of being accused of having 'asked for it' (sex), either by being out on their own at night, or in a lonely place, or by the way they dress. In the CIET (2004) study, 1 in every 10 pupils interviewed among 269 905 pupils believed girls who got raped 'asked' for it.

The London Rape Crisis Centre (1988), in a much earlier study, corroborate to some extent the Ogwini girls' views on rape myths. The myths are centred on the endless list of behavioural rules a female must observe to safeguard against rape. Examples include: avoid going out at night alone, or with female friends, or at any time for that matter, since

both encourage potential rapists; avoid going out with a male friend since some are capable of rape; do not remain at home in case your are raped by your father, grandfather, uncle or brother; avoid childhood since some rapists are 'turned on' by little girls, but also avoid old age since some rapists 'prefer aged women'; do not go out without clothes, or conversely, with clothes – since either way, it encourages men to rape women (The London Rape Crisis Centre, 1988: 2-3). Even though the above was formulated within the context of the eighties in the United Kingdom, the issues are nevertheless applicable to South Africa, where statistics demonstrate that one in two females will be raped in their lifetime (Ferguson and Collis, 2005). Rape is a gendered reality rooted in factors such as fear, violence, coercion, manipulation, brute force, and power imbalances related to sex, age or economic inequality.

South Africa's 1996 Constitution protects gender equality, and the most visible strides made are those with regards to the promotion of gender equality framed in the Bill of Rights. The visible, legal push for equality has contributed significantly towards shaking the very foundation of patriarchy, which allowed men to wield both power and authority over women. Men employ sexual violence as a tool in an attempt to keep women in their 'rightful' place under the system of patriarchy. Despite the vision of the Constitution and positive moves made to empower women, it is evident from the narratives of Ogwini adolescent girls that these dominant masculinities still prevail. These prevailing masculinities (in some cases externalised violently) underpin the sexual relationships experienced by my respondents.

According to CIET (2004), misconceptions about sexual violence and the risk of HIV infection are common among both sexes in South African youth. Around 11% of males and 4% of females claim to have forced someone else to have sex, for example. Most of these youngsters had themselves been forced to have sex, and this suggests that a history of forced sex distorted perceptions about sexual violence and the risk of HIV infection. Those who have suffered sexual violence in the past become perpetrators themselves; they see such deviant behaviour as the norm rather than the exception, particularly as it is so prevalent in South Africa.

Like other South Africans, Umlazi township dwellers cannot get away from the nation's colonial past, where skin colour determined the hierarchical order of socio-economic status, and in turn, one's health status. L'Ange (2005: 132) observes what happens when poverty denies men their basic needs:

> [...] he can't eat and he lives in a shack and his family is sick and down the road there is a mansion – the psychological force of that is going to break him.

The author asserts that in this context, South Africa's poor communities are indeed being challenged to breaking point, with the biggest problem being HIV/AIDS. He insists that when people's suffering becomes unbearable, men in particular often escape their pain by turning to alcohol, drugs or other addictions such as sex. When the dormant volcano of suppressed frustration erupts violently, women and children become the blameless targets. Consequently, sexual violence features high on the list of violent acts perpetrated by such men, some of whom blame alcohol for their offences. Ferguson and Collis (2005) reject the excuse that men only rape women due to the influence of alcohol. The two researchers claim that this excuse is neither plausible nor based on psychological fact. To support their argument, Ferguson and Collis (2005:122) cite Lisa Vetten (a prominent activist researcher on gender-based violence):

> It [alcohol] may be a disinhibitor, but it's a very convenient excuse to say: 'Oh, I got drunk, and I couldn't control myself.' If a man was that drunk, he wouldn't be able to get an erection.

Sexual violence is also reinforced (sometimes glamourised) by the media, as explained in the following section.

5.9 The media and HIV/AIDS

The sexual revolution in relation to the mass media, its depiction of sexuality and its role in fuelling adolescent sexual misconceptions, cannot be ignored. A relatively new source of information that is gaining popularity in the townships is blue movies (pornography), which indicates that township boys have a penchant for simulated sex:

Natasha: They [boys] get misinformation from blue movies.

Interviewer: Where do they get blue movies?

Natasha: They get their brothers – those over 18 – to get it for them from video shops.

Interviewer: Is it a common practice in Umlazi township?

Natasha: Yes, it a common practice. Boys cram into a small room; they close the door and the curtains and everything. When you knock at the door while they are watching the movies, they say: "No! No girls allowed."

Zoë: During those blue movie sessions, they feed each other a lot of myths on how to do sex with a girl. For example: "Pull your penis out before ejaculation and she won't get pregnant." Another example is that most boys think that girls are just sex machines; they are something to satisfy themselves, which is wrong!

Zoë suggests that discussions following the viewing of such movies spawn misconceptions, which adds to the prevailing blend of old and new thinking among today's adolescents in Umlazi. She cites sexual withdrawal by the male during intercourse as being a guaranteed safeguard against pregnancy. However, this traditional contraceptive method does not take into account the leakage of sperm prior to ejaculation. In addition to this, Zoë generalises by mentioning how the media portrays gender stereotypes: males see females as mere sex objects; commodities to be used and abused at will.

Zoë would probably agree with the views expressed by Allen (2004), though the latter specifically speaks of television rather than video – a more recent version of the moving picture. Allen cites television, which remains a powerful medium of communication today – a century after it was introduced – as a corrupter of sexual morals. Allen argues that the introduction of television in the 1950s in the United States was a major contributor to juveniles undergoing their sexual debut at an increasingly younger age. Exponents of free love or sexual liberation would condemn him as being ultra-conservative for asserting that one of the biggest lies and misconceptions people fall for is the thought that 'waiting until marriage to have sex is outdated, foolish and a sadistic joke to keep you from having fun' (Allen, 2004: 20). Allen (2004:20), however, delves into history to advance his argument about the effects of TV on the morals related to sexuality:

> In times past, until you could read about something or were told about it, you didn't know about it. TV has changed all that. Now 'the secrets of adulthood' can be seen by anyone at the click of the remote. Today we see just how far down the read we have come when we look at the erotic music videos, suggestive sitcoms, blatantly pornographic movies openly aired on the screens within our living rooms.

The blue movies referred to by Zoë fall into this category.

In addition, Cassidy (2004) observes that South African youth spend four to five hours daily watching television. Before they matriculate, they would have seen some 50000 murders on TV; over 90000 incidents of drinking and drugs; and each year, over 9000 acts of sex or sexual innuendos. The author surmises that due to limited entertainment options in the township, children living in such areas may probably spend more time watching TV.

Cassidy (2004) maintains that children may form an identity and draw values from both their TV icons and anti-heroes. In the arena of human sexuality, the media glamourises sex out of proportion, accentuating the pleasure, without necessarily giving prominence to unwelcome aspects such as unplanned pregnancy, abortion and sexually transmitted infections. Allen (2004) posits that the media are influential in selling the view that sex is a social act to be enjoyed with anyone, at any time and in any way. The young, who are relatively more vulnerable than the rest of society, are buying into the attractive lifestyles portrayed, not only by alluring media icons, but also by music stars and top athletes, some of whom are reported to have multiple relationships. In similar ways, I would argue that township youngsters are probably no exception and emulate what they see on the screen, in the music industry, in the sporting arena, and could contract HIV through experimenting with unprotected sex. The point here is that sexual titillation and arousal, which is reinforced by images generated by pornography and hedonistic lifestyles, instil in young males the idea that they can achieve sexual gratification at the expense of sexual negotiation in relationships.

5.10 Conclusion

This chapter brought into focus eight different themes that highlight the various sexual misconceptions that predispose African adolescent girls to HIV infection in Umlazi. In comparison to men, it is evident that women's disproportionate vulnerability to HIV infection is compounded by social, cultural, economic, legal and political forms of inequality. Some Ogwini adolescent girls reflect a sense of disempowerment on the one hand, and – on the other hand – some display sexual agency in which they seek sex for pleasure, survival or for consumerism. Either way, the adolescents' physiological vulnerability to HIV infection calls for the urgent need to focus on interventions and strategies that are gender-sensitive. Based on the respondents' insights that were profiled in this chapter, I now turn to some conclusions and recommendations with regard to my overall focus of this dissertation in **Chapter 6**.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

As mentioned throughout this study, African women between the ages of 15 and 24 constitute the fastest growing group most vulnerable to contracting HIV in South Africa. The severity of these statistics reinforce the need for drastic intervention in the prevention and control of HIV/AIDS. In response to this, stakeholders such as schools, the health department and other government bodies, non-governmental bodies, faith-based organisations, community based organisations, donors and the mass media have all bombarded the public with messages on the AIDS epidemic. Despite the barrage of information disseminated extensively on the subject, it is evident that there are many gaps in this knowledge, which are closely linked to what I refer to as sexual misconceptions. Such misconceptions, I conclude, have far-reaching consequences for public health since they hinder the prevention and control of HIV/AIDS. In this chapter, I revisit the central ideas of the study by interpreting and assessing the relevance of my findings in order to make some tentative conclusions and recommendations for future research and public health interventions.

From the outset, this study discussed the views of adolescent girls from a South African township, whose voices often go unheard because adults often become their self-appointed spokespeople. Another focus of the study was to involve the young girls in researching the taboo subjects of gender and sexuality, in relation to HIV/AIDS, within their age group. The spotlight was on girls aged 15 to 19 of the predominantly Zulu-speaking population in Umlazi Township, which is located on the outskirts of Durban. Through individual and groups interviews, the study probed girls' perceptions and experiences with a view to exposing the intricate web of sexual misconceptions that predispose these adolescents to HIV infection.

Earlier chapters drew attention to numerous misconceptions, which are broadly categorised under seven themes (cf. **Chapters 2** and **5**). The first was how sexual

misconceptions are linked to biomedical and epidemiological factors that predispose African adolescent girls to HIV infection in the Umlazi Township. The second theme focused on the relationship between socio-cultural factors in relation to youth culture and AIDS, and the third factor dealt with the girls' sexual agency. The fourth theme determined how economic factors influence the proliferation of misconceptions among these adolescent girls. The themes addressed the roles of significant adults in the spread of HIV/AIDS among adolescents; the media and HIV/Aids; sexual orientation, and gender-based violence. Recommendations to help curb the spread of the virus underpin the concluding aspects of the study. Before proceeding to the recommendations, I briefly summarise some of the key issues that flow from the analysis in **Chapter 5**.

6.1 A few key findings

Based on the analysis in **Chapter 5**, the factors that render adolescent girls of Ogwini Comprehensive Technical School vulnerable to HIV infection could be further extrapolated in terms of the personal, societal and programmatic. These findings do not by any means suggest that men are not as vulnerable to HIV infection, but instead that females are relatively more vulnerable due to biological and cognitive behavioural factors. Since sexual misconceptions related to HIV/AIDS are numerous, only a few are highlighted below.

6.1.1 Personal factors

At the personal level, it was apparent that adolescent girls do not always have the level of awareness, skills or experience needed to differentiate between misconceptions versus HIV/AIDS information that is relevant or accurate. The girls are seldom in a position to grasp the implications of those misconceptions in terms of the construction of their gendered identities, sexuality or reproductive health. Some girls, for example, saw themselves as unwilling and disempowered partners, who were inevitably trapped in sexual relationships they deemed themselves as having no control over, simply by virtue of being female. In boy-girl relationships, sex is considered a given. Some girls do not

refuse sex because they believe they will lose their boyfriend to other girls who are more amenable. Though practising unprotected sex, many girls hoped they would not fall pregnant, or contract STIs. Instead, they believed and hoped that such 'calamities' could only happen to someone else. Some saw themselves as being too young to contract HIV, which they viewed as an adult illness, or an illness that only 'bad girls' with multiple sexual partners contracted. Others convinced themselves that simply because they were being faithful to their partners these men would reciprocate. At the other extreme, girls who sought material benefits agreed to 'flesh-to-flesh' sexual intercourse, yet were optimistic they would not contract the virus.

6.1.2. Societal factors

Adolescent girls' vulnerability to HIV infection is linked to the broader context of societal factors that impact negatively on their lives, as discussed in **Chapter 6**. For example, sex, shame, stigma and disease that are generally associated with HIV and AIDS instils fear, to the point where they avoid voluntary counselling and testing should they discover they are HIV-positive. The stigma associated with being HIV-positive, and the fear of AIDS often makes people avoid voluntary counselling and testing, in the event they discover they are HIV-positive.

This sort of thinking is based on the assumption that HIV infection equals death. Meanwhile, girls' sexual agency challenges the notion of women's powerlessness in a sexual relationship, with the female being viewed as a 'victim'. Closely linked here is the trend of girls engaging in multiple sexual partnerships. This challenges the prevailing impression that girls have a greater commitment to a monogamous union than males do. Study findings demonstrated that girls are just as calculating as some men in juggling multiple partners, therefore, multiplying their risk of contracting HIV with each act of unprotected sex.

6.1.3. Programmatic factors

Programmatic vulnerability could be defined as the contribution of HIV/AIDS intervention programmes in either curbing or increasing vulnerability to infection. Sexual misconceptions linked to intervention also prevail among stakeholders. One of the key misconceptions is the 'ABC approach' (abstain, be faithful, and use a condom where you cannot), touted in most African countries as being among the best HIV prevention strategies for adolescents. This strategy assumes that both male and female partners have full control over what form of sex they engage in, or how and when it is performed. Often overlooked, however, is the gendered fact that 'control' remains largely a male prerogative. This incongruence is reflected in programming that targets women, rather than men, yet the latter generally tend to have greater numbers of sexual partners and are often reluctant to wear condoms. This form of programming is illustrated in annual antenatal surveys, where the emphasis is on the lop-sided prevention of mother-to-child transmission (MTCT), rather than the prevention of parent-to-child transmission (PTCT). The latter incorporates males into the equation. A similar shortcoming is evident in voluntary counselling and testing (VCT), which generally draws more females than males, yet should target males more aggressively to redress the imbalance.

6.2 Recommendations

The prevailing circumstances raise pertinent issues and questions. What should be done to curb the spread of AIDS? Policy makers and implementers of intervention strategies should recognise that certain HIV prevention programmes may actually be fuelling, rather than curbing the spread of HIV/AIDS. For example, stakeholders' failure to appreciate the complexity of HIV/AIDS may result in them attempting to work in isolation and narrow the intervention focus, for example, by only employing the biomedical approach. A multi-faceted, multi-disciplinary approach is required at different levels, rather than solutions being devised by a single group of stakeholders working in the biomedical field, for example, or solely by policy makers. The conventional,

biomedical approach needs to be backed by socio-cultural, economic, legal and political forces, if it is to succeed.

Will stakeholders choose to cling to prevalent stereotypical beliefs such as the presumed asexuality of adolescent girls, rather than critically examining related misconceptions that fuel HIV infections among adolescents? Will stakeholders advocate the prevention and control of HIV/AIDS by acknowledging that sexual desire is at the heart of sexuality, instead of ignoring it completely when planning intervention strategies? Interventions that steer clear of stereotypical explanations of girls' vulnerability (ones that ignore sexual agency and desire in the decisions adolescents make about sex) are likely to meet success.

Stakeholders need to be sufficiently proactive to take such a controversial stance when developing and promoting appropriate intervention. Such a process, which is aimed at deepening understanding on the pertinent issues affecting adolescent girls against the backdrop of the AIDS pandemic, calls for more research and funding. The process should also entail a wide dissemination of data findings, even when the information goes against the grain of popular thinking, and faces hurdles such as a lack of networking, and the risk of alienation.

In addition to this, proactive research demands that intervention steer clear of adopting behavioural change models or theories that embrace the 'one size fits all' approach, which was in all likelihood borrowed from the West. Instead, research should be modified to accommodate local conditions that recognise the importance of people's experiences. A paradigm shift is essential if meaningful changes are to be introduced when developing and implementing intervention strategies.

Stakeholders do not always recognise that the key to winning the war against HIV/AIDS does not lie with the individual, since he or she does not exist in a vacuum. Our environment determines our choices. Current intervention measures, therefore, require closer analysis in order to root out those shortcomings.

Intervention with regard to HIV/AIDS calls for the recognition that denial is common among adolescents, who prefer to imagine that their youth makes them invincible. Or they choose to believe that only other people contract the virus. In what could be seen as the 'othering' of the HIV infection, adolescents engage in high-risk behaviour, yet do not see themselves as being at risk of infection. For many, high-risk behaviour is construed to mean engaging in sex with individuals belonging to specific groups. In South Africa these may include: whites, blacks, foreigners, gay (women and men), prostitutes and those considered 'promiscuous'.

Due to this form of denial on the part of the individual, many sexually active adolescents behave as though they themselves, their friends and neighbours do not fall under any of these categories. There is a need to underscore the fact that it is not the group an adolescent belongs to or affiliates with, but rather the risky sexual practices one engages in that influence HIV transmission.

Adolescents require not only information to abstain or avoid the consequences of unprotected sex, but also the skills to do so. This calls for parents, teachers, religious leaders, health workers, advocacy stakeholders and youth leaders to first acquire these skills, and then learn how to impart them effectively. Although imparting skills is more difficult than learning them, the latter is nevertheless a critical investment since it equips young people to make good choices concerning their sexual and reproductive health.

The Life Skills Programme is a key strategy initiated by the National Education and Health Departments to cater to the secondary and primary schools in the twin areas of sexual and reproductive health. The programme's goals are to increase knowledge, develop skills, and promote positive and responsible attitudes. Learners are expected, among other things, to critically evaluate reasons to delay their sexual debut, practise abstinence and safe sex, as well as resisting peer pressure. Though commendable in its objectives, the programme has, however, hit many obstacles, including delays in government funding, untrained trainers and the inadequate development of materials.

Unless these shortcomings are addressed, the ideals of the Life Skills Programme will remain largely theoretical.

Other avenues that could be explored to try and achieve the same results as the Life Skills Programme hopes to achieve, could include extending informal sex education beyond the school setting to include the home and community; folk media, mass media (to include radio, TV, video, film, newspaper and other print media), telephone hotlines and face-to-face counselling. These avenues could be used to question and challenge misconceptions that predispose adolescents in general, but girls in particular, to HIV infection. The measures would take into account the differences between males and females in relation to age, knowledge, skills and the power dynamics between the genders.

In this study, I also highlighted sexual misconceptions that are all too often traced back to culture. Culture, as shown in my study of the Ogwini respondents, has both positive and negative influences in terms of health promotion and disease prevention with regard to HIV/AIDS. Stakeholders could enhance intervention by taking into account both sets of influences while developing their strategies. I have demonstrated, for example, that culture is 'handed down' to young people through significant adults, who play an important role in their lives. Although this form of candid communication about sex is considered 'uncultural' by many of the adults in Zulu-speaking communities, significant adults need to communicate frankly with adolescents about sexuality and HIV/AIDS. Adults cannot afford to remain silent while an average of 1700 infections occur daily in South Africa, especially when half of the new infections occur among young people aged between 15 and 24.

It is imperative that significant adults also set a good example for adolescents to follow in terms of sexual behaviour. An important setting where this can be achieved is in the home, where parents or other significant adults can lead by example. Ideally, instruction could be imparted in the simple, daily activities of family life, rather than by means of intermittent communication or counselling sessions. Time invested in this way during their adolescence (an impressionable stage of development) is likely to produce enduring

results. Another process that could be invaluable is encouraging community groups to hold discussions on sexual misconceptions and other key areas in the prevention and control of HIV/AIDS. Equally important is setting up adolescent-friendly reproductive and sexual health clinics where issues pertinent to HIV/AIDS are discussed by supportive health workers.

The current information explosion has contributed significantly to generating sexual misconceptions that predispose adolescents to HIV infection, with the loudest of voices perhaps coming through the mass media, advertising and Internet. The media referred to here includes television, movies, video, radio, newspapers and magazines. TV is considered an integral force that promotes risky practices by constantly depicting pre-marital and extra-marital intercourse with multiple partners as being the norm. To protect youngsters, either the media itself, or the listening and viewing habits of adolescents must change. Since it is easier to change the latter, significant adults need to help adolescents select what to watch and listen to. Ideally, the young should be taught early on to make good choices, bearing in mind that in some cases sexual debut is occurring as early as 9 or 10 years of age.

6.3 Limitations

My findings are by no means definitive. A key limitation in my study is the fact that it concentrates largely on adolescent girls' views, which is the research brief covering the scope of this dissertation. It is also relevant for future investigations to consider adolescent boy's perceptions of sexuality and gender relations within the context of HIV/AIDS. To this end, follow-up research to my study would prioritise how manhood, coupled with diverse masculinities is in flux. This could entail showing how manhood and masculinities are constructed, sustained and problematised, as well as the implications such constructions have on adolescent girls' sexual and reproductive health.

Overall this study was geared towards initiating a rethinking of the prevailing constructions of manhood and masculinities that render both girls and women vulnerable

to HIV/AIDS. Anti-social versions of masculinities, which are authoritarian and misogynist in nature, are responsible for the following: enforcing unequal power relations between men and women; a tendency towards violence; unnecessary risk-taking; and establishing sexual prowess by having multiple sexual partners. This behaviour could be replaced by another set of positive values that promotes and enables healthy relationship building on the part of men. This could also encompass values such as care, respect, responsibility, and other non-violent ideals that do not endanger the sexual and reproductive health of girls and women.

Another restriction was that, in my study, I relied heavily on self-reported data from interviews. In the process, it is likely that some vital information is skewed or sketchy due to respondents not being honest about their sexual activities, since they are expected to be sexually innocent. The subsequent bias could be partially minimised through longitudinal ethnographic research rather than once-off interviews or focus group discussions. Several visits over a prolonged period would develop trust between the respondents and interviewer, with the former gradually relaxing enough to discuss intimate sexual details with a greater measure of openness.

In addition to this, due to budgetary constraints, I was unable to conduct the in-depth interviews and focus group discussions in Zulu (the respondents' mother tongue), which would have elicited far richer detail. It would then have been possible to hire an interpreter and pay for transcription of the audio tapes used to record the interviews. Closely related to this constraint is the limited time I was able to spend in Umlazi at places frequented by adolescents, with a view to observing boy-girl, girl-girl and boy-boy relationships, which would have enabled a deeper understanding of sexual misconceptions.

A further limitation was my narrow sample size, which only included girls still attending school, and left out the significant group of those who had dropped out due to pregnancy or other reasons. Though harder to trace, such girls would probably offer valuable insight

on the misconceptions that led to their own pregnancies, besides also recommending practical ways to avert such occurrences in the future.

6.4 Summation

Finally, in concluding this study, I return to the beginning of my intellectual journey in respect of this study. By reading the existing sketchy literature and interviewing people on sexual misconceptions, it became increasingly clear that unnecessary deaths from unsafe sex (reinforced through misconceptions) could be prevented, if adolescents became aware of health risks stemming from these misconceptions. As my search developed, it gradually became apparent that such misconceptions were not exclusively prevalent among my respondents. Rather, these misconceptions were also common in the broader community (as verified by respondents who informed me that their peers were instrumental in shaping their own views and corresponding sexual behaviour). Misconceptions – at one extreme – included half-truths, cultural stereotypes, and manipulative ploys. At the other extreme, it dealt with outright fallacy and myth. When faced with this vast assortment, however, it occurred to me that merely cataloguing a set of misconceptions alone could hardly suffice as a contribution in curbing HIV/AIDS. The misconceptions on which I have based these recommendations (within the given context), could further deepen and inspire the understanding of HIV/AIDS with a view to improving interventions strategies. Implicit in my overall purpose in this study was not simply to list sexual misconceptions, but rather to debunk those core ideas that construct these misconceptions.

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APPENDICES: ANNEX 1

Sexual Misconceptions that Predispose African Adolescent Girls to HIV Infection in Umlazi Township, Durban

QUESTIONNAIRE: FOCUS GROUP DISCUSSION AT OGWINI COMPREHENSIVE TECHNICAL SCHOOL

I promise to keep all the information you have given me confidential, so feel free to tell me anything by answering questions as honestly as possible. To ensure that nobody knows your identity, I will ask you to give me a false name at the beginning of the interview to enable me to distinguish what you say from what other interviewees say. I shall use a tape recorder to ensure I record your information accurately. To introduce yourself at the beginning of the interview, please state your false name, your age and your grade. Each time you speak again, please begin by repeating your false name.

1. Men claim they cannot do without sex. Give reasons why you agree or disagree with this statement.

2. Can girls abstain from sex? To what extent do girls of your age in Umlazi observe abstinence?

3. At what age do girls in Umlazi become sexually active? At what age did you become sexually active yourself?

4. The first time girls you know had sex, was it their choice? If not, what happened?

5. If a man tries to force you to have sex with him, what would you do?

6. When a girl says "no' to sex, does she actually mean 'no' or 'yes'?

7. Would you agree or disagree that 'sex' and 'love' are the same? Please give reasons for your answer.

8. If you are sexually active, what reasons would you give for having sex with your boyfriend?

9. What is the earliest age that a boy can make a girl pregnant?

10. What is the earliest age at which a girl can get pregnant?

11. Do girls your age have sexual partners who are younger, the same age or older than themselves? On average, what is the average age difference between most girls your age and the age of the men they have as boyfriends? Where there is an age difference, why do girls chose to have men of a different age?

12. Why do girls your age keep boyfriends?

13. Can a girl fall pregnant the first time she has sex with a man?

14. If a man withdraws before ejaculation, can the girl he is having sex with fall pregnant?

15. In which ways do sexually active girls keep from getting pregnant?

16. To preserve their virginity, some girls have anal sex (through the rectum). Do you know of any high school girls who engage in this form of sex? What are the advantages of this form of sex? What are the disadvantages?

17. How important is virginity in Zulu culture today?

18. In your opinion, what kind of people get HIV?

19. Have you ever seen a person who has AIDS?

20. Can a healthy-looking person be carrying the virus? Can a healthy carrier pass on the virus?

21. What is the cure for AIDS?

22. Where do you get most of your information on HIV and AIDS?

23. To what extent do your friends influence you on the knowledge you have about HIV and AIDS?

24. What are the different ways in which you protect yourself from getting the virus?

25. What can you do to avoid getting sexually transmitted infections?

26. What can you do to treat sexually transmitted infections?

27. Is there a link between HIV infection and sexually transmitted illnesses?

28. On average, how many sexual partners do girls your age keep?

29. Do you see yourself as contracting HIV for any reason? Please explain your answer.

30. Have you ever been raped? How many times? Would you say there is a link between rape and AIDS. Please explain.

31. Where girls are sexually active, do they use a condom each time they engage in sex? If yes, why? If not, why?

32. Whom do discuss sexual matters with most? Who else?

33. Do you discuss matters on sex and AIDS with your sexual partner?

APPENDICES: ANNEX 2

Sexual Misconceptions that Predispose African Adolescent Girls to HIV Infection in Umlazi Township, Durban

QUESTIONNAIRE: IN-DEPTH INTERVIEW AT OGWINI COMPREHENSIVE TECHNICAL SCHOOL

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Part One (Ice breaker)

1. What would you like to be when you grow up? What are your reasons for your wish?
2. What would you consider your greatest achievement in life?
3. Where would you like to live when you complete school, and why?
4. What kind of family would you like to have? Size? Composition? Why? How different is your ideal family from the family you have now? Please tell us more about your family.
5. In traditional Zulu culture, who is considered a 'good girl'? Please list some of the qualities a good girl is supposed to have? Today, do you see these qualities in girls your age? Do you see these qualities in yourself? What do you like best about being a girl? What are the 'bad girl' qualities? Do girls your age admire good girls or bad girls?
6. In traditional Zulu culture, who is considered a 'real man'? Is today's 'real man' different, and if so, in which ways?

Part Two

1. Do you know of people who have AIDS in your community in Umlazi? How common is AIDS in your community?
2. In your community, do people say AIDS is a 'male' or 'female' disease? What reasons do they give for their beliefs?
3. As a girl, once you become someone's girlfriend, what are you expected to offer them? What does a girl expect from her boyfriend?
4. What was your age when you had sex for the first time?
5. Was having sex at the time your choice, or your partner's choice?
6. What reason/reasons can you give for having sex?
7. Did you enjoy sex the first time you had it? Do you enjoy it now? Can you describe how much you enjoy it?
8. Who usually makes the first move to have sex, you or your partner?
9. How often do you have sex in a month?
10. What kind of sexual activities have you engaged in, in the past month? Penis/vagina? Penis/anus? Oral sex (boy to girl, or girl to boy, or both?). *Ukusoma*? Any other forms of sexual activities?
11. Do you or your boyfriend take alcohol or drugs before having sex? If yes, explain.
12. How many boyfriends do you have? What ages are they? Do you have sex with all of them?
13. What kind of sex do you engage in (Penis/vagina? Penis/anus? Oral sex [boy to girl, or girl to boy, or both]? *Ukusoma?* Other?
14. Do you use contraceptives each time you have sex with your boyfriend/s?
15. What kind of (contraceptive) method have you been using to avoid getting pregnant? Why do you prefer to use this method and not the others?
16. Under what circumstances do young people in Umlazi use condoms?
17. What reasons do sexually active girls refuse to use condoms? How about boys?
18. Do you personally use a condom each time you engage in sex (Penis/vagina? Penis/anus)? Oral sex (boy to girl, or girl to boy, or both?)?
19. What kind of sexual practices put teenagers at risk of getting HIV?

20. Why do teenagers in Umlazi know a lot about AIDS but still engage in risky sexual behaviour?
21. Have you ever been pregnant? How many times? How many children do you have? Who is looking after her/him/them? Is the guardian happy looking after your child/children?
22. Have you ever aborted? If so, why?
23. Have you ever had a sexually transmitted infection? Could you describe the infection? What action do you take whenever you discover you have a sexually transmitted infection?
24. In your opinion, is there a link between HIV and sexually transmitted infections? If yes, what is the link?
25. What precautions are you personally taking against contracting the virus?
26. How much do you discuss HIV and AIDS with your sexual partners? Who makes the main decisions about sex?
27. Do you discuss matters of HIV and AIDS with your sexual partner? What do you usually focus on in your discussions?
28. Do you see yourself getting HIV in your lifetime? If 'yes', why? If not, why?
29. Have you ever gone for an HIV test? Whether your answer is 'yes' or 'no', what were your reasons?
30. What ways do people employ to 'cure' AIDS in Umlazi? Can AIDS be cured?
31. How would you define 'rape'? Have your ever been raped? How many times? What action did you take after getting raped?
32. How widespread is rape in Umlazi? What action is taken when someone is raped in Umlazi? What do you think is the best way of dealing with rape?
33. When a pregnant girl has a regular sexual partner who is HIV-positive, how would that affect the HIV status of her baby?
34. What precautions can lesbian girls (or girls who have sex with other girls) take to protect themselves and their partners from contracting HIV?