

MRS. MALA DEVI MAHARAJ

SUPERVISOR: DR. SHAKILA SINGH

UNIVERSITY OF KWA-ZULU-NATAL: EDGEWOOD CAMPUS

STUDENT NUMBER: 8218182

MASTERS IN EDUCATION: GENDER

**UNDERSTANDING RISKY SEXUAL
BEHAVIOUR AMONGST FEMALE
SECONDARY SCHOOL LEARNERS
WITHIN THE CONTEXT OF
HIV AND AIDS IN SOUTH AFRICA.**

DECLARATION OF OWN WORK

I, Mala Devi Maharaj, declare that:-

- The research reported in this dissertation, except where otherwise indicated, and is my original work.
- This dissertation has not been submitted for any degree or examinations at any other university.
- This dissertation does not contain other persons' data or other information, unless specifically acknowledged as being sourced from other persons.
- This dissertation does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers.
- This dissertation does not contain text copied and pasted from the internet.

Signed: -----
Student No. 8218182

Dated: -----

Supervisor: -----
Dr. Shakila Singh

Dated: -----

ACKNOWLEDGEMENTS

I was in a fortunate position to be supervised by Dr. Shakila Singh, who provided me with the intellectual direction and was always available to share her extensive knowledge on the subject. She helped me to keep focused and motivated. For this, I am deeply indebted.

Thanks also go to the management and staff of Brookdale Primary School who supported this research and made available an extensive body of expertise, which I drew upon. I am certain the skills acquired through my research will benefit the institution in the Life Skills Education Programme.

I am also grateful to the principal and staff of Brookdale Secondary School who willingly agreed that the school serve as the research site. Similar levels of co-operation were obtained from the learners of Brookdale Secondary School, who willingly shared their knowledge and time with me.

I am eternally grateful to my sons, Shaneel and Sumay, granddaughter Nehaa and daughter-in-law for making the sacrifices over the past two years, by allowing me the time to conduct this research. I remain indebted to my parents for the solid foundation they laid in my life, and my family and friends for their on-going encouragement. It has been a long and tiring journey, but one which I hope has and will continue to advance the future of research.

ABSTRACT

Young women in socially challenged environments engage in risky sexual behaviour for many reasons. This paper presents the findings of a qualitative research project conducted among female secondary school learners in the Amaoti- Phoenix areas. Data was elicited during both individual and group interviews. A semi-structured interview process was employed. Poverty is at the helm of most risks taken. Many of the participants hail from informal settlements where space and privacy is limited. The young women are exposed to sexual activities very early in their lives, often with multiple partners. Elders in the research community do little to educate their young people of the risks associated with unprotected sex. Often young women are coaxed to engage in unprotected sex due to the rewards that accompany this risk. To indulge in life's luxuries, young women embrace sexual risks. The young women also allude to desire for sexual pleasures. The hope of a steady relationship motivates the young women to engage in unprotected sex as they trust and love their partners enough to waiver the use of protection. Substance abuse also contributes to risk taking behaviour as the individuals are unable to make informed choices when under the influence of drugs and alcohol. Myths and misconceptions in society place young women on the risk continuum. They are in danger of being raped or violated because of the belief that HIV and AIDS can be cured by a virgin. Gender disparities place women in subordinate positions in society whilst the men are dominant and in power. These discriminatory practices further place young women at risk as they lack the capacity to negotiate safe sex. The patriarchal Black and Indian communities allow for male dominance where often coercive and violent sexual behaviour is common. The young women are knowledgeable about the STDs, HIV and AIDS. Pregnancy is cited as being of greater concern than diseases contracted during unprotected sex. These young women have not had direct encounters with HIV and AIDS patients therefore its influence is watered down. Schools are equipped to handle Life Skills Education focusing on HIV and AIDS as well as safe sexual practices. This study is located within a feminist paradigm but the theory of social construction of gender is adopted.

TABLE OF CONTENTS	PAGE
CHAPTER 1: INTRODUCTION TO THE STUDY	
1.1. Introduction	9
1.2. Motivation for my Study	9-10
1.3. An Overview of Proposed Concerns	10
1.3.1. The HIV and AIDS Concern	10
1.3.2. Poverty and Sexual Risks	11
1.3.3. Reasons for Risky Behaviour	11-12
1.3.4. Gender and Power Anomalies	12
1.4. Theoretical and Conceptual Frameworks	13
1.4.1. Social Construction of Gender	13
1.4.2. Feminist Paradigm	13
1.5. Research Paradigm Adopted	13
1.5.1. Research Approach	14
1.5.2. Sampling	14
1.6. A Brief History of my Research Community	15
1.7. The Research Site	15
1.8. The Management & Teaching Staff	16
1.9. The Learners	16
1.10. Key Research Questions	17
1.11. Conclusion	17
CHAPTER 2: A LITERATURE REVIEW	
2.1. What is a Literature Review	18
2.2. Introduction	18
2.3. HIV and AIDS in South Africa and the World	18-21

2.4.	Denial of the Pandemic	21
2.5.	The Stigmatization & Discrimination of HIV and AIDS	22-23
2.6.	Gender & Power Anomalies	24-27
2.7.	Risky Sexual Behaviour	27-30
2.8.	Strengthening Relationships	30-31
2.9.	Coercion & Violence	31-32
2.10.	Non- use of Protection	32-33
2.11.	Myths, Misconceptions & Beliefs	33-34
2.12.	Substance Use & Abuse	34-37
2.13.	Peer Pressure	37
2.14.	South African Government's Response to HIV and AIDS	37-38
2.15.	Placing the Study within a Theoretical & Conceptual Framework	38
2.15.1.	Introduction	38
2.15.2.	Social Construction of Gender	38-39
2.15.3.	Feminist Paradigm	40-41
2.16.	Conclusion	41
CHAPTER 3: RESEARCH DESIGN & METHODOLOGY		
3.1.	Introduction	42
3.2.	Research Approach	
3.2.1.	The Qualitative-Interpretative Approach	43-46
3.3.	The Research Site	46
3.3.1.	Location Selection	46-47
3.3.2.	Access to the Research Site	47
3.4.	Selection of the Participants	48

3.5.	Methods of Data Collection	
3.5.1.	The Interview Process	49-52
3.5.2.	Data Analysis	53
3.5.3.	Validity & Reliability in Qualitative Analysis	54-55
3.5.4.	Trustworthiness	55
3.5.5.	Ethical Considerations	55-57
3.5.6.	Limitations	57
3.5.7.	Conclusion	57
CHAPTER 4: FINDINGS AND ANALYSIS		
4.1.	Introduction	58-59
4.2.	Themes	
4.2.1.	Crowded Space	59-60
4.2.2.	Culture & Tradition	60
4.2.2.1.	Patriarchal Societies	60-64
4.2.2.2.	Cultural Values & Norms	64-65
4.2.2.3.	Polygamy	65-66
4.2.3.	Sex as Currency	66-69
4.2.4.	Sex as Desire	70-71
4.2.5.	Love & Trust	71-74
4.2.6.	Substance Abuse	74-75
4.2.7.	Myths & Misconceptions	75-77
4.2.8.	Peer Influence	77-78
4.2.9.	The Greater Threat: Pregnancy or HIV	78-81
4.3.	Conclusion	82

CHAPTER 5: CONCLUSION & RECOMMENDATIONS	
5.1. Study Overview	83-84
5.2. Synthesis	84-85
5.3. Implications	86-87
5.4. Role of the Community	87
5.5. Role of the School	88-89
5.6. Role of the Media	89
5.7. Implications & Recommendations	89-91
5.8. Limitations to my Study	91
5.9. Conclusion	92
ABBREVIATIONS	93
REFERENCES	94-105
APPENDICES	
Appendix 1: Request to Principal to Conduct Research at the School	106
Appendix 2: Consent Letter to Parents	107
Appendix 3: Letter of Informed Consent for Participants	108
Appendix 4: Individual Interview Questions	109
Appendix 5: Focus Group Interview Questions	110
Appendix 6: School Enrolment Statistics	111
Appendix 7: Ethical Clearance 1	112
Appendix 8: Ethical Clearance 2	113

CHAPTER 1: INTRODUCTION

1.1. Introduction

I am an educator serving the peri-urban and informal settlements of Amaoti and Phoenix. The socio-economic profile of the area bears evidence of many social challenges, which include abject poverty, abuse, rape, HIV and AIDS, teenage pregnancy, drugs, alcoholism and crime. These factors impact adversely on the youth in the community, and many are in a spiral of limited options, as there are few role-models to emulate and virtually no employment opportunities. Peer pressure to engage in deviant behaviour is high and many succumb to drugs and alcoholism (Simons, 2009). The low level of social cohesion, i.e. family support and guidance, plunges young girls into indulging in risky behaviour (Nattrass, 2004).

My study was aimed at understanding how young women within the age range of 16 to 17 develop their own sexual cultures and identities in relation to each other in heterosexual relations. *“Although sexuality is experienced by subjects as personal and emanating from within, it is not individually produce,”* (Allen, 2005, p.8).

1.2. Motivation for my Study

My research focuses on an issue that is slowing consuming vulnerable female secondary school learners (who for the purpose of my study will now be called young women), i.e. young women’s risky sexual behaviour. From my years of personal observation and contact with learners and various stake-holders, it has come to my attention that young women are engaging in risky sexual behaviour without, or with very little, protection. Magnani et al. (2003) state that young people living in under-privileged settings are likely to find themselves in situations that is conducive to high-risk sexual behaviour. School records show high rates of teenage pregnancies, sexually transmitted diseases, and drug and alcohol abuse. These social problems are continuously being handled by school counsellors, educators and local health clinics. Even though these structures exist, young women continue to indulge in risky sexual behaviour. Their risky behaviour sometimes leads to the contraction of many sexually transmitted diseases.

In South Africa the youth’s sexuality has been under scrutiny in terms of the latent risks of teenage pregnancy, sexual violence and rape and more urgently the transmission of HIV and AIDS. Although South Africa has diverse race groups, available statistics indicate that HIV and AIDS are more prevalent for the Black-African population. A national household survey was conducted in 2002 on the HIV rates for young people aged 15-24 years. It is alarming to notice that the Black youth sample had a 10.2% infection rate whilst the coloured youth was 6.4%, the Indian youth was 0,3% and the white youth aged 15-49 years was 6,2% (Peltzer and Promtussananon, 2005, p.1)

The main objectives of my studies were to ascertain:

- How do young women in the Amaoti-Phoenix areas construct their sexual identities within the context of HIV and AIDS in South Africa?
- What do young women in the Amaoti-Phoenix areas understand as risk taking behaviour and how do they assess their sexual behaviour within the context of HIV and AIDS in South Africa?

1.3. An Overview of Proposed Concerns

1.3.1. The HIV and AIDS Concern

In South Africa, much controversy was encountered during President Thabo Mbeki's reign when the President did not want to acknowledge the direct link between HIV and AIDS. The President alluded that the AIDS problem was poverty driven. Due to his adamant stance on the early roll out of ARVS, by 2007 South Africa had the largest number of infected people in the world. Furthermore, the then Minister of Health, Manto Shabalala Msimang, advocated a healthy diet as a cure for this virus. This was slightly conflicting with the President's view as he recognised HIV and AIDS as a disease of the poor and consequently a healthy diet is beyond their means. The new President, Jacob Zuma, said during his rape trial that he had a shower after his sexual activity with the view of washing the germ away. These views from senior government officials are dangerous for their electorate as they do not place significance on the repercussions of risky sexual behaviour.

In 2004 the World Health Organisation (WHO) estimated that there were 40 million HIV-positive people worldwide. It highlighted that in 2003 almost three quarters of the world's population infected with HIV were living in Africa. It was also noted that approximately 15 million Africans had died from AIDS. These statistics (Campbell & Watts, 2004) reflect the areas where high numbers of AIDS afflicted people live:

Sub-Saharan Africa	25 to 28.2 million people
South and South East Asia	4.6 to 8.2 million people
Central Asia and Eastern Europe	1.2 to 1.8 million people

The 2010 Global Report showed that in 2009 there was an estimated 2.6 million people who had become newly infected with HIV. In sub-Saharan Africa alone the number of newly infected people was estimated to be 1.8 million. This was more than half of the newly infected people worldwide.

These figures showed a large number of people living with AIDS in developing countries and third world economies.

A survey conducted by the Kaiser Family Foundation (2007) showed that one in five teenagers experimented in drugs. Twenty-three percent of high school learners across South Africa admitted to drinking large amounts of alcohol. HIV and AIDS, teenage pregnancy, sexual abuse and crime are the greatest worries for all young people. One in two 17 year-olds has had sex.

1.3.2. Poverty and Sexual Risk

HIV and AIDS are the most devastating consequences of sexual risk behaviour. Research undertaken by Hallman (2005) shows that the HIV infection in sub-Saharan Africa is most prevalent amongst young females. The knowledge of use of protection and ways to prevent sexually transmitted diseases, is either lacking, or if possessed, is not used. This might be attributed to the economic and social circumstances of their lives. Many young women live in poverty-stricken contexts and are unable to negotiate safe sex. The household survey undertaken in 2001 (AJAR) investigated how socio-economic disadvantages influenced the sexual experiences of 4000 young men and women aged 14-24 years in Kwa-Zulu-Natal. The findings show that low household wealth is associated with a variety of unsafe sexual behaviours for females (AJAR, 2001).

My study looks at understanding the risky sexual behaviour of young women within the context of HIV and AIDS in South Africa. Based on a literature review, I discovered that there are definitive studies that examine the effects of the risky sexual behaviour of young women within a research community. Research conducted by Bhana and Epstein (2007) has shown a very high rate of HIV prevalence among young people living in informal settlements and farms.

1.3.3. Reasons for Risky Behaviour

In conditions of poverty, girls often depend on sexual partners for gifts such as money or clothes, and have limited power to insist on condoms (Simons, 2009). Some are willing to risk HIV in order to have a baby to access child support grants, or to establish a stronger connection with a desirable boyfriend (Campbell et al., 2005). AIDS and poverty are linked together in some way (Simons, 2009). Poverty might prevent young people's access to a good education and they might not understand what causes AIDS. This ignorance places young people at risk. Young women are often ignorant of the ways to protect themselves. These risky behaviours and unprotected sex with multiple partners directly spread HIV and AIDS. Poverty also sends many girls to the cities to earn money for their families. Many end up working in the commercial sex trade where they are often exposed to HIV (Simons, 2009).

According to Leclerc-Madlala (2002), some young Zulu women use their sexuality as a resource that can be drawn upon for material or economic advantages. Sex can be used to secure a job or acquire material benefits from men, e.g. food, school fees, rents, fashion accessories, opportunities to drive in luxury cars and sleep in hotels. Abega et al. (1994) revealed that economic needs and parental pressure to earn money makes poor adolescent girls vulnerable to exploitive and coercive sexual relationships.

In research conducted by Reddy (2003) and Dunne (2005), many young women stated that "unprotected sex" is seen as "safe sex", and "protected sex" is seen as "unsafe sex" as it puts the possibilities of love into jeopardy. They assess risk in terms of love and trust in a partner. Many girls stated that it is easier to succumb to unsafe sex, than to raise the issues of safe sex practises and to be labelled "cheap" or "loose" by their partners.

The nature of the relationship influences the type of sexual behaviour that girls engage in, as well as their willingness to negotiate the use of a condom. Individuals view sex as something that can strengthen a relationship, or as a way to please a partner (Foreman, 2003; Hillier, 1999; and Varga, 1997). Pregnancy is even sought as a way to hold onto a boyfriend.

The 2003 National Youth Survey by Pettifor et al. (2005) shows that 3% of sexually active young people report giving sex in exchange for money, gifts, favours, good grades and other material items. Studies from South Africa indicate that relationships with older sexual partners carry higher than average risk of HIV infection for young women because these men are more experienced sexually and have relatively higher economic means, and condoms are unlikely to be used in these relationships (Kelly et al., 2001).

According to Eaton et al. (1999) the national average age is 15 years for girls who are involved in sexual activities. Sexual risk-taking includes high levels of non-use of condoms. Such behaviour has implications for risks of HIV infections and contracting any sexually transmitted disease (Hein, 1899 as cited in MacPhail, 1999).

1.3.4. Gender and Power Anomalies

Bhana and Pattman (2009, p.68) have done a great deal of research around gender and sexuality among young people yet they state that “we know very little about how youth in specific social contexts give meaning to gender and sexuality.” In my study I focus on young women living in socially challenged contexts. Women in these communities have unequal access to social and economic resources, which often leads to powerlessness, greater poverty, sexual violence or relating to sex work for income. In South Africa sexual risk behaviour is set within the context of differing degrees of power within relationships and gender- differentiated norms for sexual behaviour. Male dominance is propagated in these societies. Women are seen to be submissive and men as decision makers.

A survey done in the South African township of Khutsong indicates that HIV infection shows a sharp increase in the 16-18 years age group i.e.18.9% of the total age-population (William, Campbell and MacPhail, 1999). My study also aims to research probable causes for risky sexual behaviour among young women.

1.4. Theoretical and Conceptual Frameworks

I adopt the theory of social construction of gender and place this within a feminist paradigm.

1.4.1. Social Construction of Gender

Constructivism views human beings as active agents in their own development. Human beings are shaped by both nature and nurture, but they are active in shaping their own development. Theorists such as Vygotsky (1978) and Bakhtin (1981) maintain that knowledge is a social construct which is developed and learned through social interaction.

Thus human beings should not be understood as being passively influenced by forces around them. Everybody- the child, parent, and teacher and so on is actively making meaning of their lives through social contexts. Bruner (1983) sees the individual as a strategist who continuously discovers new and effective ways of finding knowledge and discovering the world. Constructivist researchers often address the process of interaction among individuals (Creswell, 2009). My research investigates how young women construct their gender identities in their social environment.

1.4.2. Feminist Paradigm

My study is located within a feminist research paradigm. In the mid-1800s feminism referred to qualities of females but recently the focus is to advocate equal rights for women. Feminists believe that women are oppressed and disadvantaged in relation to their male counterparts and their oppression is unjustified (James, 1998). Feminist research seeks to demolish the typical male dominated community with empowerment for the oppressed female sector. The focus of the research is women's consciousness of oppression, exploitation and disempowerment (Cohen, Manion and Morrison, 2011). Creswell (1998) suggests that feminist research strives to establish collaborative and non-exploitative relationships. James (1998) further indicates that feminists are committed to bring about social changes on women's behalf.

1.5. Research Paradigm Adopted

My research adopts the qualitative research paradigm. The main reason for choosing a qualitative paradigm is my experiences with female learners in the education fraternity. My study requires personal accounts of respondents rather than statistics, hence the choice for a qualitative study. Cohen and Manion(2006) state that in qualitative research the emphasis is placed on the uniqueness, the idiographic and exclusiveness of the phenomenon, group or individuals in question, i.e. they only represent themselves and nothing and nobody else. Qualitative research also shows how social and cultural forces shape young people's sexual behaviour (Marstan & King, 2006). My study seeks explanations for questions related to understanding and taking sexual risks.

1.5.1. Research Approach

I used an interpretive qualitative research approach. According to McMillan & Schumacher, (2000), an interpretive researcher must rely on observation, interviewing and document analysis. I began with a planning phase, in which general research questions, the research site and type of participants were identified. I then established rapport and trust with the participants. As the researcher, I focused on a bond of trust with the participants. I endeavoured to learn people's views and perceptions of the facts, to hear their stories and to discover their feeling (Woods, 1986).

The interpretive paradigm seeks to understand the subjective world of human experience. The interpretive approach focuses on action. This looks at behaviour with meaning. This is relevant to my study which relies on qualitative data, and infers meaning from it.

1.5.2. Sampling

My research draws on a non-probable, purposive sample. Purposive means that the respondents are known in advance and the selection is based on the fact that the group has the relevant knowledge to contribute to the study. My target group is female secondary school learners between the ages of 16 and 17. In the purposive domain, I hand-picked the participants to be included in the sample on the basis of my judgement of their typicality or possession of a particular characteristic. A sample was built that was satisfactory to my specific needs (Teddlie and Yu, 2007).

In a prearranged meeting with the principal of the school, I defined the sample that was required. The principal, being the gatekeeper, was best suited to assist me in my selection of ten female learners within the age cohort 16 going on 17. He had the school statistics and was able to direct me to the appropriate grades. Ten was a reasonable number to elicit personal response but if this sample provided inconclusive data then I would conduct further interviews. The participants within this cohort were free to exercise their right to participate or not. These young women represent the demographics of the school. The young women are outspoken, popular and extroverts.

A date, time and venue were negotiated with the principal. Semi-structured, focus group and individual interviews were conducted. These were qualitative interviews. Questions were posed to participants of my research study. This question-answer interview session was taped using a recording device. An analysis was done to locate common themes and inputs. The qualitative data was managed in a manner which ensured that the data was broken into discernable units to discover patterns and trends (Bogden and Biklen, 1982). Thereafter the analysis was compared to existing research findings using inductive strategies to secure its relevance, and was added to the research bank.

1.6. A Brief History of my Research Community

Amaoti is an informal settlement bordering the peri-urban settlement of Phoenix. People who live here were forcibly moved from trouble-torn black homelands like Transkei and Gingindlovu (1987). Migrant labourers who come to South Africa the “land of milk and honey” find free abode in this area. The xenophobic unrest in the year 1985 in the Inanda Township left masses homeless. These inhabitants resettled in Amaoti and have since become permanent residents. The mass flooding in 1987 forced residents from the New Farm area to find alternate abode. Historically Amaoti does not have a single root. People with a variety of values, norms, traditions and cultures have all come together. This high degree of instability provides a breeding ground for a myriad of social evils. Subsequently, in 2011, the government built transition homes with the hope of eradicating poorly serviced areas but the sprawling informal settlement cannot be relocated immediately.

This settlement is a breeding ground for drugs, alcohol abuse, rape, pregnancy, crime, violence and socially transmitted infections. The youth are exposed to inappropriate sexual behaviour as privacy is non-existent. These behaviour patterns are often misconstrued to be normal as very few leaders propagate different values. The youth living in these settings have virtually very little opportunity to rid themselves of this vicious cycle of poverty and disease.

1.7. The Research Site

My research was conducted at Bester Secondary School (pseudonym). Bester Secondary is about twenty years old. The infra-structure presents a well maintained environment with greenery between the block and trees on the ground which provides shade for learners during recess. The ambiance is ideal for teaching and learning. I arrived during instruction time and surprisingly the silence was overwhelming. A few voices were heard from classrooms when educators were teaching or when learners were responding. The buzzer sounded for break and learners queued at the tuck shop and stood in groups consuming and sharing lunches. The tuck shop queue was very long for a school which services a poor community. The principal kindly welcomed me and allowed me access to walk around and chat informally with whomever I wanted to. Most of the learners were appropriately attired and greeted me respectfully. The principal did mention that the roll of the school fluctuated annually from between 700 to 850 learners. He proudly affirmed that the matric pass rate is one of the best in ward- 141. For the past 3 years the pass rate rose from 79% to 87%. Many of the learners attain university acceptance. The school was also awarded a fully fitted computer centre by Vodacom in 2011. This makes the school attractive as it can offer information studies as a course of study.

1.8. The Management and Teaching Staff

Bester Secondary has a principal, a deputy principal, four heads of department and twenty- one teaching staff. Most of the educators are Indian except for the IsiZulu educator, who is black. The staff runs a much disciplined school despite the challenges surrounding the language barrier. A high standard of education is maintained. Educators show their commitment by going beyond the call of duty, and free tuition is offered after school and on weekends. The curriculum makes provision for extra-curricular and co-curricular programmes. This assists in the holistic development of the learner. To inculcate a sense of responsibility, prefects are chosen to assist in peer discipline. These are grade twelve learners. The gardening project sponsored by a Non-Governmental Organisation (NGO) forms part of the Life Skills Programme which teaches learners self-sustenance and skills to provide food for their communities. Attempts are made to declare the school a no fee paying institution as the learners experience dire financial problems, but to date no positive response has been received from the Department of Basic Education (DOBE).

1.9. The Learners

In the year 2011 the school's roll was 753 with 396 girls and 357 boys. The ratio of Black-Africans to Indians was 4:1. Most of the learners hail from the local informal settlement of Amaoti and a small percentage travel from the Inanda Township. The Indian learners live predominantly in Brookdale, Phoenix.

The learners come from different socio-economic backgrounds ranging from middle to low income. Brookdale was originally council dwellings with semi- detached, flats or simplex units. Many inhabitants have found the means to purchase the homes but some are long-standing tenants. Many learners experience financial constraints when school fees are demanded. Many parents apply for child-support grants, a school fee exemption and volunteer their service in the school's maintenance drives.

Living in limited spaces, especially in the informal settlements, where privacy is non-existent, makes studying difficult. The lack of luxuries like electricity confines the time allotted for studies as other means e.g. gas or paraffin are dangerous in these crowded spaces. On the other hand, some parents ensure that their children find study space e.g. library enrolment in the fervent hope of a better future.

Learners are of different religious denominations, with the majority of them following African-Cultural Traditions (these are too numerous to specify) and values learnt often conflict. A benevolent, overseas funded organisation, called Lungesani-Indlela, funds orphans and street children in the attempt to eradicate crime and promote literacy.

During recess, the different races very seldom mingle. Young couples loiter at the far end of the playground. Their expressions and gestures are indicative of a budding relationship or experimentation at a very early stage. They hide from their educators as they do not wish to be questioned about their liaisons.

1.10. Key Research Questions

The following are the primary research questions:

- Why do female secondary school learners in the Amaoti-Phoenix areas engage in risky sexual behaviour within the context of HIV and AIDS in South Africa?
- How do female secondary school learners in the Amaoti-Phoenix areas understand sexual risk in the context of HIV and AIDS in South Africa?

1.11. Conclusion

The primary aim of my study is to ascertain how and why young women engage in risky sexual behaviour. My findings will inform the Department of Basic Education on possible areas around which policies and programmes can be developed, to address the seriousness of the AIDS pandemic and provide young people with appropriate strategies to protect themselves.

The rest of my report is organised in the following way:

Chapter 2: Presents a synthesis of the literature relevant to the study. It includes previous research and reports on risky sexual behaviour and HIV and AIDS.

Chapter 3: The Methodology adopted during the research. The qualitative interview method was adopted using both individual and focus group interviews.

Chapter 4: Findings and Discussion: Salient themes are highlighted, such as poverty, love and trust, sex as currency and peer influence. These are discussed and linked to the literature.

Chapter 5: Synthesis and Recommendations: The study is summarized and suggestions advanced for future intervention.

CHAPTER 2: A LITERATURE REVIEW

2.1. What is a literature review?

The aim of a literature review is to highlight existent research findings and editorial comments on the research study topic. In my study the literature provided reasons and factors which contributed to the risky sexual behaviour of young women in the context of HIV and AIDS in South Africa. In any good literature review a researcher must organise and synthesise other researchers' and authors' input; into meaningful data for their own study (Leedy & Ormrod, 2005). Mouton (2009) further defines the literature review as readings, engaged in by a researcher, which are linked to her topic and provide more insight into the intended study. The information desired may be extracted from journals, books, editorials, theses and the media.

2.2. Introduction

This chapter presents the related literature review and inspects the chosen paradigm within a suitable theoretical framework. My study aims to understand the reasons and meanings attributed to young women's risky sexual behaviour within the context of HIV and AIDS in South Africa. The participants of my research study hail from low income-, peri-urban- and informal settlements in the Amaoti-Phoenix areas. Abundant social cohesion challenges contribute to the sexual risks taken by young women. My study also attempts to show young women's understanding of sexual risk and behaviour patterns engaged in within these risk taking situations.

My literature review focuses on HIV and AIDS and its contributing factors and circumstances which place young women in precarious situations where sexual risks are taken. I commence this literature review with previous research statistics and information on HIV and AIDS in Africa against world trends. I then present reasons cited and explanations given for the risky sexual behaviour displayed by young women within a historically patriarchal community.

2.3. HIV and AIDS in South Africa and the World

In the 1980s Africans were informed of a strange disease called "slim" as its victims lost a great deal of weight within a short period of time. By 2003 almost three quarters of the world's population with HIV lived in Africa. Approximately 15 million Africans had died from the disease (Campbell & Watts 2004).

Bhana & Epstein's study (2007) notes that in epidemiological studies of South Africa it was found that the HIV and AIDS epidemic was gendered and racially classified. The Black population, by nature of their socio-economic status, were at greater risk of contracting HIV and AIDS.

According to the UNAIDS report on the global aids epidemic (2010) statistical analysis shows that more than half the world's population living with HIV are women and girls. In sub-Saharan Africa more young women are infected with the virus. The most susceptible are young women within the ages of 15 to 24 years. Young women are eight times more susceptible to the virus than young men in the similar age group. Many of these young people are not knowledgeable or have little or no access to precautionary methods.

In the early 1980s in sub-Saharan Africa the ratio of HIV infection was 1:1 for males and females. By the year 2000 the infection rate doubled among young women aged 15 to 24 in South Africa (Botswana, 2000; Piot, 2001). In 2007 the infection rate in young women trebled in sub-Saharan Africa. According to a report done by Physicians for Human Rights (2007) the epidemic of the future bodes worse for young women than men.

The UNAIDS report in 2008 highlighted that in South Africa almost 5.7 million people are living with HIV and approximately 1000 infected people die daily. This report blames gender imbalances as the factor responsible for the severity of the AIDS pandemic. According to Avert (2008) in the context of HIV and AIDS young women are unable to negotiate safe sex and are often engaged in a sexual relationship with several sexual partners. As females are vulnerable to sexual abuse, rape and economically dependent on men, they take submissive roles.

Simons (2009) highlights HIV and AIDS as a global epidemic. She discloses the alarming findings of the World Health Organisation (WHO) and UNICEF research:

- At the end of 2007, 33.2 million people were living with HIV and AIDS globally.
- More than two thirds of the population living in sub-Saharan Africa were living with HIV and AIDS.
- In excess of 15 million children had lost their parents through AIDS related causes and many more had been made vulnerable to this epidemic.
- In sub-Saharan Africa, 55% of all women and teenage girls had HIV and AIDS.

HIV infects the blood stream via infected body fluids. These fluids are carried in blood, semen, vaginal secretions and breast milk. HIV enters a person's blood stream during unprotected sex. This encompasses all kinds of sex: anal, vaginal and oral. Women are more at risk of infection primarily through penetrative sex (Simons, 2009). Campbell & Watts (2004) state that AIDS is one of the largest killers in the world presently. Since its early discovery in the 1980s, the disease has claimed the lives of more than 22 million children and adults.

Baylies & Bujra (2004) relate that AIDS represents a human tragedy for all the countries that are worst affected. These countries will face development emergencies of enormous proportions. They also reiterate that there is an urgent need for sexual partners to consider mutual interests when seeking forms of protection, to ensure sustenance of their health.

There is a notable correlation between high rates of HIV infection and women's lack of bedroom power. "If more women have the power to say no to unwanted and unsafe sex, the HIV infection rate would dramatically decline in Africa" (Machera, 2004).

Boesten et al. (2009) state that across Africa, due to threats posed by HIV and AIDS, both men and women are afraid of “what is being lost. “A woman in a Lusuto village spoke frankly of her feelings of the AIDS threats: “all that is sweetest in life”, referring to both the satisfaction of sex and the shadow that sex casts by falling pregnant or being infected with the HI-virus. Boesten et al. (2009) further state that sub-Saharan Africa is the epicentre of the pandemic. This African HIV pandemic highlights the feminization of HIV. The young women are most vulnerable.

According to an HSRC report (2009), heterosexual sex is the main cause of HIV transmission. It shows that 14.5% of the girls within the ages 12 to 14 were sexually active and more than 25% of the young women had sexual intercourse with young men who were almost 5 years older than them. This increases the likelihood of infection among the young women and renders them vulnerable to practise unsafe sex. It also shows that young females face the highest risk of HIV infections. Weeks (2003) notes that in many western and eastern cultures, women still remain subordinate to their male partners with regard to their sexualities. This bears evidence that sexual oppression of females is largely responsible for the prevalence of HIV and AIDS in heterosexual relationships.

Holly’s (1989) studies on sexuality show that although women understand the dangers associated with heterosexual sex, many of them believe that they are at low risk with regards to HIV infection. They do not display much awareness of other STDs that can be contracted. Misconceptions about STDs have increased the urgency that young people need to be made knowledgeable about HIV, AIDS and STDs. It has to be highlighted that HIV and AIDS is a disease that permeates all races, class or gender. Campbell & McPhail (2002) state that in the light of changing sexual behaviour patterns of the youth, concern must be directed towards safe sex and prevention of disease.

According to Bhana and Epstein (2007), epidemiological research shows that young South African women are more likely to be infected with HIV than young men. These are the results of a survey conducted by the Reproductive Health Research. From a research sample of 12 000 young people nearly one in four young women in the age 20 to 24 years, tested positive for HIV, and young men were in the ratio of one to fourteen. Converted to a percentage, this is 77% of the research sample. This percentage is also differentiated by race, class, poverty, poor housing and infrastructure etc.

The Nelson Mandela Foundation Study conducted in 2002 notes a high rate of HIV prevalence in informal-urban settlements. This is indicative of the poorer sector of the urban communities, especially the African members in these communities. In South Africa there is an inclination to label AIDS as a Black person’s disease.

Bhana and Pattman (2008) note in their research that the HIV infection amongst Indians was 0, 3%. These are some of the reasons cited: All Indian religious groups prohibit sex before marriage; promiscuity is not condoned and sexuality is closeted. Elders in these communities do not broach the subject of sexual discussions with all and sundry. Young people are addressed on a need-to-know basis.

A newspaper report in the Daily News (2010, p.5) carried these HIV and AIDS statistics presented after a study conducted by UKZN, the local government and the United Nations (UN) Population Fund. The prevalence of HIV and AIDS in KZN amongst the population aged 15-49 increased from 15.7% (2002) to 21.9% (2005) and to 25.8% in 2008. This steady increase has serious implications for the development of educational and community awareness programmes.

Booyesen (2002) uses data received from the South African Demographic and Health Survey (1998) to highlight issues surrounding sexual risks. On average, 97.4% of the women, aged from 15 to 49 years old, indicate that they are aware of HIV and AIDS and the sexual transmission routes of the HI-virus. 80.8% of the study participants have sex with casual acquaintances, without using a condom. This indicates their engagement in sexual risks.

The wealth indicators in the study (WHO, 2010) suggest that poor women are less likely to be knowledgeable about HIV and AIDS or the sexual transmission routes of the virus and the risks of indulging in risky sexual behaviour. Nearly 82% of the women from the poorer sectors do not wear condoms when having sexual intercourse with a casual acquaintance, someone they have just met, or a commercial sex worker.

2.4. Denial of the Pandemic

Personal denial amongst partners assists in exacerbating the pandemic (De Waal, 2006). Even when partners disclose that they are HIV positive- this is overlooked, as loyalty to one's partner takes precedence over the HIV status. The media has been active in advertising the seriousness of the HIV and AIDS pandemic and relaying messages of the risks accompanied by unsafe sexual practises. In a survey conducted in Kenya, Malawi, Namibia, Tanzania, Uganda and Zambia the results showed that the respondents lost at least one relative or dear friend to the AIDS disease. These findings acknowledge that people accept that HIV and AIDS exist but they are in denial about their own status.

The former President Thabo Mbeki publically announced that he did not personally know anyone who had died of HIV and AIDS. This was clearly a denialist perception. In a study conducted by Cohen (2001), he distinguished between three types of denial: 'literal' i.e. refusing to accept the pandemic; 'interpretative' i.e. acknowledging HIV and AIDS but disputing the ways of transmission, and 'implicatory', i.e. people do not take responsibility for the unsafe sexual practises.

2.5. The Stigmatization/Discrimination of HIV and AIDS

The Revised National OBE syllabus (2007) for grade seven's indicates the following: people discriminate against anything that is "unknown" to them or what they do not understand. As people do not understand HIV and AIDS, their fear is compounded. At schools children who have HIV or AIDS are isolated, teased and bullied. The curriculum is aimed at teaching tolerance, understanding and respect for learners affected by HIV and AIDS.

A report by UNICEF (2004) highlights the stigma and discrimination that accompanies HIV and AIDS. It is stated that women face the most AIDS-related stigma than men. This stigma and discrimination further reduces their access to treatment and care. According to Parker & Aggleton (2002), the most poorly understood aspect of the AIDS pandemic is discrimination and stigma. Weeks & Aggleton (2002) further add that pre-existent fears about HIV and AIDS adds to the stigma attached to it.

Gennrich (2004) explains that the stigma arises from a belief that HIV and AIDS is linked to disgrace and shame. Stigma leads to discrimination and violation of the person's rights, i.e. the HIV and AIDS patient as well as their families.

In the earlier days, AIDS was associated with death, guilt, horror and shame. These metaphors have reinforced the AIDS discrimination. UNAIDS (2002) highlights the social stigmas and scorn that people living with AIDS endure. People often believe that the one infected with HIV and AIDS deserves their fate due to their promiscuous or drug related lifestyle. The disease is synonymous with fear of transmission and death. These attitudes prevent infected individuals from divulging their HIV status. People with HIV and AIDS are shunned and sometimes killed. In 1998 Gugu Dlamini was stoned to death outside a Kwa-Mashu shebeen for revealing her AIDS status (Cullinan, 2001). If stigma and discrimination continue, then prevention and care is very difficult.

The UNAIDS report of 2007 indicates that almost 1 500 new cases of HIV infection are recorded daily in South Africa. In rural South Africa there are cases reported of individuals being ostracised, beaten and murdered by community members because they admitted to being HIV positive.

Parker & Aggleton (2002) point out that some infected people are denied care because of their HIV and AIDS status, they lose their jobs and children are denied admission at schools. Aggleton & Warwick (1999) add that the HIV and AIDS stigma and discrimination is mainly gender-related. This stigma reinforces previous discriminations against women, i.e. unequal access to education, social and cultural involvement. Where the virus is transmitted through heterosexual sex, the infection is attributed to the women's behaviour. Female sex workers are considered to be the "vectors" of infection.

In a study conducted by Genberg (2009) layered stigma is noted worldwide, especially among men who have sex with men, as well as drug users. This compounds negative norms in society, connecting negative behaviour patterns with HIV infection.

McClintock (1995) argues that the HIV- stigma is linked more to the Black race than any other race. Black people are viewed as expected to be inherently diseased and promiscuous. Parker & Aggleton (2002) further state that race, stigma and discrimination interact with the pandemic, as a racist assumption about “Black (African) sexuality”. Black people did bear the brunt of social injustices and still do as the pandemic was and is still believed to be their doing. According to Bhana (2008), the media is also biased when reporting on HIV and AIDS, especially in the South African context, where Black people receive the most coverage linked to HIV and AIDS infections.

According to Allen (2005, p.62) sexuality “carries a social stigma that renders talk about sexuality and its pleasures often uncomfortable and sometimes perverse.” This signifies a general belief that young people ought to be innocent regarding sexual activity. Parents are unaware of young people’s sexual practises and if they do have such knowledge then restrictions are placed on their movements. Allen further asserts that the denial of viewing human beings as sexual beings shows a transgression of young people’s basic human right.

Cameron (2005, p.42) has this to say about AIDS:

“AIDS is stigma disgrace discrimination hatred hardship abandonment isolation exclusion prohibition persecution poverty privation. AIDS is metaphor. A threat a tragedy a blight a bolt a scar a stain a plague a scourge a pestilence a demon killer rampant rampaging murderer. It is made moral. It is condemnation deterrence retribution punishment, as in a lesson a curse rebuke judgement. It is a disease.”

Stigma is related to rejection of family and friends, employees losing their jobs, exclusion from important events and spouses and children being abandoned. Stigma is often within the person who has HIV or AIDS. Self- blame leads to self- loathing and isolation. With the lack of self-respect, denial sets in.

Nair (2010, p.1) writes that the Indian community denies that their youth are sexually active. They choose to keep “things under wraps.” Sexual activity is considered to be shameful. Nair adds that these negative attitudes and attempts to presume that young people are ignorant prevent them from making responsible choices and allaying inherent taboos.

2.6. Gender and Power Anomalies

Gender underpins most of the epidemiological models used in describing HIV and AIDS (Dowsett, 2003). Women have unequal access to social and economic resources, which often leads to powerlessness, greater poverty, sexual violence or relating to sex work for income. In South Africa sexual risk behaviour is set within the context of differing degrees of power within relationships and gender-differentiated norms for sexual behaviour. These gender inequalities in relationship-power promote unprotected sexual intercourse. Donald et al. (2004) note that the problems relating to sexual behaviour patterns in South Africa are a serious social issue. The patriarchal society has urgent implications for women's health risks.

According to Rajab (2010), Indian men do not accept women's liberation as the Indian society is patriarchal in nature. Parents in such homes are very domineering therefore young people have little or no access to discussions on personal matters. In the Indian household, hiding one's shame is more important than dealing with guilt.

Gender is a social construct. It makes reference to the dominant norms and expectations that a society has of men and women. Men and women construct their gender in relation to each another. Women often believe that it is feminine to be submissive to men; then it may be expected that men believe that women mean "yes" when they say "no" to sex (Marstan, 2006). Male dominance is propagated in society. In the South African context, power, wealth and health are unevenly distributed. The inability to negotiate safe sex because of gender inequality is a major driving force in the HIV and AIDS epidemic (Kauffman, 2004).

According to Govender (2005) construction of gender is closely linked to power. The important question lies within the persons who wield the power and how it is exercised within a relationship. In most communities the male possesses the decisive power. Campbell & McPhail (2001, p.1615) state, "Masculine sexuality is manifest in society's classification of normal men as being associated with multiple partners and power over women."

Simons (2009) documents that in many regions of the world, women lack status in their culture. Very often they are denied education and they face constant struggles in securing decent jobs. Women are also considered to be a man's property-meaning that they can be used sexually without any consideration for the woman's choices. All these disparities place women in high-risk circumstances for contracting HIV and AIDS.

According to Holland et al. (2000), different sexual standards for males and females regarding sexual practises encourage high-risk sexual behaviour. Females have to take risky decisions; either to insist on condom use and risk rejection or to remain silent and risk HIV infection. Luke (2005) argues that sexual behaviour is not an individual choice but a supposed negotiation between partners. The power anomalies inherent in society determine these negotiation skills. Risk behaviour, e.g. the non-use of protection, depends on the power differences between partners. In a dominant relationship, the less powerful partner, often the women, faces greater risk during sexual activities.

Kauffman and Lindauer (2004) states that women, especially black women, are often involved in relationships where they have very little or no power to negotiate safe sex. Black women are historically believed to be subordinate to their male counterparts and this leads to a sexual relationship that is male dominated and entirely controlled by the men. This patriarchy often translates into violence and coerciveness in the sexual relationship. In black communities it is highly likely that young women are forced to have sex as the man believes that it is his right (Richter, 1997; Varga and Makubalo (1997). Young women constantly find themselves in sexual relationships they do not control; the nature and safety of the relationship depends on their partners.

Shefer's (2001, p.10) studies have shown that women are viewed as *slags* or *sluts* or *loose* if they have too many sexual partners but men are complimented for such masculine behaviour. According to Shefer, "*sexuality gets framed as a male domain, in which men control and set the terms, and to which women must be inducted and guided.*"

According to the executive director of UNAIDS, Piot (2006), the main drivers of the pandemic are gender disparities, stigma, discrimination and marginalisation of basic human rights. Social norms and moral economies have led to gendered sexual behaviour. Discrimination against women in society and in sexual relationships is encompassed by the norms and standards embedded in religious and cultural assumptions.

Buthelezi (2006) highlighted at a conference that gender equality means the positioning of women in society. The space for women is "lower, back, narrow, private and weak; whereas men occupy the upper, front, broad, public and strong." Bhattacharyya (2002) states that culture is at the helm of the construction of sexual roles. She refers to these years of the HIV and AIDS epidemic as "an era of rapid change" (p.125) which has succeeded in demolishing interpersonal relationships.

According to research conducted by Bhana & Pattman (2008), Indian families remain patriarchal in nature. The behaviour of young women is regulated. Jewkes and Morrell (2010) add that in South Africa, the noticeable gender imbalances result in the over exertion of hegemonic masculinity which maintains the submissive role of women. This behaviour sanctions the subordinate roles of women and girls.

Power in Africa is highly gendered. Men are considered to be dominant and sexual privileges are encompassed within this power. Women assume subordinate positions in social, sexual and political encounters. African men especially are allowed many girlfriends in addition to their wives. In sub-Saharan Africa, having long-term concurrent sexual partners is common. According to epidemiologist, such accepted parallel relationships are the key to alleviating the HIV epidemic among the populous. The HIV and AIDS epidemic disturbs the moral order in societies.

According to Weeks (2003), the greatest obstacle to women's emancipation in South Africa is the patriarchal nature of societies which marginalise the roles of women. Often religious texts dictate guidelines as to expected patterns of behaviour for men and women. Furthermore, masculinity and femininity mean different things in different racial settings, and geographical site and situation. Traditional Black and Indian cultures are patriarchal in nature but urbanisation has changed sexual behaviour as individuals are distant from their strict elders.

Women have been disadvantaged in society for many centuries (Willis, 2002). This is evident in reports on HIV and AIDS. It is estimated that two and a half million women, i.e. about 80% of the globally affected HIV infected women, are to be found in sub-Sahara Africa. One in every 40 women is infected. Although a negative stance is taken against sex workers, researchers point out that 60% to 80% of all infected women have only one sexual partner.

In a report from the Centre for Disease Control in California (2002), it indicates there has been an increase in premarital sexual activity of women from 15-19 years of age; since 1970. The same study shows that one in every six young women has sexual intercourse with at least four different partners in high school. Some of these activities contribute to the transmission of HIV. Especially in Africa, rape and gang-rape are among the terrible ways that women contract HIV infections. Many women in Africa marry young. Their partners are older. Older men marry younger women with the belief that these young women are less likely to have HIV and AIDS. Many of the women in such marriages are infected by their older partners. Statistics show that over 40% of men over 35 are HIV carriers. HIV and AIDS has become the number one killer of black women in Africa.

In a study conducted by Frank et al. (2008) on the risky behaviour of high school pupils in Mthatha (previously known as Umtata), these findings are highlighted: gender differences are associated with risky sexual behaviour among high-school pupils. Many of the females report forced sex and males who admit to having non-consensual sex. The females show preference for older partners and accept money and gifts in exchange for sexual favours. The participants also indicate that there is a strong correlation between religious adherence, parental supervision and sexual activity.

Some cultures in South Africa place high values on preserving virginity while others do not. Sexual culture, gender roles and mores are rooted in religious belief systems, and may be the reason that African-traditional religious groups are twice as likely to engage in sexual activity. For young Zulu men, early fatherhood affirms their masculinity and strength.

Pupils in Eastern Cape (2008) report that having multiple partners was similar to the ancestral practice of polygamy. Parental supervision significantly affects sexual activity. Children from households where both the parents work are twice as likely to engage in sexual activity. This indicates that the presence of a supervisory caregiver or parent can deter early sexual experimentation. Greater efforts therefore need to be directed at parent group to address the issue of early sexual experimentation.

There are a number of obstacles which prevent women from becoming better educated hence they have limited knowledge on ways of contracting HIV and AIDS. Due to the fact that many women depend on men for money and security, this means that women have less power and control in their relationships.

The gendered differences lead women to engage in risky sexual behaviour.

2.7. Risky Sexual Behaviour

Poverty, HIV and AIDS are the largest global problems of the present century. All three of these crisis pandemics are intrinsically linked to each another (Nelson, 2009). Women and girls constitute the highest population figures globally and more of them are infected with HIV and AIDS as compared to men. Watts (2004) argues that the primary reason that AIDS has such a great impact in Africa is poverty. Being the poorest continent, many people risk infections in trying to make ends meet. Women are forced to sell sex, and men who continually work away from homes, engage in illicit sexual relations and often carry the virus back home with them. Many African governments also do not have the resources to provide free prevention and treatment methods.

Watts (2004) further argues that economic and cultural factors contribute to the risky sexual behaviour of young people. Many women depend on men for financial support and are unable to negotiate safe sex. Different cultural norms increase the risk to women, e.g. some societies encourage younger women to marry older and sexually experienced men. Another practice is for men to sleep with many partners, including their wives, girlfriends or prostitutes. If the men contract HIV, their multiple partners are at risk of infection.

According to Simons (2009) when people are poor, life does not afford them any choices. Access to education or a good standard of education may be non-existent. This affords limited or no knowledge about the ways HIV is transmitted. This immediately places young people at risk. These communities are thriving environments for high-risk behaviour due to frustration, anger and ignorance about the means to protect themselves. These types of behaviour and unprotected sex with multiple partners, directly spread HIV.

Baylies & Bujra (2004) state that when young woman are sexually active, they often have older partners. In the era of AIDS, this heightens the danger they face, particularly if older men seek them out in the belief that they are free from HIV infection. What is referred to as the "sugar daddy" phenomenon involves sexual encounters with young girls suffering hardship, sometimes struggling to stay in school, agreeing to sexual relations in exchange for gifts, money or support (UNAIDS 1998). Luke (2005) agrees that these sugar daddy relationships are one of the major factors steering the spread of HIV and AIDS in sub-Saharan Africa. These typical older men pay large sums of money to elicit sexual favours from much younger women. These asymmetries limit the young women's power to negotiate safe sex.

Sugar daddies generally seek younger women with the preconception that they are free of the HIV infection. Many African cultures sanction these types of sexual behaviours as men are encouraged to engage in premarital and extramarital sex with younger women. The improved socio-economic circumstances of these men give them more power to dictate the terms of their relationships. The higher rate of HIV infections amongst adolescent women supports the contention that sugar daddies practise unsafe sex (Campbell, et al., 2005). AIDS and poverty are linked together in some way (Simons, 2009).

Poverty restricts many young people from access to a good education and they may not understand what causes AIDS. This ignorance places young people at risk. Young women are often ignorant of the ways to protect themselves. These risky behaviours and unprotected sex with multiple partners directly spreads HIV and AIDS. Poverty also sends many girls to the cities to earn money for their families. Many end up working in the commercial sex trade where they are often exposed to HIV (Simons, 2009).

According to Foreman (1999, p.27) poverty for women and their economic dependency on men underlies and compels them into sexual circumstances which they may not have otherwise considered. In sub-Saharan Africa, many women are forced into premarital and multiple sexual relationships. Their main purpose is financial and for other support mechanisms. East African schoolgirls often have sex with older, wealthier men for economic reasons. A 17-year-old pupil from Tanzania said, "I needed money to buy new shoes and clothes." She also recalls losing her virginity at the age of 15; a notable fact, i.e. before the legal age limit.

Dr. Katende of the African Medical Research Foundation (AMREF), points out that young women commonly seek men who are willing to pay a small fee in return for sex. Kyeju, an educator in Kagera, says that as long as parents are unable to purchase necessities for their children, children will always find alternate means i.e. sell sex to obtain money for cosmetics, clothes, modern shoes, etc.

These risks taken have directed HIV and AIDS training programmes towards females as they are considered to be vulnerable to HIV infection (Adams & Marshall, 1998). They also state that it is extremely difficult to enforce behavioural changes towards HIV and AIDS because it often conflicts with people's personal choices. Gender, poverty and power imbalances influence HIV and AIDS intervention strategies.

Campbell, Mzaidume & Williams (1998) argue that people's sexual behaviour is based on their improved sexual health knowledge, their negotiated social and sexual identities and whether their living contexts support the use of prevention. Whiteside (2005) notes that about 64% of all people living with AIDS are in sub-Saharan Africa and approximately 76% of them are women.

The National Curriculum (2005) highlights these risky sexual behaviour practises: engaging in unprotected penetrative sex with multiple partners; unprotected anal sex; oral sex without protection and repeated use of the same condom. In third world countries, e.g. South Africa, poverty has led to most of the latter being practised due to economic benefits and constraints.

Gennrich (2004) highlights some of the salient reasons behind high-risk sexual behaviour in South Africa. In the apartheid era, migrant workers were employed in the mining industry. Most of the productive men were away from home. This led to relationships with other partners as their life partners were left in the rural areas. This situation persists today. Further Traditional African cultures do not speak freely about sex and precautionary measures. This leads to the youth practising sex prior to discovering the consequences thereof. The media adds to their interest by highlighting sex as being “cool.” Many religious groups do little to encourage their youth to attend services. The youth hence move away from religion and seek drugs, alcohol, casual sex and crime.

Unprotected sex and multiple partners are the greatest contributors to the risk of contracting HIV and spread of AIDS. STDs can be transmitted when partners engage in vaginal, anal or oral sex without a condom or dental dam (Endersbe, 2000). Women are most at risk during unprotected intercourse due to their anatomy. Younger women are more at risk as they have more sexual encounters than older women. Some STDS remain in the infected person’s body for life. Each new sexual partner is exposed to the uncured STD. Many sexually active adolescents do not believe that they are at risk as they are in their first sexual relationship. Their partner may be a carrier of the incurable STD.

Adolescents are at high risk for HIV infection. Worldwide in the year 2000 half of 5.8 million new infections occurs in the age group 15-24 years. About 52% of adolescent females are infected through heterosexual sex. This indicates the lack of awareness of the potential risk for HIV infection among sexually active adolescents.

Sexually active adolescents are also at risk for pregnancy and other STDS. According to the 1997 Youth Risk Behaviour Survey, almost half of the United States high school students were sexually active and 9% were reported to be pregnant. Almost one million teenagers fall pregnant annually. Between 74-85% of them, unintentionally. Visible pregnancy and STD infections are indicative of unsafe sexual behaviour. The STDS increases the susceptibility to HIV infection.

During adolescence, risk taking sexual behaviour and failure to take precautions is the norm. During their most recent sexual encounters most of the teenagers in the survey did not wear condoms. One in seven of the respondents indicate having more than three sexual partners. Nearly one in every five respondent reported consuming alcohol and drugs which impair their judgements and increase the potential for high risk behaviours. Among adolescents, poverty, limited access to education and health care facilities increases their vulnerability to HIV.

Many young women are forced into unwanted sex to progress at schools or businesses and to pay for favours to teachers and bosses. They subsequently become infected.

In a research carried out by the World Health Organization (WHO), it is distressing to note that unsafe sex is identified as one of the ten leading risk factors for harm globally and is the most common mode of HIV transmission. It is further noted that unsafe sex disproportionately affects individuals in the world’s poorest countries; where unsafe sex is ranked as the second most important risk factor for disease, disability and death.

Frank et al., (2008) study in Wentworth reports that 9.6% of females and 31.3% of males have their first sexual experience before age 12. Adolescents, who begin sexual activities early, are more likely to have more sexual partners and therefore there is a greater exposure to the risk of HIV. UNAIDS report in 2004 notes that urbanization, poverty, exposure to conflicting ideas about sexual values and behaviours', and encouraging premarital sexual activity among adolescents may contribute to early sexual initiation of young people globally.

The high incidence of sexual abuse among young children in South Africa indicates that, for many, their experience of early sexual initiation may be from coercion. Forced sex may also be related to misconceptions about sexual violence, such as males reporting that they do not perceive sexual violence as unwanted touching and forcing sex with someone whom one knows.

Having partners who are a few years older increases the risk of HIV infection. These older partners have higher earning power than same-age partners, and learners may seek a profitable relationship. Negotiating safe-sex is hindered in relationships of mixed ages; as a consequence of the exchange of money or gifts, this increases exposure to coercive sex.

2.8. Strengthening Relationships

Research done by Karim (2005) in Southern Africa showed that many women contract HIV and AIDS in their early teens. At a very vulnerable age they make serious decisions about prospective sexual partners (Jewkes et al. 2004). Their precarious economic circumstances lead to HIV infection and/or pregnancy (Susser, 2009, p.4).

According to Akande (1997) adolescents justify their non-use of protection with the belief that they are engaged in a monogamous relationship, and they anticipate the possibility of marriage. These girls are also convinced that any suggestions of condom use will imply mistrust and a lack of commitment. They feel that trust and knowing their partners is a sufficient indicator for not introducing condoms. This means that they are exposing themselves to a greater risk of HIV infection and other STDs (Holland et al., 1990; as cited in McPhail, 1999).

Hoffman et al. (2005) stated that sexual intercourse is an important aspect of a romantic relationship. Men generally initiate this early as proof of the woman's love. Men assume a right of access to their partners' bodies. The time and conditions of sex are defined by men. The use of protection is considered to be the man's domain as it could imply infidelity and lack of trust if the woman suggests it.

Boesten & Poku (2009) agree that introducing condoms in a relationship may be seen as a lack of trust in a relationship. Men generally begin to suspect their partners of being unfaithful when condoms are spoken off. Giron (2006) states that the meanings and beliefs associated with condom use, together with issues related to fidelity and trust play a significant role at the moment when asking or not asking a partner to wear a condom. Women have limited opportunities to negotiate safe sex as they are often economically and socially dependent on their partners. Contextually, the use and non-use of preventative measures is most often the masculine domain.

Honesty is important in all sexual relations. Trust means being honest with partners about one's sexual history. Regardless of a partner's history it is always important to plan ahead to wear protection.

2.9. Coercion and Violence

Sexual coercion is described as a string of negative behaviour patterns ranging from threats, intimidation, physical abuse, verbal harassment, unwanted touch and rape (Jejeebhoy & Bott, 2005, Youth Net, 2004). Coercion has negative consequences, i.e. limited control in the use of condoms, unwanted pregnancies and the risk of acquiring an STD especially HIV (Erulkar, 2004). In studies conducted by Wood et al. (1998) teenagers confess that they are curious about their first sexual encounters but many said that they are deceived or coerced into having sex. Some girls said that they accompanied the man home under the agreement of having a conversation, drinking alcohol or to help with his ironing. A participant indicated that she did not think that sex was the intention as it was during the day and her friends told her that sex happened only at night.

Research conducted by the HSRC (2005) found that sexual abuse of women and children is widespread in South Africa. Of all the reported rape cases, 41% are of persons under the age of 18 (CPU, 2001). Many young women report violent behaviour if they refuse to have sex with the man. The girls report the following, "he told me that if I didn't want to do it, he would force me to. He beat me up and forced my underwear down," (Wood et al., 1998). To avoid violence, many of the girls accepted sex, "I continue because he beat me so badly, I regret that I said no in the first place," (Wood et al., 1998). Some said that sometimes the reason for violence was the use of contraception. The men tear up contraceptive pill cards as they say that this leads to vaginal wetness which reduces their sexual pleasure.

As indicated by Vogelmann & Eagle (1991), violent practices against South African women are endemic. Human Rights Watch (1995) records the highest figures for rape in South Africa. They found that many women, especially the Black women, do report sex related violence as the authorities do not act on these reports and these women face added violence when their perpetrators return home.

Hoffman et al. (2006) identified changes in behaviour in relation to threats and sexual coercion. Generally men who consume alcohol before sex are prone to use threat or force to engage in sex. Risks of pregnancy are associated with sexual coercion. The non-use of protection is also gendered behaviour.

The strong African and Indian traditions stress that women obey their partners and that it is natural for men to have more than one sexual partner. Often men turn to violence to indicate their control over women. Hoffman et als. (2006) research further shows these alarming statistics:

- South Africa has the highest rape and crime statistics. It is estimated that one woman is raped every 17 seconds.
- Over 20% of women in each one of the provinces is abused by their partners.
- It is estimated that one woman is killed in every 6 days in Gauteng.

In South Africa, more especially in the poor Black communities, many married women have been infected by their single partners i. e. their husbands. Many women are raped or forced into having unsafe sex or into becoming sex workers. This coercive behaviour makes them more vulnerable so therefore they become more vulnerable and easily infected by men.

2.10. Non-Use of Protection

Kauffman & Lindauer (2004) found that there is a difference in the ways that males and females understand sexual protection methods. The males' interpretation of safe sex is skewed in favour of condom use but without an aorta of commitment to a monogamous relationship. In contrast, women know that condoms protect them but are in favour of fidelity and a single partner to prevent HIV infection. Condom use according to Meyer-Weitz et al. (1998, p.49) is symbolic of "distance and barriers", and implies no love or care between partners. Some women indicate that condoms are only for use by "those kinds of women", indicating sex workers, and are used by "loose and cheap girls who have multiple partners."

In a study done by Foreman (1999, p.74) he quotes the sentiments of his research participants. A worried citizen in Muleba Town says, "*With a condom on you do not feel the sweetness very well.*" A 19-year old Andrew says, "*Condoms are not displayed openly in rural areas. People have to ask for them covertly, often using veiled terms like*": "*sell me a weapon, candy from a wrapper.*"

Arnfred (2004, p.167) discusses a new phobia called condom-phobia. This is a fear displayed by men for the use of condoms. Some men feel that it is less manly to wear condoms. A participant says, "*It's like begging for what belongs to you, it's like eating a sweet with the wrapper on, and you cannot get the true taste of sex with a condom on.*"

The proper and consistent use of condoms helps to prevent STDs and unplanned pregnancies. Condoms prevent the possible entry of HIV fluids into the females' body. It is noted that intercourse is 10 000 times safer with condoms on than without them. Studies show that using condoms reduces HIV transmission substantially.

Wearing condoms greatly reduces the spread of most sexually transmitted infections and the non- curable hepatitis B; HIV transmission to an HIV- negative partner and unwanted pregnancies. Many women still continue to struggle to ask their partners to use condoms. They fear that their partners will not trust them or have slept with someone else if they insisted on wearing condoms. Condom use has become equated with unfaithfulness and is not seen as part of a healthy sexual practice. These cultural barriers need to be addressed.

Young people need to be educated to change their sexual behaviour in order to reduce transmission of the virus by encouraging the continued use of condoms. Young people need to take informed choices when addressing their sexual behaviour. In societies facing many challenges, women are not allowed to decide for themselves about the choice of sexual partners or how and when they will be involved in a sexual relation. In conditions of heightened poverty, women do not have many choices or a voice over what they can or can't do.

2.11. Myths, Misconceptions and Beliefs

HIV and AIDS have propagated a sex panic in many societies. This is reinforced by many stereotypes, myths and perceptions that are socially and culturally founded (Watney, 1997).

In their study, Kauffman & Lindauer (2004) found an increased report of child-rape, in some cases of infants under a year old. This is in response to the widespread myth that sex with a virgin is a cure for AIDS. In a youth survey by the Love-Life Organisation entitled: - 'Hot Prospects, Cold Facts' (March 2001), 7% of the interviewees believe that sex with a virgin will cure AIDS and 18% did not know. This means that there is a two-fold danger facing young woman: the myth itself and the expectation that very young girls are less likely to be infected.

Boesten & Poku (2009) stated that the deadly HIV infection can be contracted by conventional sex, homosexuality and adultery but also through polygamy, widow-inheritance, male and female circumcision, dry sex and sex by capture. These practices are now deemed to be dangerous and risky.

According to Morrison & Smith (2004) there is a belief that if you have sex with fat women, babies, young virgin girls and boys, infection from HIV will not occur. Alternatively, AIDS sufferers believe that if they have sex with these people then they will be cured of their affliction.

The general misconception is that Black people are historically diseased and are a race feared by all other races. According to the 2005 South African National HIV Prevalence Incidence Behaviour and Communication Survey, 10.8% of South Africans are infected with HIV.

Mather (2002) highlights that in many parts of South Africa, young men are sent on a ritual-initiation ceremony where they are circumcised. The belief following such a practise is that transmission of STDs is then prevented. This is a misconception as circumcised young men can transmit HIV and other STDs.

There are a belief among traditional Black men, writes Gennrich (2004) -that men must have sexual intercourse when they are aroused. Therefore men view their arousal as a right to have sex with women. Another belief is that when a young man has his first “wet dream”, he is expected to have sex or else his penis will fall off.

Gennrich (2004) further alludes that many young women believe that they are safe from contracting HIV as long as they are having sex during their periods. As HIV is transmitted through vaginal secretions, semen and blood, it is not safe to have sex at the time of menstruation. If a woman is HIV positive, her partner is likely to be infected during this time.

Young women are also under the misconception that if they are having sex with only one person then they are safe from infection. They do not consider the possibility that if the one person they are sleeping with is infected, then they are at risk of being infected themselves. If the partner engages in casual sex or intravenous drug use, the chances of infection are higher.

Societies view HIV and AIDS as a punishment from God. De Waal (2006) cites an example from the Bible and Koran about ‘Sodom’ and ‘Gomorrah’ who were punished for their homosexual behaviour by the AIDS disease.

Initially HIV and AIDS are seen as a disease of the gays and lesbians. Subsequently when other people get infected, they are also discriminated against. The people who are infected are seen as bad and dangerous. With the persons, the person’s family and their whole community suffer. Being discriminatory did not help people to understand HIV and AIDS but placed them at risk of being infected as they did not know about HIV and AIDS

Male circumcision is assumed to reduce a heterosexual male’s risk of contracting HIV by 50- 60%. When men are circumcised, their privates take a few weeks to heal. During this period the risk of transmission from an HIV- positive man to an HIV- negative female partner may be higher than for uncircumcised men. It is important for men to know that they should not engage in sexual activities during these times (Mather, 2002).

2.12. Substance Use and Abuse

Substance abuse leads many young women to land in precarious situations where they are placed in risky positions. Some women agree to continue drinking with their friends in the anticipation that if sex takes place later, it will not be considered as their conscious choice but a lack of sane judgement and the loss of ability to protect themselves from their lustful male partners (Boesten & Poku 2009). Men assume that the women who continue drinking are the ones who want to get laid.

Intravenous drug use allows HIV-infected blood to pass between users who share needles. This encourages the passing of the hepatitis-C-virus. Drugs dull the senses, which sometimes lands young people in situations where they engage in unprotected sex (McPhee, 2000). Sharing needles affords the HI-virus the opportunity to travel from the infected person to the next person. Blood from the HIV infected person remains on the needle and is transferred to the next person when the needle is injected into the next person’s blood stream (Cefrey, 2001).

Dowsett (2003) found that using intravenous drugs has a significant connection to one's sex life; for example, during sex work or recreational sex, a greater desire is felt when a needle is injected before sex.

The World Health Organization (2005) noted that the co-existence of alcohol and risky sexual behaviour is exceptionally harmful. Risky sexual behaviour allows for many opportunities of acquiring HIV infections and alcohol intake increases high-risk sexual behaviour. Many cases in South Africa are cited as having links between substance intake and sexual risks. In South Africa, illicit and home brewed alcohol is consumed by the poorer sectors in the country. Uncontrolled alcohol intake is associated with morbidity and mortality in South Africa. Policies controlling alcohol intake are often ignored and the active promotion of alcohol via the media is approved.

Heterosexual sex is the predominant means of HIV transmission found at the research sites. In many countries, including South Africa, HIV infection is associated with drugs use, homosexual and bisexual male behaviour. The WHO (2005) also highlight that there is increased alcohol intake by teenagers and women. In different societies, women generally have limited social liabilities, in respect to alcohol consumption and drug intake, than men. When under the influence of alcohol and drugs, the use of protection is limited or non-existent. These types of behaviours from young women place the women at high risk.

The abuse of alcohol and drugs is often associated with specific sexual activities such as group sex and unprotected casual sex. Alcohol use and risky sexual behaviour are noticeable in nightclubs, dark houses, shebeens and eating outlets. Young people who are generally reserved consume alcohol as ammunition to boost their self-image. These young people acquire the courage to approach the opposite sex. Masculinity is linked to multiple partners, uncontrolled consumption of alcohol and promiscuous behaviour patterns. The costly repercussions among women who have consumed too much alcohol, includes unwanted pregnancies and STDs.

Endersbe (2000) highlighted that the use of drugs and alcohol heightens the risk of transmission of STDs. These substances limit a person's ability to think clearly. When under the influence of drugs and alcohol, people may be more willing to take risks, such as engaging in unprotected sex. They may not be able to control their sexual limits and may also violate their partner's sexual rights.

Anderson (2000) writes that the cognitive effects of drug use can result in disease exposure. Users have impaired decision making skills and place themselves at risk. The use of 'crack'- a type of drug is associated with high risk sexual behaviour and the exchange of sex for money. Sexual activity and drug related HIV risk behaviours are mainly associated with women. Women generally show a lower rate of drug use than men, they are more likely to become infected with HIV and other infections by their own drug use habits and sexual contact with their partners. Anderson (2000) further notes that 60% of AIDS cases in women are drug related.

HIV risk behaviours intersect with other risky patterns of behaviour, which includes excessive drinking and drug use. Recent research suggests a correlation between heavy and harmful drinking patterns and an increase in likelihood of sexual risk-taking behaviours, e.g. engaging in unprotected sex. It is suggested that heavy drinking patterns might influence sexual risk-taking by affecting judgement and reducing inhibitions or excusing behaviour which is seen to be socially unacceptable. Higher levels of alcohol in the blood have been associated with a reduced intention to use condoms.

The relationship between risk-taking, drinking, and HIV and AIDS is influenced by cultural and societal norms. The WHO has also noted that the inebriation is considered a culturally acceptable excuse for irresponsible sexual behaviour. The relationship between alcohol and sexual conduct is context-and-community-specific. The outcomes are varied depending on situation, gender, sexual and alcohol experiences, cultural norms, drinking patterns, and individual physiological responses to alcohol. Expectations encompassing the effects of alcohol and personality traits associated with both drinking and sexual risk-taking may influence unsafe sexual practices.

The Russian Federation believes this common misconception: a person without alcohol is incapable of engaging in sex. Several studies have linked alcohol intoxication with greater injection drug risk behaviours. HIV transmission rates through sexual contact is also shown to be higher in the presence of harmful drinking patterns, especially among groups whose behaviours, context, or lifestyle already place them at risk. In lure of these findings, many of those persons at risk of experiencing alcohol-related problems may also be at risk for HIV infection. The link between alcohol misuse and HIV risk behaviours is particularly visible among populations adversely affected by poverty, inequality, discrimination, instability, insecurity, and limited opportunities, and lacking social or institutional support. These factors may expose individuals to sexual coercion and violence, and may contribute to the incidence of transactional sex for drugs, money, or shelter.

A study in the refugee camp in Kakuma, Kenya, described the link between women brewing, selling, and consuming traditional alcohol and transactional sex. This report also highlights the increased vulnerability of women, while under the influence of alcohol and drugs, to forms of gender-based sexual violence and rape.

Studies have also shown a higher rate of HIV infection among individuals with drinking problems. The potential link between sexual risk-taking and problem drinking among people living with HIV and AIDS can have significant implications for the spread of the virus.

In drinking establishments, sexual network is likely to occur. Two studies in South Africa reports that 75% of respondents identified local drinking places as public venues where people went specifically to meet new sexual partners and with the intention to engage in sex. In these studies condoms are seen as less important or even forgettable when drinking, and many male participants perceive alcohol as a sexual performance booster.

Heavy drinking impacts negatively on the body's immune functions. The misuse may decrease the body's ability to defend itself upon exposure to the HIV-virus. The combination of alcohol and HIV infection may also increase the risk of subsequent opportunistic infections and accelerate progression of HIV to AIDS.

The study conducted in Wentworth in 2008(Frank) highlights the use of alcohol before sex as highly risky as it reduces one's cognitive ability to consider protective sex, and increases susceptibility to coercive sex.

2.13. Peer pressure

Adolescents can be very persuasive when encouraging their peers to indulge in risky behaviour (Kelly, 1998). Often young people believe that nothing wrong can happen to them and that HIV and AIDS are things that others contract. They often do not think of the consequences of their actions. Peer pressure plays a significant role in their behaviour. A case of two youngsters is cited where Will asks Cassie to go to a party. She drinks a beer for the first time in her life. Then another one follows and it carries on for a while. They end up in a bedroom and when Cassie asks him about wearing a condom he answers: "Honey, I really want to be with you, right next to you, not in a condom," (Kelly, p.114).

Cassie is lucky not to contract HIV but herpes simplex 2- an incurable STD. Here Cassie allows herself to be pressured into having unprotected sex. Peer pressure is a fact of life for most young people and it may prove to be deadly for some young people.

2.14. South African Government's Response to HIV and AIDS

The country's constitution (1996) protects its citizens' human rights. Freedom of access to information, health and safety are the prerogative of all South Africans. Special provisions are made for education and imparting of knowledge to inform learners of their rights and responsibilities. Of particular interest is the clause that states that children have the right to information about sexual health and HIV prevention. Educators are bound by the constitution (South African School's Act 1996).

Silin (1995) emphasises that HIV is a part of everyone's life and it should be addressed early at schools. Schools are tasked to provide correct information. Educators are expected to teach learners aspects of healthy sexual relationships. Learners should be guided to resist peer pressure when coaxed to engage in sexual relationships, drugs and alcohol intake. In light of this, the Department of Education (1999) introduced sexuality education from grade R to twelve. Bhana (2006) advocated that at schools there should be sexual literacy and openness when teaching Life Skills Education. Learners should be allowed the right to speak freely about issues surrounding sex and sexuality. Educators need to provide the necessary guidance without being judgemental about the learner's sexual knowledge.

Allen (2005) refers to other ailments that are a result of STDs, which impact on the economic and social position of the state. Governments need to be knowledgeable about sexual cultures or else the socio-economic impact will result in serious political repercussions and negative media coverage. The state is directly involved as in health initiatives which impacts on its ability to provide medical care and support for pregnant teenagers as well as patients infected with HIV and AIDS.

In light of the state's responsibilities, the respective ministries i.e. Health and Education, have partnered together to establish programmes aimed at imparting knowledge on responsible sexual health to the youth. These programmes shape young people's behaviour and bridge gaps in the limited knowledge base.

Bhana and Pattman (2009) note that the inclusion of HIV and AIDS in the South African school's syllabus has been delayed due to the importance of creating a balance between practice and theory. Currently, on-going research is being conducted among 16 to 17 year-olds and their sexual behaviour patterns.

Considering the information I gathered through my literature review, I decided to place my studies in an appropriate theoretical frame in order to understand risky sexual behaviour of young women.

2.15. Placing the Research within a Theoretical and Conceptual Framework

2.15.1. Introduction

Any theory in research is concerned with the development of a systematic construction of knowledge of the social world. Theories employ the use of concepts, systems, models, structures, beliefs and ideas in order to make a statement about activities, and analyse their causes, consequences and processes (Hitchcock & Hughes, 1995). One of the primary tasks of a study is to identify in ontological and epistemological (Crotty, 1998) terms the views of the participants in the research study. This provides the context for an appropriate framework. My study adopts the theory of social construction of gender within patriarchal societies. The study is positioned within a feminist paradigm. In my study I refer to the development of sexual identities as a social process that is influenced by culture, race, class and gender.

2.15.2. Social Construction of Gender

Constructivism views human beings as active agents in their own development. Humans are shaped by both nature and nurture, but they are active in shaping their own development. In so doing, knowledge is actively constructed (Donald, Lazarus and Lolwana, 2002). Theorists such as Vygotsky (1978) and Bakhtin (1981) maintain that knowledge is a social construction which is developed and learned through social interaction.

Thus human beings cannot be understood as being passively influenced by forces around them. Everybody- the child, parent, teacher and so on - are actively making meaning of their lives through social contexts. Bruner (1983) wrote that the **individual is** a strategist who continuously discovers new and effective ways of finding knowledge and discovering the world. Constructivist researchers often address the process of interaction among individuals (Creswell, 2009). My research investigates how young women construct their gender identities in their patriarchal environment and their resultant risky behaviour.

Van Roosmalen (2000) agrees that young women construct their own definitions of sexuality and gendered relationships in terms of the “male gaze”. Baym (1995) stated that society does not guarantee women their constitutional rights and privileges. Liberal feminists agree that whatever any culture deems to be important, the women get much less than men. It is argued that sexuality is socially constructed but young women are actively engaged in constructing their femininity and sexuality (Holland et al., 1990).

Wharton (2005, p.17) states that: “gender is reflected in who people are or how they behave.... and may be understood in terms of masculinity or femininity,” Wharton (2005, p.2) argues that many people construe gender to be “unproblematic, self-evident and uncontested.” Modern society sees it feasible to make their own choices regarding their sexual orientation. Furthermore, the patterning of relationships in society is gender based. Pattman (2006) highlights that masculinities and femininities exist in cohesion with each other.

Allen (2005) refers to heteronormative behaviour, which simply means that the masculine and feminine bonds are a social construct which is generally accepted by society. Kimmel (2004) indicates that the differences between males and females in society are skewed to a certain degree, where women are subjected to some forms of male domination.

The work of Weeks (from 1986 onwards) explores sexualities from a socio-cultural perspective. According to Weeks (2003, p.102), at the outset the blame for the emergence of AIDS was laid at the feet of those who became infected due to their “social attitudes or sexual practices”. Allen also claims (2005, p.8) that sexuality is the “consequence of social practices which was infused by power and mutable.” Allen states that young people create their own identities and that they have their own agencies.

According to Lorber (1994) gender is a social difference where the roles of men and women are defined. Individuals learn what the expected behaviour is and together they construct and maintain the gender order. In society men are ranked above women within the similar race and class. Men are favoured as being the more prestigious and powerful group. Within certain societies economic resources, education and job opportunities are only afforded to men.

Paechter (2001) defines gender as the biological sex of the individual upon birth. Gender identity refers to one’s own perception of their gender. Prescribed gender roles are culture specific. When young people are trying to establish their engendered adult roles in society, guidance must be provided in a typical stereotypic environment where roles of men and women are clearly defined.

2.15.3. Feminist Paradigm

Feminist researchers Guy-Sheftall, (2003) point out that historically the lives and experiences of women have been ignored or misinterpreted. An awareness raising and the impact of feminism have developed a consciousness of the inconsistencies in societies. Hearn (1996) states that women are encouraged to make known their knowledge and experiences which they have kept secret for centuries so that they can be justly acknowledged.

In light of the above information, my study is located within the feminist research paradigm as it puts emphasis on the women's lived experiences in their life contexts and encourages them to inform and support each another (Unger, 2001). Feminists argue that women must be a focus in order to change sexual oppression in a male dominated society hence my study focuses only on young women.

In the mid-1800s feminism referred to qualities of women but the focus is now- in advocacy of equal rights for women. Feminists are aware that women are oppressed and disadvantaged in relation to their male counterparts and their oppression was unjustified (James, 1998). Feminist research seeks to demolish the typical male dominated community with empowerment for the oppressed female sector. Feminist in the 1960s initially highlights the common experiences that women face under male domination, but recently the focus has shifted to disaggregating women's diverse experiences within their race, class and sexual orientation (Ramazanoglu, 1989).

The focus of my research is women's consciousness of oppression, exploitation and disempowerment (Cohen, Manion and Morrison, 2011, p.40). Creswell (1998) explains that feminist research strives to establish collaborative and non- exploitative relationships. De Laine (2000) argues that research must empower women and engage with the construction and reproduction of gender and sexual difference. James (1998) identifies that feminists are committed to bringing about social changes on women's behalf. Paechter (2001) notes that women are bound by their bodies due to their child-bearing status and are often considered being incapable of sustaining rational thoughts. Further, they are exposed to the constant danger of having bodily harm inflicted upon them. Mill (1986, p.27) argues that women do not think differently from men.

Wood & Jewkes (2001) emphasise that the teenage years are the important era for sexual exploration and development. This is the period when young women use relationships to assess their femininity and female identity. Women must be forceful and not be willing to submit to the men's desires. In South Africa, suppression of women is of major concern and gender equity laws aim to address this inequity.

According to Holland et al. (2000), femininity constitutes an unsafe sexual identity for young women, and their conventional feminine behaviour places them at continued risk. Traditional femininities disempower young women. O'Lincoln (1985) notes that feminists uncovered the social structure, that is, the patriarchal system where men rule the world. This type of patriarchy oppresses women. Wolf (2012) asserts that according to orthodox feminism, gender has been always and everywhere socially constructed, that is, it is real in individuals' minds and in social attitudes.

In Hallman's (2005) study on the gendered socio-economic conditions of young people in South Africa, it is noted that whilst youth have the knowledge on how to protect themselves against infection, they do not know how to apply this knowledge in their given situations, i.e. gender violence, subordination and denial of access to protection. Feminism acknowledges the various forms of female sexual subordination (Weeks, 2003). These movements insist on recognising women as people who have powers, rights and ownership over their own bodies.

Feminism acknowledges the inherent oppression of women and asks questions on how women should be emancipated. Feminists attempt to bring about social changes on behalf of women. Paechter (2006) states that gender is primarily about who one considers oneself to be instead of how someone else perceives one to be.

2.16. Conclusion

This chapter covers the review of the pertinent literature for my study and the theoretical framework within which my study is placed. Most of the literature highlights sexual identity as being a social construct which is subject to cultural influences. In the next chapter I explain the methodology used in my research process.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

This chapter describes in broad terms the methodology used in my study. It also discusses the overarching approach used in the research process. My research aims to understand the ways in which ten young women in a peri-urban, low income community construct their sexual identities, and highlight their understanding of HIV and AIDS. This study is significant as it seeks to understand young women's sexual risk-taking behaviour within the context of HIV and AIDS in South Africa. Explanations are also given for the actions of these young women, in other words, "*What is going on here?*"(Schutt, 2006).

Dawson (2002) stated that methodology is the philosophy or the general principles that guide research. Cohen et al. (2007, p.78) state that "there is no single blueprint for planning research". This chapter identifies the suitable research design, methods and sampling techniques and explains how these strategies are utilized to collect data for the purpose of my research.

My research addresses the following key questions:

- How do female secondary school learners in the Amaoti-Phoenix areas understand sexual risk within the context of HIV and AIDS in South Africa?
- Why do female secondary school learners in the Amaoti-Phoenix areas engage in risky sexual behaviour within the context of HIV and AIDS?

In the first section of this chapter, I present the research methodology which I decided would be most appropriate to my study. To achieve the aims of my study I embarked on the qualitative-interpretive methodology. I conducted focus groups as well as individual interviews to give voice to students who received the curriculum but have no access to the structuring thereof (Kehily, 2002). I also draw on previous research to authenticate the need to research risky behaviour of young women. Included in this chapter is the process of data collection as well as the data analysis. This is in keeping with Henning's (2004) contention that the group of methods chosen must be coherent and represent a good 'fit' in order to deliver data and findings that suit the research question. In this chapter, I also refer to how I overcome participant's bias, and methods that I use to lend validity, reliability and trustworthiness to my study.

3.2. Research Approach

3.2.1. The Qualitative-Interpretive Approach

According to Leedy & Ormrod (2005) the qualitative approach is used to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participants' point of view. This approach is also referred to as the interpretative approach as it analyses data received. Qualitative researchers seek a better understanding of complex situations. Their work is often exploratory in nature, and researchers use their observations to build theory from the ground up. The qualitative research process is more holistic and emergent with the specific focus, design, measurement instruments (e.g. interviews) and interpretations developing and possibly changing along the way. Researchers enter the setting with open minds, are prepared to immerse themselves in the complexity of the situation and interact with their respondents.

Taylor (2006) stated that there are many different approaches to conducting a research study. A paradigm has to be chosen which best suits the nature of the study. A paradigm, according to Guba & Lincoln (1994), is a set of beliefs which deal with principles. A paradigm constitutes a person's worldview, which defines the nature of the world for the individual concerned and the interaction with others in this natural environment. In research, the choice of the method employed is determined by the topic chosen and by the kind of data collected (Hitchcock & Hughes, 1995). According to Creswell (1994, p.95), *"a qualitative study is defined as an enquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting."*

Qualitative researchers recognize that the issue they study has many dimensions and layers. Most researchers strive for objectivity in their research. They believe that their observations should be influenced as little as possible by any perceptions, impressions, and biases they may have. Researchers believe that their ability to interpret and make sense of what he or she see is critical for understanding any social phenomena.

In an attempt to ascertain an in-depth understanding of why young women engage in risky sexual behaviour, I adopt the qualitative-interpretive approach. Operating within a feminist perspective, qualitative methodology is preferred as it allows the participants free reign to share their experiences fully in their own language.

Qualitative research methodologies seek to learn about the social world in ways, which do not rigidly structure the direction of inquiry (Oakley, 2004). Qualitative research methodology is employed because it allows the researcher to make use of several strategies to understand the risky behaviour of young women.

Qualitative research is a naturalistic investigation. It allows for the use of non-interfering data collection methods to discover the natural flow of events and processes and how the respondents translate them (Denzil & Lincoln, 1994). A good qualitative research is inductive, meaning that a researcher attempts to understand the circumstances without imposing pre-existing outcomes on the setting. The eventual aim is to attain insight and understanding into the respondent's life world (Berg, 2001). An important assumption of the qualitative paradigm is the value in understanding the situation from the stance of the participants in their specific settings. The qualitative approach is subjective in that it focuses on the experiential state of the participants and their views of a situation. The participants are thus, conceptualized as active agents in constructing and making sense of the realities that they encounter.

The qualitative approach may be described as a "*generic approach in social research according to which research takes as its departure point the insider perspective on social action*" (Babbie & Mouton, 2001, p.270). This approach stresses the importance of listening and seeks to see the world through the participant's vision. It places the participant at the helm of the research process, and sees people as actively constructing their social world, giving personal understanding to their circumstances and situations, and making informed choices to act in specific ways. According to Mthiyane (2007) the role of the researcher is to understand the respondent's interpretation of the world, rather than to impose the researcher's interpretations on the respondents.

I found the qualitative-interpretive approach ideal for my research, as the aim of my study is to understand the circumstances which contribute to young women's risky sexual behaviour. As a qualitative study, it goes beyond descriptive questions to answer "how and why" questions (Yin, 1993). The main reason for choosing a qualitative paradigm relates to my personal experiences with female learners in the education fraternity. My study requires personal accounts of participants rather than statistics. Cohen and Manion (2006) state that in qualitative research the emphasis is placed on the uniqueness, the idiographic and exclusiveness of the phenomenon, group or individuals in question; that is they only represent themselves and nothing and/or nobody else.

According to Cohen & Manion (2001, p.22), "*people are deliberate and creative in their actions, they act intentionally and make meanings in and through activities.*" Qualitative research also shows how social and cultural forces shape young people's sexual behaviour (Marstan & King, 2006). The study places importance on understanding how 16 to 17 year-old young women give meaning to their sexualities, at school. This paradigm is the ideal method for me to understand what was being said and to listen to what was being said during the interviews. Young people have voices too; they try to make sense of their bodies through their actions and thought processes.

To discover what goes on in people's minds means giving them voice or rather to accept that young women have voices but voices that need to be heard. This hearing includes the expression of thoughts through the use of language, hence the decision to conduct interviews with the participants. "*The stories, experiences and voices of the respondents are the medium through which we explore and understand reality*" (Nieuwenhuis, 2007, p.55).

Qualitative research means studying the young women in their “natural” schooling environment rather than under artificially created conditions. I also wanted to understand what the participant’s actions are and the meanings which they ascribe to their actions. The interpretive framework is the most suitable choice for this study as it is not concerned with formulating generalizable theories, but rather aims to produce “thick” descriptions that emphasize interpretation and in-depth understanding. It is imperative under the qualitative approach that “thick descriptions” (Henning, 2004) of conceptual behaviour be recorded.

According to Cohen, Manion & Morrison (2007) the interpretive approach aims to understand how each individual experiences her own personal development. The priority is to “*understand the subjective world of human experience*” (Cohen et al. 2007, p.21). I sought to understand the reasons for the behaviour and thought processes of young women in the context of sexual risk taking activities. Interpretivists base their assumptions on the understanding of human life from a person’s subjective experiences; by studying people in their social contexts. This renders it possible to understand and interpret the young women’s construction of social life and analyze the complexities of the ways they behave in their social environment. According to Nieuwenhuis (2007), the social world does not exist as an entity by itself: it is influenced by human knowledge. Denzin & Lincoln (2003, p. 33) state that interpretive research is “*guided by a set of beliefs and feelings about the world and how it should be understood and studied.*”

The interpretive approach acknowledges that people actively construct their social world—they are not “cultural dopes” or “passive dolls” (Becker, 1970; Garfunkel, 1967) as cited in Cohen et al., (2011, p.17). Interpretive approaches focus on action. Actions are only meaningful to us in so far as we are able to ascertain the intentions of actors in order to share their experiences. A large number of our everyday interactions with one another rely on socially shared experiences. Berger & Luckmann (1966, pp.210-211) write, “*The sociology of knowledge understands human reality as socially constructed reality*”. This infers that human beings are constantly constructing and reconstructing knowledge as societies and cultures evolved.

Interpretivism seeks to understand the social world and attempts to decipher people’s views, feelings and ideas. The objective is to understand entire social structures within the living premise of the participants. The view is that knowledge is subjective and dependent on different person’s views. Henning et al. (2004) suggest that Interpretivism is interested in people’s feeling and what they think of or see in the world. The researcher is seen as an independent participant as she has control of the research outcomes by framing the questions accordingly. Henning (2004) further indicates that the participants are key players in the study as they are the people who are interviewed about their lives and circumstances.

Therefore interpretive research is termed a communal process, because it is informed by the participants and scrutinized by the researcher (Henning, 2004). Interpretivists see individuals as the active driving force in social affairs and are capable of personal judgements, perceptions and decision-making (Garrick, 2000). The purpose of this study is to gain a deeper understanding of the risky sexual behaviour of young women in a specific school context.

Added to the interpretive approach, I borrow from post-structural feminist research approaches (Mendick, 2004; and Paechter, 2001b) in my research and thus engage methods that theorize the identities of the respondents as fluid, contradictory, transforming and rational. I realize that there is no knowledge outside or beyond the relations of power. Drawing on feminist research, I place gender and other social anomalies such as class, patriarchy and power at the centre of my research process and understand these separations as unequal divisions of power.

The prime reason for the choice of a qualitative approach is my interest and experience with the young women being studied. Having been an educator for 26 years, I have experience in issues relating to gender violence, sexual abuse, rape, and teenage pregnancies, and I have witnessed the effects of HIV and AIDS in the lives of learners in communities that face a myriad of challenges. Sound qualitative research also has distinct merit for understanding complex and sensitive issues, which is why I thought it would 'fit' (Henning, 2004) this study perfectly.

In order to obtain a deep understanding of how young women comprehend the repercussions of risky sexual behaviour in the context of HIV and AIDS in South Africa, I utilized qualitative methods of focus group discussions as well as individual interviews to obtain data. By adopting qualitative research methods, I was able to describe the subject of interest in great detail, in the authentic language of the research participants.

3.3. THE RESEARCH SITE

3.3.1. Location Selection

While indulgence in risky sexual behaviour is practiced globally, for the purpose of this study I chose a school located on the borders of a sprawling informal settlement, RDP (Reconstruction and Development Programme) housing settlement and a low income community. This working class community is an ideal background to understand risk-taking behaviour by young people. Working within a public, peri-urban secondary school setting was ideal for my study because this research community displays characteristics of a patriarchal regime, and genders disparities are rife. Various social cohesion challenges prevail such as alcoholism, drug abuse, high levels of crime, unemployment and others.

This research was conducted in a state, secondary, co-educational school in the Mafukuzela-Gandhi Circuit in KwaZulu- Natal. For the purpose of this study, the school is referred to as Bester High. The total learner enrolment for 2011 was 753 learners. The total female learners were 396 and the male learners were 357 (Refer to Appendix 6). In the age cohort 16 going on to 17, the roll for the females was 165 and males were 136. Bester High has a higher Black African population than Black Indian, in the ratio of 4:1 per class unit.

I was purposeful in choosing to locate my studies in this context. Accessibility was a strong determining factor. I am an educator at a primary school which is the feeder school for Bester High. I enjoy a cordial relationship with the principal, staff and learners at Bester High. I presumed that my ex-learners would be comfortable to participate in my study. The feasibility and permissibility of the site was important. The issue of time and cost are considered in the selection of the school. The entire research process was conducted at Bester High as it provided a natural environment the participants are familiar with and this permitted me to play an unobtrusive role.

3.3.2. Access to the Research Site

It was vital to negotiate gaining access into the research site with the various authorities both within the school and the research community. This encompassed the principal, parents, guardians and learners.

Gaining entry was relatively easy. On November 2011, I drafted a letter to the school principal explaining that I was interested in conducting research at his school (Refer to Appendix 1). I further indicated that I intend to select participants within the age cohort 16 going on 17 years. I also provided the principal with my supervisor's details in the event that he wished to contact her to further discuss this research. The principal consented to my request, conceding that the topic is relevant to the learners at his school but he insisted that the research was reliant upon the willingness of the individual learner to participant.

An agreement was reached with the principal that all interviews would be conducted on site, in the school's boardroom. Interviews were to be conducted during school hours beginning at 12h30 and continuing until 14h30. These times were allocated to the Life Orientation periods on the school's time-table. Considering that my research fell within this ambit, it was ideal to conduct interviews during this session. My research did not drastically interfere with the normal school's programme.

Since the interviews would involve my interaction with the participants alone, it was necessary to inform other staff members of the research because interviews were conducted within lesson time. The interviews were of a highly personal nature and the participants needed the assurance that I would not violate their trust. Therefore my study was conducted as unobtrusively as possible.

According to Allen (2005, p.20), *"gaining access to schools for research is often challenging due to a highly regulatory environment"*.

3.4. SELECTION OF THE PARTICIPANTS

This research focuses on a non-probable, purposive sample. Purposive means that the participants are known in advance and the selection is based on the fact that the group has the relevant knowledge to contribute to the study (Flick, 2009, Imas & Rist, 2009). My target group was female secondary school learners between the ages of 16 and 17. My sample does not represent the wider population thus is non-probable.

Since my study is about the risky behaviour of 16 to 17 years old, purposeful sampling was the most suitable technique to utilize in selecting the participants. Purposive sampling in qualitative research involves the selection of participants on the basis of certain characteristics, needs or purpose (Cohen, Manion and Morrison, 2007, p.115). According to Stake “qualitative researchers are guests in the private spaces of the world” (2005, p.45). They should practice good manners and a strict code of conduct.

Mendick (2004, p.33) argues that “*there is no simple relationship whereby increasing the sample size of a study necessarily makes it a more worthwhile piece of work.*” Participation selection was not based on race representativeness, but was rather to understand why these young women in Bester High engage in risky sexual behaviour and what their understanding of risky behaviour is.

In February 2012, as telephonically arranged with the school’s principal, I scheduled a meeting with all the female learners between the ages of 16 to 17. The meeting was held in the school’s boardroom. At the outset, I explained that the meeting was to identify participants for my research study. I explained that I am studying towards a Masters Degree and that I had reached the stage where I had to start my research. I further explained that I was interested in understanding the reasons why young women engage in risky sexual behaviour in the era of the HIV and AIDS pandemic in South Africa. I further elucidated what participation in the study would entail and that the learners were under no obligation to participate. I also mentioned that the participants could withdraw from the research process at any time during the course of the study. I also explained the criteria for my research study.

Participation was voluntary. All participants were 16 years of age but not yet 17 years. All of the participants must have been involved in a relationship with a young man. Consequently, the participants “fit the criteria of desirable participants” (Henning, 2004, p. 127). In closing the meeting, I asked the young women to ask clarifying questions about the research study. Eight eager young women immediately selected themselves into the sample. At this stage I used the volunteer purposive sampling strategy. A further two young women later indicated that they were willing to participate. The sample was a mix of African-Indian and Black-African young women.

The ten participants’ main concern was about confidentiality and parent’s approval. It was important to request permission from the parents/guardians of all participants before the collection of data. Hence all participants were given consent letters for their parents/guardians to acknowledge their participation in my study (Refer to Appendix 2). Where the young women were the heads of the house, that is, running child-headed homes, I requested that the principal grant permission in the capacity of the gatekeeper.

3.5. METHODS OF DATA COLLECTION

The main methods of data collection were individual semi-structured interviews and two focus group interviews.

Qualitative research data collection took a great deal of time. The bulk of the data collected depended on my personal involvement in the research setting, i.e. interviews, observations and field notes. "*Permission to carry out an investigation must always be sought at an early stage,*" (Bell, 1987 as cited in Cohen & Manion, 2001, p. 53). The first stage of my research project involved obtaining permission from the respective stakeholders to carry out research at Bester High.

Both verbal data (interview inputs and field notes) as well as non-verbal data (gestures and facial expressions) were collected. While all research methods had their strengths and restrictions, it was determined that individual interviews and focus group interviews best suited this research study. Patitu (2000) argues that in face-to-face interviews the researcher has the ability to analyze both verbal and non-verbal responses. The non-verbal behaviours can help to gauge the need to further elucidate questions. In face-to-face meetings, a researcher is able to inspire the participants and help them probe more deeply into a problem, especially an intensely emotional one. Any potentially useful data should be recorded thoroughly, accurately and systematically using field notes, audio-tapes and jotted memos about the participants' initial interpretation of what they are seeing and hearing (Leedy & Ormrod, 2005).

3.5.1. The Interview Process

Feminists have written volumes in theorizing the role of interviews. The focus of this work is power, understood in terms of relative positioning of the interviewer and interviewee within social structures, notably those of gender, class, patriarchy and power. In research focusing on gender it is appropriate that I am a woman. Finch (1993, p. 35) argued "*that in woman-to-woman interviews, the fact that both parties share a subordinate structural position by virtue of their gender makes a special interview relationship possible.*" It was beyond my reasonable power that I took my age, race, professional position, class, gender and bias into every interview.

For the purpose of this study, I engaged the learners in two focus groups as well as ten individual interviews. The difference between the individual interviews and the focus group was that: I became the catalyst for communication amongst the participants in the focus group interviews whereas in the individual interview it was a one-to-one process (Gaskell, 2000). The participants were more amicable to answering personal questions in the individual sessions rather than in the focus group interview.

The purpose of the focus group is to provide a platform for the participants to hear each other and to respond to each other to determine whether there are significant differences or correlations with regard to the research study. It allows for social interaction (Gaskell, 2000, p. 46) and includes participant's interjections with unsavoury comments, e.g. "You tell lots of lies", which immediately leads to disruptive discussions. Thereafter derogatory and offensive comments are made.

In the first meeting, I spoke to the ten participants collectively and we engaged in discussions about my research study. I explained to them that should they decide that they were unwilling to participate at any time during the interviews, they were free to leave the interview quarters with no repercussions. I also explained that they were not compelled to answer questions if they decided not to. I stressed the matter of confidentiality and anonymity in order to rid them of their fears and anxiety of being exposed whilst answering questions related to their sexual activities. I further highlighted that their names and responses would not be divulged to their principal, teachers, parents or friends.

After having acquired trust and having set the ground rules, I found the participants to be relaxed and at ease with me and other learners in the group. I sensed their anxiety and eagerness to participate. I divided the group of ten learners into two groups of five. This was done randomly as they were seated in the board room. Two focus group interviews of duration of between sixty to eighty minutes were conducted on two different afternoons (Refer to Appendix 5). Thereafter ten individual interviews were conducted for the duration of between forty to sixty minutes over the next five days (Refer to Appendix 4). The individual and group interview strategies were employed with a view that the limitations of one tool would often become the strength of another.

To avoid unnecessary glitches during the interview process, I informed the young women that if the interviews were to continue after school hours, then I would personally escort them to the taxi rank or have the school's caretaker walk them home. They were at liberty to make use of my cell phone to inform their parents of their late coming.

The interviews were conducted in the school's board room: an ideal round-table setting for the focus group interviews. For the individual interviews, adjustments were made so that the participant faced me. Regular eye contact had to be maintained as this was a good gauge to ascertain the validity of the responses given. The recording device was placed at the centre of the table. I again reinforced the ethical issues of confidentiality and anonymity.

I suggested the use of pseudonyms as a means of ensuring anonymity. These pseudonyms were known only to me and the individual participant. Some participants were elated and wanted to choose their own pseudonyms. Most of the young women chose names of glamorous artists. Four of the young women requested that I choose names that would best reflect their personalities. Nueman (2000) argues that if the participants realize that they are respected and the information they provide is treated with confidentiality, they become secure and open up to allow the relationship of trust to develop.

The collection of data at this point was through semi-structured interviews. I opted for the use of semi-structured interviews because it allowed the respondents to digress and provide additional information which I might not have thought of. Nieuwenhuis (2007, p. 82) refers to "new emerging lines of inquiry" which can be explored. On the other hand, the semi-structured interview permitted me to redirect the participants if they completely lost focus of the study at hand.

The aim during the interviews was to provide a forum for the participants to speak freely in their own language about a set of questions posed to them as well as any other related issues that did arise. This kind of research approach was appropriate, where people spoke about their lived-world. On the question of the efficacy of interviews, Cohen, Manion & Morrison (2000) said:

“Interviews enable the participants to discuss their interpretations of the world they live in and express how they regard the situation from their own point of view.”

Although an idea of the basic issues to be covered in the interview was set up, free narration by the participants was encouraged. These narrations were guided by key questions as suggested by Bogdan & Biklen (1992), to ensure that the interviews and data collected contributed to the research objectives. The questions asked served as a guide to ensure that all appropriate sub- topics were covered during the interviews.

For the duration all of the interviews I categorically stated that I expected to learn from the participant’s thoughts, emotions and experiences. I began the interviews with everyday biographical questions and then moved to the pre-determined semi- structured research questions. Thereafter I employed the probing strategy which related to the participants responses to elicit a deeper understanding of their thoughts and feelings. These interviews were a learning experience for me as each interview presented its in-depth and unique understanding of the research topic.

I utilized the principle of personal identity in interviewing. This is based on acceptance of the individuality of each respondent with regard to religion, personality and social background, as suggested by Best & Khan (1993). I had to experience the participants in their individual and group positions and accept them in their life’s world. The focus group interviews allowed the participants to interact with one another and the information elicited here could bring out information that may be omitted in the individual interviews. My main concern was whether the participants would understand how delicate the information was that was provided, and respect one another’s right to privacy.

Cohen et al. (1999) maintain that semi-structured interviews allow for flexibility and freedom to ask modified follow-up that will lend extended clarity to the discussion, which in turn would provide thorough insight into the study. The semi-structured interview allows the schedule to be fairly open-ended to enable the responses to be reordered, expanded and further probed into. Therefore, throughout the interviews the emotions underpinning these young women’s stories of their experience was probed in an attempt to acquire an in-depth understanding of the meaning, kinds and effects of sexual risk. Further questions were also posed to clarify the meaning of their responses. These forms of interviewing allowed the participants the opportunity to explain their understanding of sexual risk from their own experience.

According to Leclerc- Madlala (2002) in as much as there are AIDS research studies that are conducted on a large scale, research studies conducted on a smaller scale in specific locations also reveal important information about sexuality and risky behaviour. I tried to develop a detailed explanation *“to account for human and social behaviour”* (Cohen, Manion & Morrison, 2007, p. 23).

It was crucial not only to ask questions in such a way that the participants were encouraged to answer and elaborate further in their own words but also to allow them sufficient time and space to do so. The rationale for conducting focus group interviews is that in the informal grouping the nature of questions and the interaction amongst the participants stimulate in-depth discussions of the topic to an extent that would be difficult in a more formal situation (Ferreira & Puth, 1988).

The real value of using the focus group interviews was that participants were given a pronounced view of theirs and other participant's experiences of sexual risk. This assisted in ensuring that each participant would speak at least once and assisted the participants to become acquainted with one another. My role was non-directive, interjecting only enough to start the conversation and prevent it from going astray too far from the issue under discussion. The principle for encouraging a free flow discussion among the young women was that the discussion might disclose important information that would not otherwise arise in response to face-to-face questioning. The method employed was based on the opinion that if people are allowed to be spontaneous in a non-evaluative and non-threatening environment, this reveals much more information about them; information that they will otherwise hide (Morgan, 1997).

During the focus group interviews, intra-group encouragement resulted in active discussions among the participants and reinforced memories, feelings and experiences. Considering that the environment was friendly and lenient, the participants eventually became free to share personal experiences. The contributions of one participant spurred the others to offer additional information. This interview evoked mixed reactions. One participant remained fairly quiet and only spoke when a question was directly posed to her and her responses were mainly one word or a very simple statement. On the other hand, one participant attempted to dominate the discussion but I continued to redirect questions to others in the group.

It was difficult to control the flow of responses as a few participants would continuously interrupt with a comment whilst others spoke. I was however keen on the focus group interview as it was necessary to ascertain how it correlated with responses from the individual interviews. Individual interviews often resulted in "I don't know" responses.

It was ideal that we reached a consensus to record the interviews, as writing notes as learners spoke would have been a futile activity and would have meant unnecessary disruptions in the flow of the conversations. The recording allowed me the flexibility to be fully involved in the interview itself. Recording the interviews allowed me the leverage to transcribe them verbatim at a later stage and I could return to the recordings on numerous occasions in order to get the correct version of what was divulged in the interviews.

Once the interviews were successfully concluded, I expressed my gratitude to the young women for their time and valuable contributions, highlighting that without them the study would not have been possible. I undertook to share with each young woman the findings of my study once it was completed. The young women and I collectively planned a debriefing session at the end of the year, after the final examinations.

3.5.2. Data Analysis

Data analysis involves organizing and making sense of the data collected (Cohen, Manion & Morrison, 2011). The final hurdle is a huge volume of information which has to be worked through. According to Dawson (2002) the method used to analyze data depends on whether the researcher has chosen to conduct qualitative or quantitative research. As the research was informed by qualitative research principles, the data collected was to be reduced in two ways: commencing with physical reduction as suggested by Lindlof (1995) which; consisted of organizing the raw data into conceptual categories, then; prioritizing data and analyzing it using emerging themes. This is referred to as thematic analysis.

This type of analysis is highly inductive, that is, the themes emerge from the data and are not imposed upon it by the researcher (Dawson, 2002). Lindlof (1995) points out that thematic analysis renders information manageable. Data analysis is subjective in nature. Researchers scrutinize the body of data in search of patterns (Leedy & Ormrod, 2005). Leedy concludes that qualitative inquiry is primarily interpretive. I engaged in an active process of interpretation i.e. noting some inputs as significant but ignoring others as insignificant.

Cohen, Manion and Morrison (2011) state that there are seven steps in qualitative data analysis: To show similarity and differences in responses; clustering and grouping of themes; establishing links between the themes; formulating inferences; writing a preliminary précis; categorizing disconfirming ideas; and formulating a theory with findings from the data analysis.

Notes and recordings were transcribed and transcripts were copied. Thereafter I looked for units of general meanings within the interviews. I looked for meanings that were relevant to the research question developed before the commencement of the research (Berg and Bruce, 2001). In order to formulate themes, I highlighted passages with similar ideas in the transcripts that were examples of themes. The process of highlighting enabled me to quickly retrieve and collect all the text that was associated with the same idea. Field notes from the observation during group interviews were also documented.

Responses were documented using pseudonyms. The data was then checked against tape recordings for accuracy. At this juncture, I revisited the theory and the literature review and I tried to establish links to see if there were relations between the theory, the literature and the themes elicited from the interviews. Qualitative data analysis includes the range of processes and procedures whereby we move from the qualitative data that has been collected into some form of explanation, understanding and interpretation of the phenomenon that is being investigated (Lewis, Taylor & Gibbs, 2005).

One of the difficulties I experienced in presenting the data findings was to compartmentalize the themes because they are inextricably related and often it appeared as if there was a repetition of certain themes.

3.5.3. Validity and Reliability in Qualitative Analysis

Leedy & Ormrod (2005) state that validity of a measurement instrument is indicated by the extent to which the instrument measures what it is supposed to measure. Validity looks into the content and construction of the research instrument. Given that the research falls within a qualitative ambit, the question of validity is important. Leedy (2005) further refers to the strategy of “thick” description in support of validity of the research findings, i.e. the situation is described in sufficiently rich, “thick” detail that the reader is able to make their own deductions from the resultant data.

Qualitative research has limitations. My participants may have been subjective in their responses. They may have been unwilling to be totally honest or open in answering questions as they may have identified me as an educator who may judge them based on their answers to cited questions. Some may have exaggerated their responses to impress me. All data received was treated with circumspection and the relevant qualifiers were applied to them.

Validity is an important key to effective research (Cohen, Manion & Morrison, 2007). According to Silverman (1994), research has to be intellectually challenging, vigorous and critical; and the researcher’s reliability and validity must dictate the rigidity.

To ensure validity in the study the following precautions were taken:

- I kept a detailed diary of important dates, personal observations and any aside comments that were levied by the participants.
- All interviews were recorded and transcribed verbatim. Participants were welcome to peruse the latter. The personal experiences, beliefs and value systems of the participants lent bias and subjectivity to the data, however qualitative research accepts the data as the truth because they are the expression of lived experiences; therefore the data is valid (Nieuwenhuis, 2007).

Reliability is the consistency with which the measuring tool generates a certain result when the entity being measured has not changed. Lincoln & Guba (1985) describe reliability in qualitative research as credibility, dependability and consistency. Silverman (1993) suggests the use of “highly structured” interviews with the identical format and “sequence of words and questions” for each participant. However the process of probing and explanations are restricted hence the need for semi-structured interviews (Nieuwenhuis, 2007, p. 87). In order for the data to be reliable, the interviews had to be conducted in a similar context for all participants.

I had to be objective and not interject with my own comments during the course of the interview as that would have made the participants uncomfortable. Qualitative research usually involves small samples and the reliability of the interview schedules and representativeness of the sample is an important methodological issue, however the authentic understanding of the participants' experience takes precedence to sample size (Silverman, 2006, p. 20).

Denzin & Lincoln (1994) state that reliability in qualitative research can be addressed in many ways: being in a stable situation when observing participants; as the researcher giving full attention to the interview process and not allowing her to be side-tracked; and ascertaining if the interpretation is similar to the conclusions of other researchers studying a similar phenomenon. Reliability is seen as a "fit" between the recorded data and the natural environment of the participants.

3.5.4. Trustworthiness

Truth is the primary principle used to establish trustworthiness (Lincoln and Guba, 1985). The truth value of the research asks whether the researcher establishes confidence in the truth of the findings for the participants in the context of the study. I ensured trustworthiness through:

- Reflexivity: I used the voice recorder and a detailed transcript to ensure that all responses were correctly translated.
- Field notes: I recorded any relevant detail or findings at all times during the research period.

An important concern for me was whether the participants were honest in providing data or they were simply telling me what they believed I wanted to hear. Trustworthiness is of paramount importance to me for the research to be an honest reflection of what 16 to 17 year-olds really think and experience with regards to their relationships and sexualities. The participants expect the same of me with regard to how I interpret and present the data they have provided. My task is to present transcripts and data analysis to them to ensure that there are no inconsistencies. According to Flick (2006, p.248), "*credibility refers to the accurateness of the documentation, the reliability of the producer of the document, the freedom from errors.*"

3.5.5. Ethical Considerations

Leedy & Ormrod (2005) argue that we must look closely at the ethical implications of what we are preparing to do, that includes protection from harm, informed consent, right to privacy, and the exploitation and consequence for future research in health care. I followed the necessary protocols and adhered to the ethical guidelines of the University of KwaZulu-Natal in terms of my research. This included obtaining the necessary permission to use information for research purposes, ensuring that validation takes place, and acknowledging sources of information.

In conducting any type of research, it is imperative that informed consent is obtained from the research participants and all involved stakeholders. Potential participants were given a general idea of what the study is about, i.e. understanding the risky sexual behaviour of female secondary learners within the context of HIV and AIDS in South Africa. My ethical responsibility includes the principles of integrity, honesty and respect for other people.

According to Flick (2006, p. 46), participants in a research study participate on the basis of informed consent. In their aim to obtain written consent, researchers should not harm participants of the study but give participants time to make a decision.

The following steps were undertaken:

- I obtained permission from the principal (Department of Basic Education Representative) to conduct the interview at the site and his agreement to use learners from the school. The details of the study were included in the letter as the issue under research was a very sensitive one. The supervisor's details were included in the event that enquiries needed to be conducted.
- Consent forms were sent to the participants' parents/ guardians/gatekeeper as all the participants were minors. The attached letter outlined all the information of the research study to be conducted. The topic was explained and my personal details were provided. The institution for which the research was being done was stipulated. The issue of confidentiality was highlighted.
- Participant's consent was also sought. The purpose of the study was explained to the participants in order for them to be informed and to obtain their voluntary consent. It was emphasised that my research would be confidential and the anonymity of the participants and the institution would be maintained at all times. Pseudonyms were used to protect the learners and institution.
- Participants were informed that their participation was voluntary and they could at any time during the course of the interview terminate their consent. Before the interviews, I facilitated a "role playing" (Bhana, 2007) activity and participants practised the use of pre-arranged signals to facilitate withdrawal from the focus group interviews without drawing attention to them.
- Findings of the research were only to be used for research purposes. No post interview discussions would ensue with the participants, the families or the school.
- I informed learners of the benefit of my study: their inputs may initiate further research in this field and may encourage more awareness of the plight of young women in society.

I avoided asking too sensitive questions to the young women, bearing in mind that the participants may be affected/infected with HIV and AIDS. I also consulted with the class teacher to gain background knowledge on the general living contexts of their learners. This knowledge informed me of the vulnerability or suitability of my research site. During the interviews, I drew on my own notions of morality and ethical values to guide my conduct during the interview.

Appropriate data storage security measures were taken to minimise the possibility of any parties gaining access to the study data. After submission of the thesis, the data will be stored in a secure location as arranged with my supervisor.

3.5.6. Limitations

My challenge was my position of power, seeing that the participants identified me as their former primary school educator and now the researcher. The uncertainty dwelt as to whether the participants did receive parental consent or whether these documents were self-acknowledged. Some young women were somewhat shy to mention certain types of sexual behaviour. I would then refer to it in the proper term and they would confirm. Some were reserved and did not want to speak about explicit matters. The young women were a little wary of being judged negatively when questions were being answered. Their levels of honesty in answering questions of a personal nature were questionable. Some learners fabricated responses to tell me what I wanted to hear, which might have skewed my findings. I had to ensure that they were comfortable enough to respond honestly.

My sample did not represent the entire school population aged 16 to 17 years. However their contributions provided valuable information which assisted me in understanding the young women's sexual risk taking behaviour.

Language may have been a problem since most of the participants were second language English speakers. Responses could have been more in-depth, if the young women were interviewed in their mother tongue.

3.5.7. Conclusion

The focus of chapter three was on research methodologies, data collection, and analysis of data and the process adopted to ensure validity, reliability and trustworthiness. I also focused on the limitations of my studies. In the next chapter, data will be presented and analysed.

CHAPTER 4: FINDINGS AND ANALYSIS

4.1. Introduction

My study aims to understand the sexual risk among young women attending a local secondary school, Bester High, in the Amaoti-Phoenix areas. The context of poverty in these communities forces these young women to face a myriad of social challenges.

The critical questions are:

- How do female secondary school learners in the Amaoti-Phoenix areas understand sexual risks in the context of HIV and AIDS in South Africa?
- Why do female secondary school learners in the Amaoti-Phoenix areas engage in risky sexual behaviour in the context of HIV and AIDS in South Africa?

In my analysis I handle both my critical questions concurrently as they are intrinsically linked. The responses elicited from the participants encompass both these questions simultaneously. I attempt to provide an understanding as to why young women engage in risky sexual behaviour and explanations for sexual risk in the context of HIV and AIDS in South Africa.

My study participants were eight Black-African young women and two Indian young women. Only two of the ten participants were not sexually active at the time of being interviewed but they were quite knowledgeable about sex and its associated risks. The data from my studies suggested that all the participants were aware of the HIV and AIDS pandemic and the causes of HIV infection.

My results are based on the data that was gathered during the individual and focus group interviews; as well as general observations during the interview process.

The data is presented and analyzed with themes that emerge from the data collected. The themes are presented in order of the most cited reasons to less likely circumstances.

The following themes were identified during transcript analysis:-

- Crowded Space
- Culture and Tradition
- Sex as Currency
- Sex as Desire
- Love and Trust
- Substance Abuse
- Myths and Misconceptions
- Peer Influence
- The Greater Threat: Pregnancy or HIV

4.2. Themes

4.2.1. Crowded Space

From the data elicited during my research it is noted that the majority of the participants reside in informal- or RDP (Reconstruction and Development Programme) settlements. These are some of the responses to a question related to area and living conditions:

Palesa said: *“Amajhondolo in Amaoti. Nine in one small house.”*

Whitney added: *“In Amaoti. A jhondolo. One big room and kitchen.”*

Angel sounded quite frustrated: *“The jhondolo in Amaoti. Too crowded, five each room.”*

Over-crowdedness is the general living norm. In these situations these participants are exposed to many negative influences. These responses are related by some of my participants:

Palesa sighed: *“Don’t have space for me. Mum and boyfriend sleep next to me on the mat.”*

Whitney agreed: *“Mama and her boyfriend, Gogo and me. No space for being alone. I see mum and her boyfriends. I learn new things from them and teach Colin.”*

Beyonce also had the similar response: *“Amaoti..all jhondolos. Too full. Everyone next to another. Lots of drinks, stealing, whoonga and abuse.”*

Angel retorted: *“Can’t have any peace or a good night’s sleep. Mum brings her boyfriend’s home...then its worse.”*

My participants acknowledge being exposed to sexual activities, multiple partners, physical abuse, and alcohol and drug abuse.

According to research conducted by Baylies & Bujra (2009) residents in informal settlements experience serious social cohesion challenges. It is a context where young women attribute their own meanings to abuse, gender violence, alcohol, drugs and HIV.

The above data shows that privacy in informal living environments is very limited and that my participants are exposed to sexual activity early in their lives. This places them at risk as they witness sexual activity, often with multiple partners, and they may view these as the norm in society.

This is also demonstrated by Bhana and Epstein (2007) who conducted studies in KwaZulu-Natal. Their findings show a very high rate of HIV prevalence among young people living in informal settlements. They further indicate that the conditions of life in these settlements leave little or no opportunity for privacy and provide an environment conducive for young people to witness sexual activities. Hallman (2009) reinforces the conclusion that low household wealth is associated with higher rates of early sexual debut of young women. She adds that young people living in under-privileged settings are faced with circumstances that are conducive to high-risk sexual behaviour.

Akeroyd (1997) noted a decade ago that many poor young people in South Africa lived in dense informal settlements and unsafe sexual relationships were a means of economic gain. A wide range of sexual cultures and poverty exacerbates these young women's vulnerability to HIV- infection. According to Hunter (2006), the poorest South Africans live in informal settlements and HIV prevalence is at its highest. Jewkes et al. (2002) also state that in informal settlements, sexual abuse often goes unnoticed.

4.2.2. Culture and Tradition

Morals, values and etiquette are qualities that are culturally fostered. Culture and tradition often dictate the patterns of behaviour of its followers.

4.2.2.1. Patriarchal Societies

My data reveals that the majority of my research participants come from predominantly Black communities where patriarchy is rife. The young women in my studies added their views on male dominance:

Whitney vociferously voiced: *“Men can sleep with many girls as they are the bosses and we must listen to them.”*

Whitney's suggestion that men are in charge indicates the dominant roles that men fill in certain communities.

Beyonce also stated: *“The men abuse the women. They do what they want and women must not complain. They demand sex from many women and use no protection. They carry diseases from one woman to the other.”*

Beyonce reiterated the previous response as she observed men in her community engaging in multiple sexual activities without the use of protection. The women's health is compromised and they submit to their partner's desire.

Rehanna suggested these reasons for male dominance: *"The black men have many women. This makes them strong and powerful. I think that they must respect women."*

From the data received, my participants suggest that Black communities encourage multiple partners for the men whilst women are considered to be asexual. They have little control of their sexual choices and continue to remain subordinate to their male companions. The disregard for the use of condom, a noticeable norm within the black community, as alluded to by my participants, increases the risk of HIV transmission and unplanned pregnancies (Leclerc- Madlala, 2002).

In a response to a question posed on how some cultures believe that young women are the objects of men's sexual satisfaction, the following salient statements were levied:

Palesa highlighted these occurrences in her home:

"My baba has two mamas. My mother is on the farm and my step is here. It's ok for the man. You know mam if girls dress up so lovely and get raped then it's her fault cos the girl wanted it."

Palesa suggested that any negative affliction on the women is to be attributed to the women 'asking for it' by means of her attire. This is an internalization of society's accepted norms for dressing among women as it is assumed that this is a means of seduction.

Nafisa had this to add: *"Mam in the Muslim faith the man can have 7 wives. This is not fair as the rules are not the same for the lady. Men can carry disease from one lady to the next."*

Nafisa observed that there are unfair sexual standards for Muslim men and women. Cultural practices that sanction polygamy also sanction promiscuity.

Monica then gave her views: *"Mam in our tradition the man has the freedom to have many women. They sometimes don't marry because of lobola. This is not fair to the lady as she and all the others can get diseases and can't know for sure who gave it to them."*

Monica observed that unfair rules in society place women at sexual risk.

Whitney added: *"Us blacks don't protect our children any-more. The children are used to sell sex to older men just so the family can have money for food and clothes."*

Whitney talked about poverty stricken communities, and sex being used as a commodity.

Holland et al.'s (1990) research finding remains true as evidenced in my research. They state that men and women define their sexuality within societal norms and that relationships are socially constructed. The data shows that men make the rules concerning the status of most sexual relationships.

Constructivist theorists such as Lorber (1994) and Hubbard (1991) assert that society and culture play a vital role in defining the role of men and women within communities.

The power disparities within heterosexual relations do not allow young women the opportunity to negotiate safe sex or the use of protection (Varga, 1996 and Wood et al., 1998). Marstan & King (2006) highlight the historical expectations that societies have of men's and women's behaviour. Men are expected to be heterosexually active whilst women are to be chaste. Men are allowed to use women for their sexual pleasure but once women display their sexual desire then they are deemed to be morally cheap. This demonstrates dominant masculinity and traditionally submissive femininity.

Kambarami (2006) asserts that many cultures are lenient on male sexual behaviour. Men are awarded the freedom to experiment sexually. No mention is made of protective measures. In South Africa, the HIV and AIDS epidemic is gendered and classed in favour of the male (Bhana & Epstein, 2007).

My participants suggested that men by sheer nature of their gender were afforded more power than the women. In response to a question on who generally initiated the sexual advance, these responses were offered:

Palesa shouted: *"The boy mam. Sometimes I do to but not as much as he does. It's not good to show him that I want it.... he is the man and we listen to what they say."*

Gender disparities are constructed within male dominant communities and men are allowed to initiate and control in all sexual transactions. The young women sometimes feign ignorance to allow the man the opportunity to be in control. This is done in light of the fact that they will receive more rewards and attention when they pretend to know very little.

Then Pinky answered: *"Has to be the boys. They very forward. When girls walk passed them, they touch our bums and boobs.... Even if they don't know us at all."*

Pinky alluded to the dominant roles that men have in society. They were allowed to demonstrate their power by physically handling young women whom they know or do not know.

Beyonce added: *"Boys do because they have more experience than girls. They also practice from a very small age and are brave to ask these things from girls."*

Prudence agreed: *"He does mam. He is the man and knows more about these things."*

Society sets different norms and standards for their citizens. Men have more power and can manipulate a relationship in their own favour. Women are expected to be submissive and accept what a relationship has to offer.

Rehanna stated: *“Boys do. They like to be in power of the girl’s life.”*

The men want to be in power to show that they control the relationship. This subordinate position occupied by the participants often places them under sexual risk, where they may indulge in unsafe sexual practices.

Baylies (2000) argues that women are deemed to be vulnerable with no choice about using protective strategies. Research conducted by Reddy (2011) concludes that young men display traits of dominant masculinity. They acknowledge that it is natural for them to have uncontrollable sexual urges and they decide the status of their sexual relationship.

Levett (1994) elucidates that the gender-related social values which provide more prerogatives to the males, heighten the risk of rape and sexual abuse in a relationship. A study conducted by Wood et al. (1998, p. 236) in Khayelitsha highlights the coercive sexual dynamics within relationships. Violence is related to most sexual relationships. “Date rape” and coercion amongst regular partners was documented. Men misunderstand their refusal and claim that the women had other partners and were “worn out.” Many cases of gang-rape are cited in cases where males believe that their partners have been unfaithful.

Jejeebhoy & Bott (2003) estimate that between 15 to 30% of women’s first experience is forced by someone the woman is acquainted to. Campbell (2003) reported that rape and emotional pressure are common in most South African youth’s first sexual experiences. Varga (1997) stated that for some young men, resistance from a young woman is seen as a form of sexual foreplay. Many women conform to hegemonic versions of femininity.

A question on women being the objects of male fantasies and sexual satisfaction, elicited this response from Beyonce:

“The men abuse the women. They do what they want and women must not complain. They demand sex from many women and use no protection. They carry diseases from one woman to the other.”

Another cause of abuse is contraception use. Some partners tear up contraceptive cards with the notion that it causes vaginal wetness which diminishes male sexual pleasure. Fear of being beaten or being accused of infidelity leads to the non-use of protection.

When asked if the young women insisted on the use of condoms, these responses came forthright:-

Beyonce sighed: *“Can’t do that mam as he will say that I do not love him enough or that I have another boyfriend and he will hit me. He is black and they don’t wear these things.”*

Beyonce suggested that by virtue of being Black, a condom should not be negotiated. This clearly places the women in a position of risk of contracting HIV from men who live in a community that condones multiple partners.

Violence against women is harmful and generally reduces the women's physical and emotional capacity to care, to earn a living and to decide on the relations they maintain. Violence reduces a woman's capacity to negotiate the conditions of safe sex (Jewkes et al., 2003; and Dunkle et al., 2006). Men who perpetrate violence against their partners are less likely to wear condoms.

Feminists believe that women are oppressed and disadvantaged in relation to their male counterparts and their oppression is unjustified (James, 1998).

4.2.2.2. Cultural Values & Norms

As suggested by the responses elicited in my study there seems to be different expectations on appropriate and accepted sexual behaviour of young women in the African and Indian communities.

When a question was posed about the elders' awareness of the sexual behaviour of the young women in the community and their response to condoning or forbearance of such behaviour, these were some of the responses:

Palesa swiftly responded: *"Nobody says anything. Long as the money keeps coming. The tatas like us young girls. They flock us when we walk home."*

Monica further added: *"Nobody worries about what you do. The neighbours know what's happening but they need the money and its fine to use your body."*

The apathy demonstrated by the community seems to be guided by poverty rather than inherent values. This observation presumes that community members turn a blind eye because of financial benefits to the family.

Whitney further clarified: *"Everyone knows but nobody does anything. The children are better behaved than the big men. The men want the 'fresh' girl for their filthy tricks."*

When asked to explain 'fresh'. Whitney says: *"The young girl who does not have a boyfriend."*

Seema, a Hindu girl had this to add: *"They are very strict but the young girls know how to fool the parents. They will not hear of us sleeping with boys before we are married."*

These differing responses indicate that cultural norms are dependent on the lived-communities. The Indian communities foster abstinence before marriage. This is indicative of traditional expectations of femininity.

Nafisa added: *“In the Muslim community parents are strict. Rather than having young people messing around, they get them married when they finish school.”* She also adds that: *“messing around meant having too many sexual relations before getting married.”*

The comment suggests that early marriages are encouraged within the Muslim societies as a means of preventing experimentation with multiple sexual partners.

Nelson (2009) defines culture as a set of customs, traditions and behaviour shared by a group of people. My participants note that cultural values sway towards favouring the male. Unlimited freedom is afforded to men, and women are seldom afforded protection and respect. Feminists such as Paechter (2006) view this as placing women in subordinate positions where they can be exploited.

Nolen (2007) states that the poorer Black cultures suggest young women try “umalaya”-sex for money. Bhana and Pattman (2008) further add that society expects Indian girls to be “quiet and defined”. They are not permitted to drink, smoke, use drugs and to stay out late at night. These restrictions are placed to protect the youth from taking risks. Rajab (2010, p. 4) says that “Indian culture is a shame-orientated culture rather than a guilt-orientated culture”. This is indicative of a culture that promotes very restrictive behaviour for its young people.

Bhana & Pattman (2008) highlights that the sexuality of young girls, of Indian origin, is regulated by their parents and families. Crompton (1971) stated that in the Indian culture, the family unit is an important facet and a guide to the correct path to their way of life. Religious values in respect to contraception, roles of men and women, sexual behaviour and the acceptability of condom use; affect the development of the youth sexuality. Values imbibed in the family help to shape the individuals actions and attitudes towards others in society (Greathead, 1992).

It is noticeable that apathy from society indirectly allows young women to indulge in unsafe sexual practices. The young women who indulge in these unsafe sexual activities have knowledge of the repercussions but poverty is the factor that allows for risk taking behaviour. These research findings are appropriate to my study.

4.2.3. Polygamy: A Cultural Practice

The Oxford Dictionary defines polygamy as the practice or custom of having more than one husband at the same time. The World Book encyclopedia calls it a system in which a man is married to more than one woman at the same time.

My participants who follow the Islamic faith agree that the religion permits marriage between a man and up to four women.

Nafisa confirmed: *“Mam in the Muslim faith the man can have seven wives.”*

These men are constructing their own masculinities within an acceptable cultural norm. These practices contribute to women’s being submissive. Women are also constructing their own gender in respect to dominant male demands.

Some cultures in South Africa practice polygamy. In the face of the HIV and AIDS pandemic, this practice places women at risk. Traditionally the African and Muslim cultures make provision for the men to have multiple partners. The reasons cited historically are family wellness and protection of the clan. Today this practice is abused to provide for the dominant male, to the detriment of the women's health. This male promiscuity can render a man an HIV carrier and place all his wives at risk.

When asked if the community is in favour of multiple partners, these responses were elicited:

Palesa said: *"The Blacks do. Men get all the favours and women are treated badly."*

Nafisa had this to say: *"It's a man's world. Muslims can also have many wives. The wives cannot fuss ... the man sleeps with all of them."*

Rehanna added: *"Common in our community. I think it's not culture. Men do it to show they are stronger."*

These participants again talk of a society where the male is dominant and multiple partners are allowed for the men.

Seema, a follower of the Hindu culture said: *"Our culture does not allow this but nowadays everyone is modern. The man gets away with murder."*

Seema talks about another cultural perspective where men follow western trends rather than cultural dictates. Many of my study participants suggested that values in society are skewed in favour of the men and women are at risk of contracting sexually transmitted diseases.

4.2.3. Sex as Currency

The participants suggested that living in poverty-stricken conditions forced many young women in the community to indulge in risk taking behaviour where their basic needs and wants took precedence over their health and safety. This entailed the use of sex as a commodity.

When asked the question on how their financial predicaments influenced their sexual behaviour, these are some of the responses:-

Nafisa stated: *"I think in all cultures money is the main factor for sleeping around."*

Monica then agreed: *"Rather than being hungry and die, why not sell your body to help your family."*

Seema also affirmed this: *"Definitely mam. We see the poor girls selling themselves for money, clothes, food, school fees, and rents."*

Prudence sympathetically said: *“Sure. Poverty is terrible. We don’t blame the girls for wanting to help their family.”*

Poverty thrusts a few of my participants into engaging in risky sexual behaviour. They risk their health because their need for luxuries and money is more important.

Sex becomes the commodity that is available to trade. Sex is viewed as a social currency. According to the Oxford Dictionary, currency refers to the value that something has. According to Baumeister (2009) when women lack opportunities to earn their own money, they up the value of sex. Sex is placed on the economic scale.

When my participants were asked to explain the reasons for sleeping with their boyfriends, the following responses were cited:

Palesa stated: *“You know mam.. Every time I need something from him, I have to do something for him. I sleep with him and he rewards me. Buys me great stuff...fashion clothes, boots, cell phones, school fees and air time when I don’t have. My boyfriend can’t take me to a hotel but da malumes take me there and we stay all night.”*

Palesa highlighted the desire for material goods and opportunities to spend nights in a hotel. This was a luxury that is non-existent in the informal settlements.

According to Robert (2003) many young women view economic prospects as the reason for engaging in risky sexual activities.

Angel affirmed: *“He spoils me and gives me all that I need.... Money, clothes...”*

My participants’ stated that their dire economic position placed them in situations where monetary gain was viewed as a priority compared to risky sexual behaviour patterns.

Palesa suggested that there was a connection between circumstances and faithfulness when she said:

“Mam... If I lived in Mhlanga I will only have one boy cos I will have enough money. Then I can give my love to my sweetie only.”

Another participant, Nafisa said:

“But the blacks are very poor and they will do anything for money.” And when asked what she meant she said *“Sleep with all the boys for money.”*

Nafisa suggested that in her observation, young girls of different racial backgrounds responded to sexual behaviour according to their economic situations, assuming that the young women of the African race were in a less advantaged economic position.

This is confirmed by Whitney who said:

“Lack of money makes us all do things to survive. Miss before Colin I was sleeping with mama’s boyfriend. He hit me, tied me and even burnt me when I did not want to sleep with him, but I didn’t fuss because he gave us lotsa things. I didn’t even tell mama.”

Whitney expressed the use of force by the male partner, for example threats with knives, beating and punching when she refused sex. This coercive behaviour was tolerated due to the gains received later.

Charvet (1982) stated that some women are willing to accept all sexual demands in order to “please” rather than to be beaten every day. Violence in relations lessens women’s ability to refuse sex or to negotiate safe sex. It is also noted that this undermining of the female sex is due to the fact the women are viewed as sexual beings rather than human beings.

Beyonce added: *“We will go hungry if we don’t look for ourselves. Girls sleep with men for money, clothes, and cell phones.”*

Angel reiterated: *“I am very sad that I can’t do my school work properly cos I am making money in that time, selling my body. I wish I was rich....”*

Angel added that she sometimes had to sacrifice her studies to ensure that she earned money for her family. The data suggests that there is a close link between the young women's need to uplift their present living circumstances and situations that drive them to indulge in potentially risky sexual behaviour.

Hallman (2005) states in her research findings that young women in need, exchange sex for money, goods or favours. In a youth survey by Pettifor et al. (2004) it is reported that almost 3% of women exchange sex for money, gifts, favours, good grades and material goods. Webb (1997) also notes the commercialization of youth sex in South Africa. According to Peltzer (2005), the youth in South Africa exchange sex for money, drinks and gifts. In sub-Saharan Africa sex, is seen as a way of obtaining money and gifts from boyfriends.

The participants indicated that selling sex without a condom reaped greater benefits.

Palesa pointed out: *“Can’t....then I will not get any money and air time. Once a malume gave me R500 for the whole night...many times with no condom. When I don’t use the wrapper, I get more things...”*

This indicates that financial gain is more important than the use of protection to safeguard the health of many of the young women in the research community. This behaviour places the young woman at risk from contracting sexually transmitted diseases.

Angel said: *“No I can’t do that cos then he walks away and I am left without a cent. What is mama going to do for food?”*

Rather than facing rejection and the loss of income, Angel chose to engage in risky sexual behaviour.

Risky sexual behaviour is linked to the economic conditions of these young women. If parents and guardians are incapable of providing adequately, then these luxuries are sought elsewhere using the only commodity the men in society want and will pay for, i.e. sex.

My data also picked up on the trend among my participants of choosing older partners. These were some of the ages of the chosen partners. As anticipated, their partners were employed.

Nafisa: 22 years old. He works with his father at the shop.

Beyonce: 23 years. He is a taxi driver.

Angel: 22 years old. He is a "kondaai".

Prudence: 22 years. Works in Checkout.

In the focus group interviews these responses were elicited:

Palesa: Above 20. They are working and can provide money.

Monica: 21 years. They are not childish and have money.

Whitney: Miss I prefer older boys as they know how to treat u well.

Older partners generally signify to a young woman, a partner who is employed and can afford opportunities to those who experience dire straits at home. Most of my participants had older partners; in some instances the age gap was six years.

For these young women, the ideal of being in a lucrative and beneficial relationship outweighed their personal health and welfare issues. Some of the participants cited that older partners treated them with respect and love. They also fervently hoped of being treated with dignity and hoped for the prospects of a long term, monogamous relationship. Feminists also observe that women often use their personal possessions as a tool to achieve what they normally will not have. As social constructivist note, these young women continually construct their own sexual identities in respect to selling sex for money and luxuries. They knowingly place themselves at risk.

Abdool-Karim et al. (1998) also notes that young women often choose older partners. By sheer virtue of their age dominance, men have greater power to dictate the terms of their sexual relationships. Calves (1996) adds that poverty often forces young women to indulge in relationships with older men as they are seen as prospective sponsors of their lifestyles and are in a position to satisfy their needs. Women in these types of relations are exposed to greater risk (Luke, 2005). In a study conducted by Peltzer (2005), he finds that many female students have sex with older men for economic security.

4.2.4. Sex as Desire

In my study, the young women expressed a desire for sexual activities. They were actively constructing their sexuality in a way that conflicted with the traditional feminine view of submissive females. The data from my study indicated that many of the participants and young people in the research community engaged in sexual activity due to personal choice and a desire for these activities.

Some of my participants argued that the values inculcated by their parents and society suppressed their attempts to act out their sexual desires.

Nafisa said: *I sometimes lie to mum that I have classes....I duck and go to meet him. Then we book a room, he has lotsa money and can afford to spoil me.*"

Nafisa indicated that her parents would not condone her sexual behaviour therefore she secretly engaged in these activities. Being a Muslim made her behaviour non-conformist.

Desire is prevalent among the youth irrespective of traditional social and cultural values where sex before marriage is deemed to be taboo. Although values learnt in society provide the reasoning for not being sexually active too soon; desire provides the logical explanation for indulging in experimental sex.

Beyonce blurted: *"He takes me home every weekend. He stays alone in the shack. We have lotsa sex."*

These young women were evidently engaging in sexual activities of their own free will as they did not show any signs of being coaxed or coerced. They knowingly indulged in risky behaviour as they did not wear protection during these desired activities.

The young women further provided these reasons for sleeping with their boyfriends:

Whitney happily answered: *"Yes miss. I like it miss."*

Beyonce indicated: *"Yes mam. I love him and he loves me a lot."*

These participants seemingly enjoyed their sexual behaviour and often indicated that they were in a long term relationship. Love and desire outweighs the traditional view about feminine behaviour that marriage will precede sex.

In a study conducted by Kaufman & Stavrou (2004, p. 383) boys believe that they needed to "move around" as the ages 14 to 22 "were the best years of our lives". They feel the opportunities to "play the field" will be limited if they settle on a steady girlfriend. Wood et al. (1998) claim that few young women acknowledge wanting sex, as in a male dominated society women are not expected to express desire and certainly not initiate sex. Desire will be misinterpreted as indicating she is a loose woman.

Feminists (Butler, 1990) agree that young women enact their liberated status and respond to their sexual desires. Young women constantly construct their sexual identities within the realm of sex and desire. Risks are taken because these young women desire sex but make no mention of safety precautions.

4.2.5. Love & Trust

The young women in my research study believe that love and trust are synonymous with each other. Love compliments trust.

Prudence said: *“Yes mam. I love him and he loves me very much. He is going to marry me soon.”*

Many of the participants stated that they had known their partners for a period of time and felt safe in their sexual relationship. The feeling of trust motivated them to engage in unsafe sex. When asked as to how long one should know a partner before sexually committing to him, these were some responses:

Whitney suggested: *“within a week is fine.”*

Angel replied with disgust: *“maybe a year or more.”*

Palesa added: *“a week or two is enough to know if a boy is right for you or not.”*

The short time period is insufficient to ascertain the HIV status of a partner. Trust is a notion not based on knowledge but personal choice.

When questioned if condoms were used:-

Nafisa retorted: *“No I know that I’m the only girl for him. . . I love him and know that we will marry when I’m finished school.”*

Whitney agreed: *“No miss, Colin and I trust each other. His mama likes me and she will get us to marry.”*

Prudence also added: *“No mam. He is my man and I trust him so I don’t ask him to wear one.”*

Knowing their partner for a period of time is perceived as non-risky behaviour. Skidmore & Hayter (2000) agree that knowing a person facilitates a feeling of trust.

Although my participants displayed an awareness of the risks as they engaged in unprotected sex, they were vociferous when stating that the loss of love would be greater than their risky behaviour. These young women viewed unprotected sex as a way of proving love for their partner and ensuring a longer lasting relationship. This was evident in their response to a related question.

When asked if they insist on the use of a condom during sexual activities,

Beyonce uttered: *“Can’t do that mam as he will say that I do not love him enough or that I have another boyfriend and he will hit me.”*

Prudence added: *“No mam. He is my man and I trust him so I don’t ask him to wear one.”*

My participants indicated that trust was more important than the use of protection. According to Green (2009) the patriarchal value in society plunge young women into practising unsafe sex as it is more important to hold onto ones partner and to display their love by not insisting on condom use. Feeling of love among women make them want to trust their partners. Holland et al. (1990) found that many young women state that sex is something which they do only because they love their partners. Sex is the means of convincing their partner that they love and trust them.

According to Reddy & Dunne (2007) the quest for love among young women may be exercised as unsafe sex and the risks accompanied by this behaviour. These young women assess trust in terms of love for their partners. Further studies conducted by Reddy (2011) show that young women are aware of the risks of engaging in unprotected sex, but are in a dilemma about the use of protection as there is a greater fear of the loss of love. Many young women indicate that they do not have sex with a condom as they are in a long term relationship.

Peltzer & Promtussananon’s (2005) studies in a rural South African school also finds that participants complain that the condom limits sexual pleasure and is indicative of a lack of trust among partners, challenging the male partner’s faithfulness, as condoms are often associated with STDs.

MacPhail & Campbell (2001) further find that their research participants indicate that trust waives condoms use within regular relationships. Many of the young women concede that insisting on condom use by a steady partner indicates a lack of respect and trust and can destroy one’s reputation.

Many of the study participants consented to sex because they loved and trusted their partners and anticipated that this steady relationship would end in marriage. Some adolescents appear to justify their non-use of condoms with the belief that they are not necessary because their current relationship is monogamous and promises to be long term (Akande, 1997).

Constructivist suggests that women continue to act in subordinate roles and allow their male partners to dictate the terms of the relationship. This places young women at risk as they seem to lack bargaining power. The participant’s responses were not aligned with the conventional feminine views that sex should come after marriage.

In response to a question on any fears linked with unprotected sex and HIV transmission: -

Prudence said: *“Not really mam. I am only sleeping with one boy. Other girls are stupid and sleep around...they ask for trouble.”*

Beyonce added: *“Yes, but my boyfriend says that he is clean so I need not worry.”*

Once again trust and the notion of a steady relationship compromises the safety of these young women. There is a greater concern of losing love rather than the risks of contracting HIV and AIDS.

According to Aggleton & Warwick (1999) stigma and discrimination linked to HIV and AIDS is gender related. Most South African cultures are traditionally male dominated where women are viewed as having a lower status, are inferior and submissive. These unequal power relations heighten women’s vulnerability to HIV and AIDS. Wood et al. (1998) agree that the male primarily requests to form the sexual liaison. When the young woman is willing to commit to love, she indirectly agrees to have sex with the man. Meanings ascribed to love are entirely constructed by the male and this is the preamble of a continued sexual relationship which places women at risk. Women are unable to control their traditional femininity in a male dominated society.

Holland et al. (1990) says that sex for girls is a way of demonstrating her love and trust for a partner, but on the other hand she is concerned about her career and parent’s reaction. This forces them to inhibit their desires as the odds are stacked against them.

When questioned as to why boys did not wish to wear condoms: -

Monica said: *“They wana feel the girls... say can’t go into the tunnel with an umbrella on. They also feel that if they wear condoms the girls will think that they have AIDS.”*

Angel added further: *“He doesn’t enjoy me with that rubber...it comes in the way. I don’t like it too, causes me to itch.”*

The discomfort and non-pleasurable feeling when condoms are worn, motives the non-use of protection. Monica also suggested that when a condom was requested, it meant that the female was an HIV carrier.

Reddy (2011) states that her participants lacked trust in the effectiveness of condoms. They express that condoms are unreliable and not worth the trouble and they choose “flesh to flesh” instead. People have unprotected sex because they want to experience flesh to flesh sex, so they can feel what their partners feel for them.

Condom use seems symbolic of “distance and barriers” and according to Meyer-Weitz et al. (1998, p. 48) implies a lack of love or care between partners. Other women say that condoms are for use “for those kinds of women”, implying sex workers.

4.2.6. Substance Abuse

The intake of intoxicating substances often places the individual in a compromised situation. My data suggests that many young people consume alcohol and drugs which often leads to risky sexual activity.

A question was posed about young people visiting clubs and my respondents had this to say:-

Seema said: *“No mam, dad will break my legs and besides terrible things happen there.”*

When asked to elaborate she said:

“People spike your drink and you can get raped You will never know who to blame.”

My respondents did concede that certain weekend activities often end in alcohol and drug use. They suggested having knowledge of the dangers that substance abuse posed to them. Many of the participants were aware of the influence of drugs and alcohol. They did not practise these abusive behaviour but others could not resist. Although these are pleasurable for a short stint, the risk of engaging in unsafe sex looms.

Angel said: *“Go to parties and drink and we don’t know in the morning what we did. Our memories get blank.”*

Palesa added: *“We go to the shebeen. Here we drink, dance, smoke, have sex and fall asleep on the floor.”*

When asked if she was certain that she had sex with her own boyfriend:

“Mmm.. I think so. But you know mam sometimes we are so babberlaas that I get up next to someone else. I don’t know what happened.”

These participants conformed to the risk-taking behavioural profile. Many situations where risky behaviour is perpetrated are sometimes beyond the control of these young women.

People who are using drugs or are under the influence of alcohol have a duller sense. They may forget to wear or use a condom or not even consider wearing one during penetrative sex (Orr & Patient, 2008). Sowadsky (2010) also argues that when a person is high on drugs or drunk from alcohol, they tend to place themselves at risk for HIV and STDs, which normally they will not have. They have sex without a condom or may use them incorrectly. They may be knowledgeable about STDs and HIV prevention but their predicament compromises them. Frequently they are more likely to engage in risky sexual behaviour and encourage unwanted sexual advances from strangers, which may lead to rape and violation of the women's dignity.

Dowsett (2003) finds that using intravenous drugs has a significant connection to one's sex life; for example during sex work or recreational sex a greater desire is felt when a drug is injected before sex.

4.2.7. Myths & Misconceptions

In my research study, some of my participants' suggested that myths and misconceptions in the local community place young people at risk. These beliefs and misunderstandings are propagated in communities as a possible means of finding a cure for HIV and AIDS.

These were some of the responses to a related question about the elder's attitudes to the young women's sexually activities:-

Prudence said: *"Some of them scold us girls but others want to sleep with us themselves cos they say they will get beta from the HIV."*

Palesa added: *"Not too sure, but they say HIV cums outa their bodies when the have sex with small girls."*

Myths and misconceptions have a negative impact on the lives of many innocent victims and leads to widespread stigmatization, gender violence and ignorance of the HIV and AIDS pandemic. The Human Rights Monitor (2001) finds that rape of young girls by male relatives shows women's lack of control over their sexuality.

According to my data, the most common myth is that: having sex with virgin cures an HIV infected person of the virus. Rose-Innes (2006) speculates that the increase in the number of rape cases of female children may be the result of men's attempt to avoid HIV infection or the belief that sex with a virgin will cure AIDS.

As penetrative sex carries a higher risk, oral sex is considered to be a safer option.

Angel said: *"Sleep with the boys many times... suck him...it is safe."*

The belief, according to Sowadsky (2010), that oral sex is low risk for HIV is a myth. Receiving oral sex which only exposes the person to saliva is a very low risk for HIV but giving oral sex which exposes the person to sexual fluids, is risky for HIV. The more these body fluids get into the person's mouth, the greater the risk. People may contract the following STDs through oral sex: gonorrhoea, herpes and syphilis.

Nafisa related an alternate belief about a safety net:

“Mam he is Muslim and had a circumcision. This makes him safe... the moulana says this will prevent diseases even AIDS.”

As Marge Berer (2008) points out at the Mexican IAS conference, male circumcision is a preventative measure but only one of the partners in a sexual encounter was protected. Women report that the men use the “cut” to force them into consenting to unprotected sex. However, this may increase the rates of infection among some women.

Beyonce chose the option that she read about as cited to by our president:

“Ja mam, every time I quickly have a bath... hoping to wash the germs out. AIDS kills people but we sometimes have no choice.”

Beyonce was referring to the controversial newspaper article where President Zuma said he had a shower after a sexual encounter with the attempt to clean himself off the HI-germ that may have been on his body.

Peltzer & Promtussananon’s (2005) studies also find widespread belief in these myths: having sex with virgin cures one of AIDS, AIDS can be caused by witchcraft and AIDS can be cured by having sex with a disabled or old woman. Boesten & Poku (2009) state that the deadly HIV infection can be contracted by conventional sex, homosexuality and adultery but also through polygamy, widow- inheritance, male and female circumcision, dry sex and sex by capture. These practises are now deemed to be dangerous and risky.

Palesa added an alternate strategy: *“Sometimes when I’m bleeding he asks me to turn around ...my bum is dry. I don’t enjoy this.”*

Anal sex is also considered high risk for STDs (Nolen, 2007). The anal lining is very thin and tears easily when penetrated. Blood is released and this is conducive for HIV transmission. Anal sex is high risk for both partners if protection is not worn. When a woman is menstruating, the risk for HIV transmission is greater as more blood is present during penetrative sex. Blood carries a high percentage of HIV.

Palesa added another misconception when asked if HIV is a fear during unprotected sex.

She said: *“We use Vaseline and when it’s slippery then the germs slip out and can’t get inside me....no HIV.”*

Palesa assumed that applying a lubricant prior to penetration meant that the virus can slip out of the body. She does not understand that the lubricant makes penetration comfortable.

The Indian participants had the misconception that HIV and AIDS was predominantly a Black African disease.

Seema noted: *“I see other African girls suffer. They lose weight and can’t come to school. They get ARVS but this is too strong for their weak bodies. They die very quickly...what a waste of a young life.”*

This is an assumption rather than a reality. Society continuously makes deductions of outcomes relative to their assumptions.

Social constructivist emphasize that sexual norms are created and manipulated within societies for the consumption of the misinformed citizens. Often the women in society are the ones inflicted with the consequences of mistaken beliefs and misconceptions.

4.2.8. Peer Influence

The young women in my study mentioned that often their peers had an influence on decisions taken about their sexual behaviour. Peer pressure is cited by Campbell et al. (2005) as an unquestionable determinant of sexual behaviour. My participants concur that they often did what their friends expected them to do.

When asked about possible issues discussed in social settings, the young women say:-

Nafisa noted that: *“The black girls tell us everything but the Indians hide lots. The Black girls dare us to do it.....say its lots of fun especially if you have many guys.....teach you more tricks.”*

Pinky added: *“I just listen and learn for when I need to know what to do. They know very secret things about sex...and things to do to get more money.”*

Monica admitted: *“I have to pretend to know things or else they won’t keep me in the group.”*

Rehanna also said: *“Sometimes I make up stories from the programmes I watch on TV. They won’t be my friend if I’m not like them.”*

Conversations on issues such as intimacy and sexuality are likely to occur in an atmosphere of trust and mutual understanding among young people who feel that they have common life goals and face similar life problems (Campbell & MacPhail, 2002).

Wood et al. (1998, p. 236) finds that many young people, like the participants in my study explicitly express that sex is a way to avoid peer rejection: “If you want to belong to that group you end up doing it, otherwise you become isolated and nobody wants that,” stating that it is not that peers “force” others but that there is no other alternative but to get involved in a sexual relationship in order to avoid being distinguished as “weird”. Peers are willing to listen and talk about sexual experiences whilst parents often find it difficult to broach this subject.

Fisher & Misovich (1992) reveals that on many occasions peer norms encourage risk. This clearly denotes that peer norms operate to promote unsafe sexual behaviour and not to view sexual health as a priority. Peers often demonstrate negative attitudes towards condom use. Negative peer norms impinge on the consistent use of condoms.

Baylies & Bujra et al. (1999) declares that young people initially learn about sex from their peers, and this knowledge is not always accurate. In a study conducted by McPhee (2000, p. 28) a participant says, "The desire to fit in" is often a vital determinant. The need to be liked by everyone, leads to their drug and alcohol use, sexual involvement and not knowing when to refuse sexual advances. She adds, "I didn't want them not to like me."

This question was posed to the participants in my study: Do you and your friends talk about issues related to sexual activities?

Monica responded rather sadly: *"Sometimes. We tell each other about our experiences and share ideas. Thandi told us about a bad experience. She was talking to her neighbour after school... he wanted to know how to do his SS project. She let him in the house....Thandi has no mama at home. Sizwe tried to put his hand into her panty... lucky she is strong... she kicked him and made him leave. But Thule wasn't so lucky... her tata raped her when she was sleeping."*

Monica noted many facets of their discussions. She highlighted the bad and good experiences. This bears testament to the fact that peer pressure is not only negative. Peers provide information on issues of safety and of abuse and rape.

4.2.9. The Greater Threat: Pregnancy or HIV

Most of my participants were knowledgeable about the risks posed by their sexual activities but assumed that their own sexual activities did not place them at risk. Many of my participants feared HIV and AIDS but the more serious concern was teenage pregnancy.

When asked if they were aware of the repercussions of having unprotected sex, these were some of the responses:-

Palesa said: *"Can fall pregnant but won't happen to me cos my boyfriend takes me to Ma-Gandhi for the injection. Then I go every 3 months for more. You know mam, now I'm safe."*

When asked if HIV was a fear, she said:

"We use Vaseline and when it's slippery then the germs slip out and can't get inside me....no HIV."

Nafisa exclaimed: *"I could fall pregnant. But I am having the pill."*

Whitney answered: *"Yes HIV, AIDs and pregnant. But I take the clinic pill and Colin is the only boy I'm sleeping with now.... so no diseases."*

These participants suggested that pregnancy was a bigger concern, perhaps due to the fact that pregnancy is visible and it could mean the end of schooling and being branded as having loose morals in society. HIV is not noticeable. The virus can be disguised as another health affliction.

According to Holland et al. (1990), young women adopt a tendency to take the contraceptive pill as a means of indicating the seriousness of a relationship. As love and trust develop in the relationship, the women are safely protected against pregnancy but still run the risk of STDs and HIV infection. Magnani et al. (2005) indicate that the youth in Africa are very knowledgeable about oral contraceptives, injectable contraceptives and condoms.

When a question was posed on the participants views on teenage pregnancies, these answers were provided:-

Nafisa said: "Not good at all for the poor girl. The blacks don't care. They leave the babies with the granny.... Collect the grants and come back to school. Us Indians will have to leave school and look after the baby. The girl is too embarrassed to come back to school."

Nafisa boasted the fact that certain cultures-view pregnancy as shameful and taboo as sex was only supposed to follow marriage.

Monica said: "Very tough to be a teenage mum. You a baby yourself and you must care for someone else. Some girl's mamas make them leave school and look after the baby. They can't finish their school."

Pinky added: "It's not good as sometimes the mamas chase the girl out and how can they look after them and the baby. The boys generally run away."

Pinky added the prospect of the male not showing any responsibility towards the child and the women having to toil even harder to provide for the offspring.

Boberg (2009) states that heterosexual partners need to understand the risks of having unprotected sex, which are HIV transmission as well as pregnancy. Often young women on birth control think that it protects them from all the risks of unprotected sex, not just pregnancy. Case (2000) indicates that the rate of teenage pregnancy is very high in the South African society it has been estimated that 50% of the female youth were at school when their first child was born.

Harrison et al. (2001) state that girls are more likely to mention pregnancy as a risk. Some girls state that it was better to fall pregnant than have HIV and AIDS.

Hollard et al. (1990) says that for many young women, the fear of pregnancy is a prime concern and that she may neglect condoms in favour of the pill.

Pregnancy is a sign of being sexually active and this risks their reputation. Fear of pregnancy is more real than a fear of HIV infection. A study done by Ramadhein (2010) indicates that pregnancy is a very real fear. Pregnancy will be a stumbling block in their future plans. They will consider it unbearable to be pregnant in an unstable relationship.

According to the HSRC report on HIV prevalence (2009) the denial to home HIV tests was higher among males (31%) than females (26.8%).

When asked if they were afraid of being infected/ affected by HIV or whether they had experience of being acquainted with an HIV and AIDS sufferer, these responses were given:-

Palesa answered: *“Not me mam, you know we use the Vaseline and its good for me. I see people in Amaoti who are suffering. They get skinny, can’t eat or walk. Last week my neighbour died. She’s 15 years old. Didn’t listen to her mama... run away from home two times to stay with the old tatas.”*

Palesa had seen people who may have had HIV but none of them were her friends or peers. She had not seen her peers dying with HIV and AIDS therefore it was easy for her to be in denial about the magnitude of the affliction.

Nafisa added: *“No mam. I only have one boyfriend. But I see many of the black girls losing weight and getting TB. When they get too sick they don’t come to school.”*

It is suggested that the Indians believe HIV and AIDS is predominantly a Black African disease.

Monica skeptically said: *“Very scared mam. The school nurse showed us pictures of girls dying from the disease. Thandi told me that her baba died from HIV but outa does not want her to believe the stories she heard.”*

Pinky further added: *“Yes sure. I will die and then all my dreams are gone. My neighbour’s maid died... they say the baas raped her but I’m not sure.”*

Rehanna affirmed: *“No mam. I will protect myself. Cos I know that AIDS kills, my auntie died from AIDS.”*

From these responses it was positive to know that the young women were aware of the sexually transmitted diseases. My participants indicated that they were well aware of the consequences of AIDS; however the issue of pregnancy and its consequences took precedence.

There are mixed views on the use of condoms as a means of protection. The participants who were in a steady relationship indicated the non-use as they trusted and believed in their partners. Others said that condoms helped to protect them and they respect their partner’s willingness to wear them or not.

Monica stated: *“I have to take care of my body cos I’m still young. I don’t wana have a baby or get Hepatitis like Mangi from Scandal.”*

Seema said: *“We always wear a condom to protect both of us from HIV and falling pregnant.”*

Both Monica and Seema were assertive young women and showed their insistence on wearing protection. This shows the possible emancipation of the women in traditionally patriarchal societies.

The use of condoms is motivated by the possibilities of unwanted pregnancy and the contraction of STD. Unplanned pregnancies is clearly undesirable amongst young Indian people. Their education and future are more important (Nayak & Kehily, 2008, p. 61). According to Panday et al. (2009), “over two thirds of young women report their pregnancies as unwanted because it interferes with educational aspirations and imposed greater financial hardship in a context of high levels of poverty and of a young life.”

Kaufman & Stavrou (2004, p. 388) notes that “Indian participants of both genders argued that the use of condoms was important, not necessarily because of AIDS, but in order to avoid unwanted pregnancies. Indian boys argue that they will be mad to engage in sex without condoms.” This indicates their knowledge of engaging in unprotected sex.

If young women are determined to wear the condom, they have to find a way to negotiate their use with their partners. Marstan & King (2006) vouch that if women carry or buy condoms this implies sexual experience and low morals. In South Africa the intention to wear a condom may be interpreted as an indication of being a carrier of HIV and AIDS. Magnani et al. (2005) finds that the rate of condom use at first sex is substantially low among African males. Holland et al. (1990) argues that female participant’s think that they should not be planning prior to the sexual activity because of the ideology of femininity which equates sex with romantic love and being swept off one’s feet, and may reject the possibility of carrying condoms.

Many of the young women in my research had negative ideas of condom use. They argued that condoms “break the flow,” make you “lose the moment” and ruin the romance.

Harrison et al. (2001) stated that boys feel that condoms should be used with casual partners and not a steady girlfriend. Girls on the other hand voice that they expect the boys to wear them in order to protect the partners they care for. Condom use is supposed to be male initiated. Since most boys take decisions about the sexual relationships, condom use is their domain.

When questioned on the protective measures that they and their boyfriends used, my participants responded:-

Whitney: “Colin is a good boy and can’t pull a condom up the right way, so I say leave it..it spoils the mood ...”

Condoms protect young girls against unwanted pregnancies and infection from STDs. This indication of non-insistence shows that some young women aim to please and willingly place themselves in risky situations. Other women show their liberated status by insisting on the use of protection.

This indicates that the young women are constructing their own sexualities in respect to the use of protection and preventative methods.

4.3. Conclusion.

This chapter presents and analyses the data collected during my individual and focus group interviews. The themes grouped together the data appropriate to my research topic. The themes discussed are:

- Crowded space
- Cultural & tradition
- Sex as currency
- Sex as desire
- Love & trust
- Substance abuse
- Myths & misconceptions
- Peer influence
- The greater threat: HIV or pregnancy

Male dominance in society and socio-economic inequalities are found in the data analysis and literature review to be the key factors linked to the risky behaviour of young women. This qualitative study explores reasons levied by the participants as to why they engage in risky sexual behaviour.

CHAPTER 5: CONCLUSION & RECOMMENDATIONS

5.1. Study Overview

My study aims to understand the reasons why young women in the Amaoti- Phoenix areas engage in risky sexual behaviour in the context of HIV and AIDS in South Africa. My study further attempts to deduce how these women construct their understanding of sexual risks. My focus is on young women aged 16 to 17 years. My research community is an economically challenged environment in which these young women face dangers which compromise their health.

I was intrinsically motivated to choose this research community and the young women from the secondary school as they depict behaviour patterns that show risks being taken. I am an educator in this environment and am aware of the high levels of social challenges the community faces. I want to ascertain how these young women understand HIV and AIDS as it is very prevalent in low income communities. AIDS is not caused by poverty but it is exacerbated by poverty. My participants allude that AIDS is primarily the black communities' disease. In South Africa there is a vast difference in the class-status of its population. HIV and AIDS cases are higher in the poorer communities, which are predominantly black.

In informal settlements, ablution facilities are often communal and outside the living space. In these locations, the exposure to sexually enticing behaviour of adults and youth are viewed by the community. This provides the opportunity for everybody, irrespective of age, to practice these types of socially acceptable behaviour.

The HIV and AIDS epidemic has affected the lives of all South Africans, irrespective of race, colour, creed or age. Certain communities are apathetic and continuously place their young women at risk. Bhana (2006) writes of the context of danger and poverty in the young girl's living space: the girls are vulnerable to HIV and AIDS, rape and abuse by older men.

Many of the young women in my study situate their relationships within a love and trust continuum and hope for a steady, monogamous partner. Their partners often do not share the same views. The harsh reality is that sex has become a commodity to trade in low socio-economic communities.

In South Africa, most cultures afford more privileges to the male and gender imbalances are highly noticeable. This places young women on the lower rung of power at the higher end of the risk continuum. Women are historically expected to be subservient and in a subordinate position. Societies display patriarchal tendencies.

My study shows that evidently many young women become sexually active at a very young age. Young women generally become sexually active around the age of 16 (Peltzer & Promtussananon, 2005). The Sunday Tribune (2012) reported that the most critical gap in South Africa is the failure to contain the virus in young people between the ages of 15 and 24. It also reports that in some parts of KZN, 50% of pregnant women are HIV positive by the age of 24.

Similar to the study conducted by Bhana (2008), stigmas related to HIV and AIDS are deeply embedded in social values. The black community fosters beliefs in unfounded myths and mythologies. This further places the young women at risk as they are seen as a possible cure for the virus. Elders' behaviour is skewed in favour of the myths and these compromises the young women's safety and sexual health. The community leaders can address these beliefs and relay that myths do not cure health issues.

5.2. Synthesis

My study notes that many of my participants within the ages of 16 going on 17 were sexually active in their early teens. My data highlights the following reasons for engaging in unsafe sexual behaviour.

Poverty is a common factor in many of my participant's lives. Living in informal settlements and crowded spaces provide the environment for early exposure to sexual activities. Multiple sexual partners are condoned in these environments. These activities have financial rewards which are welcome in the dire economic positions of these communities. Taking sexual risks is an alternative to a life of poverty. Young women in poverty stricken environments compromise their health to earn money for their survival or to support their need for luxuries. Poverty seems the prime determinant for risky sexual behaviour among young women.

Some of my participants indicate that they desire sexual intimacy. This is by choice rather than coercion. In these situations the eagerness to find pleasure and feel their partners warrants the non-use of protection and is the ideal situation for the transmission of STDs and HIV.

My participants highlight that they are in love with their partners. They value their relationships and hope for a long-term monogamous partnership. In such circumstances it is assumed that condoms ought not to be negotiated. The use of protection will indicate distrust in one's partner. Trusting in one's partner is also another determinant for sexual risk.

Culture, tradition and economic circumstances play a significant role in the engendered behaviour of young women. Cultural stereotypes and stigmas favour the male in society. These factors contribute to these young women engaging in unsafe sexual behaviour and placing themselves at risk. Historically our societies have favoured men as being the stronger sex and women being their subordinates. This has led to many women assuming a submissive role in society. Often males in these patriarchal societies lead females to believe in their loyalty, but when "all is lost" the young woman face the wrath of STDS, HIV, AIDS and teenage pregnancy.

My participants suggest that men, by sheer nature of their gender, are afforded more power than the women. Gender disparities are constructed within male dominant communities and men are allowed to initiate and control all sexual transactions. The men want to be in power to show that they control the relationship. The young women sometimes feign ignorance to allow the man the opportunity to be in control. This is done in light of the fact that they will receive more rewards and attention when they pretend to know very little. This subordinate position places the women in a risky situation, where they indulge in unsafe sexual practises.

These young women suggest that their roles are predetermined and constructed by society. Their feminine status often goes unnoticed in these prescribed situations. Within the South African context, negative influences impact substantially on the young women. The patriarchal societies continue to render females submissive and at risk for contracting sexual diseases.

My participants are aware of STDS, HIV and AIDS. They understand how these infections are transmitted but their personal circumstances encourage them to indulge in unsafe sexual behaviour. These young women are unable to assimilate their knowledge with their needy social context. It can be argued that society empowers individuals differently. Often members in society are powerless against the odds stacked against them.

Pregnancy was also seen to be of greater concern than HIV and other STDs. The young women are knowledgeable about the use of injectables and the contraceptive pill and use these to prevent pregnancies. They are comfortable taking them as it does not interfere with their sexual pleasures. Society does not ascribe good tidings to young women who are pregnant. Pregnancy is a blatant indication of sexual activity. Its visible nature deems it a greater shame than any sexually transmitted disease. Disease can be camouflaged as non-existent. Despite the seriousness of sexually transmitted diseases, the possibility of contracting them is treated lightly by my participants.

Gender coercion is a very strong factor that forces young women to indulge in unsafe sexual behaviour. The fear of being battered or raped forces many young women to indulge in unsafe sexual behaviour. Often when the conversations approach the use of protection, the men beat the young women and suspect them of being unfaithful or promiscuous.

Belief in unfounded myths also places young women at risk. The most common myth is that HIV and AIDS can be cured by having unprotected sex with a virgin or a fat, old woman. This places young women under threat of being raped and exposed to sexually transmitted diseases. Consuming alcohol and drugs places individuals at risk. These substances dull the senses of the consumer and make them indulge in unsafe sexual practices which they may not do under normal circumstances. Often substance abuse is initiated by the peers. Peer influence has great consequences; leading individuals to indulge in substance abuse thwart their senses, which place them highly on the sexual risk continuum.

In light of the ways in which sexuality is constructed in the modern feminine domain, crucial strategies have to be considered to protect South African young women from engaging in risky behaviour that seriously compromises their health.

.

5.3. Implications

The findings of the study have urgent and far-reaching implications for the government, schools, community and individuals, where a change in attitudes towards handling sexual risks and repercussions should be implemented. Sexual experimentation begins at school, sometimes at a very young and non-consensual age. According to the national law, the age of consent is sixteen. The participants in the study often share their experiences with peers but parents or teachers are not informed in the fear of being judged or ostracized. They feel that their peers understand their desires but parents and teachers are clinical in their approach to sexuality and promote abstinence and sex after marriage rather than educating them on safe sexual practices.

The participants indicate the choice of older partners. This signifies a need to have someone to support them and offer stability in these young women's lives. These partners provide luxuries, gifts and money; many of which are not forthcoming from family members. This common practice of having an older partner indicates a type of age-sex sexual coupling where new HIV infections are common.

Risky behaviour is further entrenched in poverty. Young women have limited opportunities to negotiate safe sex as this sometimes leads to living in poverty. The need for basic survival and acquiring items of luxury compromises their health. Many young women place their relationships within the realm of love and trust. The hope of a long lasting and steady relationship drives them to risk their health by having unprotected sex. Men have the power to steer the relationship according to their preferences. This provides the setting for non-use of protection and the onset of sexual health risks of the partners.

The young women display a comprehensive awareness of STDS, especially HIV and AIDS. They are knowledgeable of the consequences of having unprotected sex but fear unwanted pregnancies more than HIV and AIDS. Possibly because pregnancies are highly visible and often meant the end of schooling. Pregnancies are also an unquestionable indicator of being sexually active. In many communities, especially the Indian community, it shames the family to have a pregnant, unmarried woman in the home. HIV and AIDS status is not divulged as it is not visible. Young women are aware of the pill and injectables to prevent pregnancy but these do not protect them from contracting HIV.

A few participants quote substance abuse as a factor that unwittingly pushes young people into practising risky sexual behaviour. Drugs and alcohol dull the senses and young people under these influences may be unable to protect themselves. These situations are dangerous as they compromise the individual's sexual health and provide the ideal background for the transmission of HIV.

The use of protection, i.e. to condomise, is a controversial choice. Using a condom indicates lack of trust, and that one is a loose woman and a diseased individual. Non-use indicates a steady, trusted relationship and the hope of a monogamy. The Indian culture promotes monogamy and African culture advocates non-use of condoms. According to Kaufman & Stavrou (2004) Indian boys and girls consider condoms as an important form of contraception. According to the survey conducted by the SABC (2007) as cited in the Love Life Magazine, it was found that many sexually active youth had neither wore condoms during sex or when they did, they were worn incorrectly.

5.4. Role of the Community

The perpetuation of gender inequalities and risky behaviour by adults does not auger well for young people in society as the norms set by them are understood to be the status quo. Communities needed to understand the changing circumstances surrounding sexual risk and aim to conscientise the youth about risky behaviour.

The seriousness of HIV and AIDS needs be stressed and the means of contraction has to be explained. Condom use needs to be encouraged, rather than attempting to stifle the young people's desire and forcing monogamous relationships. In light of the increasing rate of HIV infection and pregnancy, community members need to provide young people with the skills to protect themselves as it is quite evident that many young people lack clear information about sex and are unable to make sound decisions when they are faced with a decision concerning relationships and delaying sex.

The young people in the community should be socialized that men and women are equal role players, irrespective of biological differences. Elders and religious leaders should run youth empowerment campaigns to conscientise all members in the community about responsible sexual behaviour. Fears and myths need to be allayed concerning misconceptions, particularly in relation to possible cures for HIV and AIDS. Actual facts need to be presented in order to avoid irresponsible sexual behaviour.

Alcohol distribution points within communities, such as shebeens, bars, hotels, and guesthouses, can be the fertile grounds for intervention programmes based on community-specific patterns of alcohol purchases and drinking. Men must be emphasized as being the target groups for HIV education interventions in risky drinking settings, underscoring the dominant role men play in sexual partnerships. Men are important parties in effective alcohol-HIV and AIDS interventions, as concepts of masculinity generally afford them more social liberties with respect to alcohol consumption and sex. Community settings can be used to provide social skills training for women, affecting their ability to negotiate condom use and increasing awareness of counseling on alcohol, STDs and HIV issues. In complementary activities, educational and informational campaigns must focus on responsible drinking and awareness of associated sexual risks.

5.5. Role of the School

Schools should be a safe haven where discussions around social diseases are discussed. A supportive school environment allows respect for all personnel. A non-discriminatory stance against health issues has to be adopted. Schools have to adapt life skills education to educate around issues relating to the HIV and AIDS pandemic due to it affecting the lives of both learners and educators. Learners have to be taught the ABC of HIV education. In adopting this approach, there is still a general failure to take into account young children's lack of control over their sexuality.

Knowledge about STDs, HIV, teenage pregnancy, use of contraception and condoms must be incorporated into the curriculum. Life Orientation and sex education programmes have to focus on protective methods and the need to condomise. The Life Orientation and learning area educators are guided by the prescribed syllabus of the DOBE. The National Curriculum Statement (2008, p. 7) Life Orientation syllabus had the following assessment standard under outcome 1: "responsible decisions regarding sexuality and lifestyle choices in order to optimize personal potential."

The participants indicate that educators have been successful in making them aware of risky sexual behaviour. An excerpt from the government's policy highlights that "parents of learners and students must be informed about all life- skills and HIV education offered at the school, the learning context and methodology to be used as well as values that would be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their roles as sexuality educators and imparters of values at home" (DOE, 1999). Parents and schools need to work together to protect their children from becoming infected with HIV and AIDS.

Age-appropriate information on HIV and AIDS must be incorporated into the curriculum. From an early age, first aid principles should be emphasized on precautions to be taken when handling blood. Educators should emphasize the role of drugs, sexual abuse and violence in the transmission of STDs, especially HIV. Information on prevention strategies should be given to the parents, guardians and community members as they are ultimately responsible for the behaviour of any child.

Teachers need to listen and engage without being judgemental. The concern should be to inculcate responsible behaviour patterns within young people. According to Reddy (2005), adults should desist from policing young people but rather affirm and advise them. According to Panday et al. (2009), community perceptions and stigma should be addressed when teachers are preparing a sex education programme.

Learners need to be educated against stigmatization and discrimination when presenting issues related to sex education (Panday et al., 2009). Considering that young people are sexually active so early in their youth, it is impractical to preach about abstinence, but the ABC of AIDS education needs to be highlighted. Parents and schools have to join forces to assist the youth in becoming knowledgeable on risky sexual behaviour and its consequences.

According to Walcott (2008) school psychologists working with STD prevention should consider contextual and intrapersonal factors associated with sexually risky behaviour. HIV prevention strategies should be gender sensitive. Schools have to provide the space for young men and women to speak about their sexual identities. This socialization process allows for free debate around appropriate sexual conduct.

Schools have the resources to shape young, enquiring minds. Continuous liaising with parents and a restructuring of the curriculum should ensure gender equity and safer, responsible sexual behaviour. My findings are similar to Panday's (2009) where it is highlighted that preaching about abstinence is insufficient. A comprehensive discourse encompassing both abstinence and safe sexual behaviour should be considered and is a reasonable approach.

5.6. Role of the Media

The media plays a vital role in the lives of the young. Advertisements and related programmes guide behaviour patterns of the viewers. All the participants are familiar with the term "safe sex" and its association with condoms. They claimed to have learnt this from the Love Life Magazines and the VCT advertisements on bill-boards and television. The media has been careful to report facts that help educate people about the reality of HIV and AIDS. HIV and AIDS have become the subjects of many television programmes and documentaries (Routh, 2005). Karim (Sunday Tribune, 05- 09- 2012) made reference to a new drug PrEP which is an HIV-prevention strategy where by uninfected individuals who are at risk of contracting this virus takes the drug in an effort to prevent infection. This could be a means of protecting uninfected people from contracting the virus.

5.7. Implications & Recommendations

Schools, government and community leaders need to formulate policies to address some of the issues surrounding sexually risky behaviour. The following considerations should be catered for:-

- Strategies to encourage women of all ages to recognize potential risky situations that may compromise their sexual health.
- Equal access to be afforded to all women in urban and rural settings in respect of education, employment and status. This will place them on an independent wrung, where they will be able to dictate the status of their relationships.
- Future efforts to focus on men and their empowerment on treating women with respect and dignity.
- Considering that teenagers are the high risk group in communities, it is vital that they have access to information, condoms and other safety mechanisms along with the necessary guidance and counseling on use of preventative strategies.

- Parents, educators, guardians and elders in the communities need to adopt a supportive role to share in these young people's concerns and questions. They should not be part of the structures that oppose the protection of community members.
- According to Bhana (2006), the sexual struggles amongst the young people have been highlighted in South African HIV and AIDS research. The need has now arisen for children in their formative years, i.e. in the early childhood education programme, to be granted the opportunities to think and speak about their sexual rights and responsibilities.
- The youth of South Africa have to be socialized to address men and women with equal respect without any inherent inferiority. This should be practised at home as it will be a normal practice when faced with similar situations in society.
- Laws need to be amended to grant women equal sexual freedom as their male counterparts.
- Young women should be counselled on prevention strategies to avoid teenage pregnancies and risk for STDS. Public health centres should provide a range of information and services regarding an individual's choice to practise in safe sex within their cultural values and beliefs.
- AIDS education should be aimed at dismantle beliefs in cultural myths on the ways of curing the virus. It must be stressed that the virus lives in the blood stream and to date there is no cure. Myths and misconceptions are culturally devised and have no scientific merit. Individuals have to be responsible and not place their hopes on supernatural beliefs.
- At schools, the Life Skills Programme must place impetus on improving HIV knowledge, skills and associated values with the hope of averting more cases of HIV transmission. Risk taking behaviour must be minimized and the youth are to be encouraged to seek health and safety advice from local clinics.
- The government needs to allocate funds for educational programmes, media campaigns, condom availability and voluntary counseling and testing centres.
- The religious centres e.g. churches, temples and mosques have to assist in educating and supporting their youth to practiced safe sex rather than forcing them to vow celibacy. The reality of the situation is that the youth are adventurous and providing safer means is more sensible.
- The government should allow for peer education programmes. Peers generally listen to the experiences and advice of members in their own age groups. Relaying negative experiences may impede the youth from practising safe sex.
- We need to instill in our children tolerance and respect for both boys and girls. They need to be taught that violence against women and children is unacceptable.

- We need to dispel all forms of AIDS-related discrimination so that our children live in an inclusive environment regardless of race, class or gender. This will dispel myths and misconceptions surrounding HIV and AIDS.

5.8. Limitations to my Studies

- The choice of a single school in Phoenix did not allow for a comparative study between different communities.
- Transcribing accurately was challenging as some of the participants mumbled, laughed, sighed and made aside comments. It was difficult to get this on tape.
- One participant dominated the focus group interviews and it was difficult to ascertain whether she was telling the truth or making up stories along the way to tell me what she thought I needed to hear.
- Two of the participants were not sexually active but they relayed their peer's experiences. Yet again the element of doubt set in.
- At the group interviews, the young women responded in a specific manner but some changed their views during the individual interviews. I was unsure which responses were true but I decided that perhaps they were awkward when facing me as they did not want to be judged.
- Language could have been a problem as the interviews were in English and most of my participants were IsiZulu speaking.

5.9. Conclusion

My study aims to understand the sexual risks taken by young women in Bester Secondary school in Amaoti-Phoenix. It also seeks to assess the young women's understanding of risky behaviour. My participants are continuously constructing their sexual identity in respect to their male partners.

Social pressures and differing expectations for men and women have to be assessed to assist in reducing potential sexual risk-taking behaviour. Patriarchy and intimate partner violence increases the HIV infection among young South African women. Government policies and schools' intervention programmes must address risk factors and devise means to protect young women in society. Laws need to be amended to grant females the sexual freedom that their male counterparts enjoy.

To ensure this, everybody has to display commitment and determination to encourage this change. Men should engage in innovative approaches to change harmful social and cultural practices as a means of preventing HIV transmission.

My study reveals that the young women are aware of the AIDS pandemic that is affecting South Africa. A few of the participants are proud to acknowledge using condoms during sexual activities. This is primarily among the Indian community. The Black- participants' precarious economic positions does not warrant, they feel the use of protection during sex.

Being responsible for one's sexual health is an achievement which will augur well for all individuals and communities. Perhaps education will help to add to the list the number of individuals who take responsibility for their sexual health.

ABBREVIATIONS

- AIDS: ACQUIRED IMMUNODEFICIENCY SYNDROME
- AJAR: AFRICAN JOURNAL OF AIDS RESEARCH
- AMREF: AFRICAN MEDICAL RESEARCH FOUNDATION
- APHRC: AFRICAN POPULATION & HEALTH RESEARCH CENTRE
- ARVS: ANTI- RETROVIRALS
- ATICC: AIDS TRAINING, INFORMATION AND COUNSELLING CENTRE
- CPU: CHILD PROTECTION UNIT
- DOBE: DEPARTMENT OF BASIC EDUCATION & TRAINING
- HIV: HUMAN IMMUNE DEFICIENCY VIRUS
- HSRC: HUMAN SCIENCES RESEARCH COUNCIL
- KZN: KWA-ZULU-NATAL
- OBE: OUTCOMES BASED EDUCATION
- NGO: NON-GOVERNMENTAL ORGANIZATION
- PrEP: PRE-EXPOSURE PROPHYLACTICS
- SABC: SOUTH AFRICAN BROADCASTING CORPORATION
- STDs: SEXUALLY TRANSMITTED DISEASES
- UKZN: UNIVERSITY OF KWA-ZULU-NATAL
- UNAIDS: UNITED NATIONS AIDS PROGRAMME
- UNICEF: UNITED NATION'S CHILDREN'S EMERGENCY FUND
- VCT: VOLUNTEER COUNSELING & TESTING
- WHO: WORLD HEALTH ORGANIZATION

REFERENCES

- Abdool-Karim, Q. (1998). Women & AIDS: the imperative for a gendered prognosis and prevention policy. *Agenda*, 39, 15- 25.
- Adams, H., & Marshall, A. (1998). Off- target messages of poverty, risk and sexual rights. *Agenda*, 39, 87- 92.
- Aggleton, P., & Warwick, I. (1999). *Household and community responses to HIV and AIDS in developing countries* Geneva: UNAIDS.
- Allen, L. (2005). *Sexual subjects: young people, sexuality and education*. Hampshire: Palgrave Macmillan.
- Allen, L. (2008). Poles apart? Gender differences in proposals for sexuality education content. *Gender and Education*, 20(5), 435- 450.
- Amuzu, J. (2007). HIV/ AIDS: The challenges for young people. *Commonwealth Youth Development*, 5(1), 11- 25.
- Anderson, J. (2000). *A guide to the clinical care of women with HIV*. U S Department of Health and Human Services.
- Arnfred, S. (2004). *Re- thinking sexualities in Africa*. Sweden: Armqvist & Wiksell Tryckeri.
- Avert. (2008). AIDS orphans in South Africa: HIV orphan's statistics.
- Babbie, E., & Mouton, J. (2006). *The practise of social research*. Cape Town: Oxford University Press.
- Bailey, V. I., Bemrose, G., Goddard, S., Joslyn, E., & Mackness, J. (1996). *Essential research skills*. London: Collins Educational Publishers.
- Bauer, W. B., & Gaskell, G. (Eds.). (2000). *Qualitative researching with text, image and sound: a practical handbook*. London: Sage Publications.
- Baumeister, R. (1995). The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation. *Psychological Bulletin*, 117(3), 497- 529.
- Baylies, C., & Bujra, J. (2004). *Aids, sexuality and gender in Africa*. London: Routledge.
- Baym, N. (1993). *Women's Fiction: A Guide to Novels by and about Women in America*. USA: Cornell University Oress.
- Baym, N. (1995). The Agony of Feminism: Why Feminist Theory Is Necessary After All.
- Beck- Sague, C., & Beck, C. (2004). *HIV/AIDS...Deadly disease & epidemic*. Philadelphia, USA: Chelsea house publishers.

- Bell, J. (1993). *Doing your research project*. Buckingham Philadelphia: Open University Press.
- Berer, M. (2004). HIV/ AIDS, sexual & reproductive health: intersections & implications for national programmes. *Oxford*, 19(1), 162- 170.
- Berg, & Bruce (Eds.). (2001). *Qualitative research methods for the social sciences*. Bostan: Allyn & Bacon Publishers.
- Berger, P. L., & Luckmann, T. (1996). *The social construction of reality*. New York: Penguin Books.
- Best, J. W., & Khan, J. V. (Eds.). (1993). *Research in education* (7th ed.). Boston: Ally & Bacon.
- Bhana, D. (2006). The (Im) possibility of Child Sexual Rights in South African Children's Account of HIV/AIDS. *IDS Bulletin*, 37(5), 65- 68.
- Bhana, D. (2007). Childhood sexuality and rights in the context of HIV/AIDS. . *Culture Health and Sexuality*, 19(1), 309- 324.
- Bhana, D. (2007). The price of innocence: teachers, gender, childhood sexuality, HIV and AIDS in early schooling. *International Journal of Inclusive Education*, 11(4), 431- 444.
- Bhana, D. (2008). Sex & the Rights to HIV/ AIDS Education in Early Childhood. *Journal of Psychology in Africa*, 18(3), 277- 282.
- Bhana, D., & Epstein, D. (2007). 'I don't want to catch it.' Boys, girls and sexualities in an HIV/AIDSs environment. . *Gender and Education*, 19(1), 109- 125.
- Bhana, D., & Pattman, R. (2009). Researching South African youth, gender and sexuality within the context of HIV/AIDS. *Development*, 52(1), 68- 74.
- Boberg, C. E. (2009). *Aids & you*. New York: AlphaHouse Publishing.
- Boesten, J., & Poku, N. K. (Eds.). (2009). *Gender and HIV/AIDS: perspectives from the developing world*. England & USA: Ashgate Publishing.
- Bogdan, R., & Biklen, S. K. (Eds.). (1992). *Qualitative research for education. An introduction to theory and methods*. (2nd ed.). USA: Allyn & Bacon.
- Booyesen, F., & Summerton, J. (2002). Poverty, Risky Sexual Behaviour, and Vulnerability to HIV Infection: Evidence from South Africa. *Health, Population and Nutrition*, 20(4), 285-288.
- Boyce, P., Lee, H. S., Jenkins, C., Mohammed, S., Overs, C., Paiva, V., . . . Aggleton, P. (2007). Putting sexuality (back) into HIV/AIDS: Issues, theory and practice. *Global Public Health*, 2 (1), 1- 34.

- Brink, A. (2000). *Debating AZT: Mbeki and the AIDS drug controversy*. Pietermaritzburg: Open Books.
- Buthelezi, T. M. (2006). *What gender is your piece of meat? The binary system of space in Zulu culture, a challenge for rural education*. Paper presented at the Teacher Development Conference, Edgewood Campus, Pinetown.
- Butler, J. (1990). *Gender Trouble: Feminism & the Subversion of Identity*.
- Cameron, E. (2005). *Witness to AIDS*. Cape Town: Tafelberg Publishers.
- Campbell, A., & Watts, F. (2004). *HIV and Aids*. Sydney London.
- Campbell, C. (2003). *Letting them die: Why HIV/AIDS prevention programmes fail*. Oxford: James Curry.
- Campbell, C., Foulis, C. A., Maimane, S., & Sibiyi, Z. (2005). The impact of social environments on the effectiveness of youth HIV prevention: A South African case study. *Routledge Taylor & Francis Group, 17(4)*, 471- 478.
- Campbell, C. N., Maimane, S., & Nicholson, J. (2007). A Multi- level Model of Roots in HIV- related stigma in Two South African Communities. *Journal for Health Psychology, 12(3)*, 403- 416.
- Castro, W. (2008). *Economic and Social Empowerment: reducing the feminization of HIV / AIDS in South Africa*. Hilton San Francisco.
- Charvet, J. (1982). *Modern ideologies: feminism*. London: J. M. Dent & Sons Ltd.
- Clark, L. (2012, 5 August 2012). The beginning of the end of Aids?, *Sunday Tribune*, p. 19.
- Cohen, L., Manion, L., & Morrison, K. (Eds.). (2001). *Research methods in education* (5th ed.). London: Routledge.
- Cohen, L., Manion, L., & Morrison, K. (Eds.). (2007). *Research methods in education* (6th ed.). London: Routledge.
- Cohen, L., Manion, L., & Morrison, K. (Eds.). (2011). *Research methods in education*. London: Routledge.
- Cohen, S. (2001). *States of denial: knowing about atrocities and suffering*. London: Polity.
- Connell- Carrick, K., & Scannapieco, M. (2004). Taking a New Look: Using a Social Constructionist Theoretical Model in Child Welfare. *ProQuest Psychology Journals, 9(1)*, 133- 142.
- Corrigan, L. T., & Mills, A. J. (2012). Men on board: Actor- network theory, feminism and gendering the past. *Management & Organizational History, 7(3)*, 251- 265.

- Council, H. S. R. (2009). South African national prevalence, incidence, behaviour and communication survey, June 2008- March 2009: A turning tide among teenagers. Cape Town: HSCR Press.
- Cresswell, J. W. (Ed.). (2009). *Research design: qualitative, quantitative and mixed method approaches* (3rd ed.). London: Sage Publications.
- Dawson, C. (2002). *Practical research methods: a user- friendly guide to mastering research techniques and projects*. United Kingdom: Cromwell Press.
- De Vos, A. S. (2002). *Research at grass roots*. Hatfield: Van Schaik Publishers.
- Denzin, N. K., & Lincoln, Y. S. (1994). *The landscape of qualitative research*. Newbury Park: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *Collecting and interpreting qualitative materials* (2nd ed.). London: Sage Publications.
- Denzin, N. K., Lincoln, Y. S., & Stake, R. E. (Eds.). (2005). *Qualitative case studies: handbook of qualitative research* (3rd ed.). London: Sage Publications.
- Department-of-Education. (1999). *National policy on HIV/AIDS, for learners and educators in public schools and students and educators in Further Education and Training institutions.*: Government Gazette.
- Department-of-Education. (2008). *National Curriculum Statement: Grades 10- 12. Learning programme guidelines: Life Orientation*. Pretoria.
- De-Waal, A. (2006). *AIDS and power: Why is there no potential crisis yet?* London: Zed Books.
- Donald, D., Lazarus, S., & Lolwana, P. (Eds.). (2002). *Educational psychology in context* (2nd ed.). South Africa: Oxford University Press.
- Dowsett, G. W. (2003). Some considerations on sexuality and gender in the context of AIDS. *Reproductive Health Matters*, 11(22), 21- 29.
- Dunkle, K. L., Jewkes, R. K., Nduna, M., Levin, J., Jama, N., Khuzwayo, N., . . . Duvvury, N. (2006). "Perpetration of Partner Violence and HIV Risk Behaviour among young men in the Rural Eastern Cape, South Africa.". *AIDS*, 20(16), 2107- 2114.
- Durepos, G., & Mills, A. J. (2012). "Actor Network Theory, Anti-History and Critical Organizational Historiography". *Organization*, 10.1177.
- Endersbe, J. K. (2000). *Sexually transmitted diseases. How are they prevented?* USA: Capstone Press.
- Erulkar, S. A. (2004). "The Experience of Sexual Coersion Among Young People in Kenya.". *International Planning Perspective*, 30(4), 182- 189.

- Everett, K. (1995). *Get wise about AIDS*. Swaziland: Macmillan.
- Ferguson, A. G., & Morris, C. N. (2007). "Mapping Transactional Sex on the Northern Corridor Highway in Kenya." *Health and Place*, 13, 504- 519.
- Finch, J. (1993). *"It's great to have someone to talk to": ethics and politics of interviewing women*. London: Sage Publications.
- Flick, U. (2006). *An introduction to qualitative research*. London: Sage Publications.
- Ford, N., & Kittisuksathit, S. (1994). Destinations unknown- the gender construction and changing nature of the sexual expressions of Thai youth. *AIDS Care*, 6, 517- 531.
- Foreman, M. (Ed.). (1999). *Aids and men*. London: Panos/ Zed Books.
- Foucault, M. (1976). *The history of sexuality: the will to knowledge*. London: Penguin.
- Frank, S., Esterhuizen, T., Jinabhai, C. C., Sullivan, K., & Taylor, M. (2008). Risky sexual behaviours of high-school pupils in an era of HIV and AIDS *South African Medical Journal*, 98(5), 394-398.
- Govender, P. (2005). *Gender instruments in Africa: critical perspectives, future strategies*. Midrand: Institute for Global Dialogue.
- Greathead, E., Devenish, C., & Funnell, G. (Eds.). (2002). *Responsible teenage sexuality*. South Africa: Van Schaik.
- Groes- Green, C. (2009). Safe sex pioneers: class identity, peer education and emerging masculinities among youth in Mozambique. *Sexual Health*, 6, 233- 240.
- Guest, E. (2003). *Children of AIDS: Africa's orphan crisis*. London: Pluto Press.
- Guy- Sheftall, B. (1995). *Woods of Fire: An Anthology of African Feminist Thought*. USA: New Press.
- Hallman, K. (2005). Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa. *African Journal of Aids Research*, 4(1), 37- 50.
- Hammersley, M., & Atkinson, p. (Eds.). (2007). *Ethnography: principles in practice* (3rd ed.). New York: Routledge Taylor & Francis Group.
- Harrison, A., Xaba, N., & Kunene, P. (2001). Understanding Safe Sex: Gender Narratives of HIV and Pregnancy Prevention by Rural South African School-Going Youth. *Reproductive Health Matters*, 9(17), 63- 71.
- Hart, C. M., Durepos, G., Mills, A. J., & Mills, J. H. (2010). Performing the Past: Anti-History, Gendered Space and Feminist Practice. *Paper presented at the EGOS Colloquim, Lisbon, Portugal*.

- Hearn, I. (Ed.). (1996). *The organisation violence, in violence and gender relations*. London: Sage Publishers.
- Henning, E. (2004). *Finding your way in qualitative research*. Hatfield: Van Schaik Publishers.
- Hitchcock, A., & Hughes, D. C. (1995). *Research and the teachers: a qualitative introduction to school based research*. London: Routledge.
- Hoffman, S., O'Sullivan, L. F., Harrison, A., & Monroe- Wise, A. (2006). HIV risk behaviours and the context of sexual coercion in young adults' sexual interactions: Results from a diary study in rural South Africa. *American Sexually Transmitted Disease Association*, 33(1), 52- 58.
- Holland, J., Ramazanoglu, C., Scott, S. S., & Thomson, R. (1990). Sex, gender and power: young women's sexuality in the shadow of AIDS. *Sociology of Health & Illness*, 12(3), 337- 350.
- Holland, J. R., Sharpe, T., & Thomson, R. (2000). Deconstructing virginity- young people's accounts of first sex. *Sexual and Relationship Therapy*, 15(3), 221- 232.
- Holliday, A. (Ed.). (2007). *Doing and writing qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.
- Holly, C. (2001). *AIDS...epidemic: deadly disease throughout history*. New York: The Rosen Publishing Group Inc.
- HSRC. (2005). HIV Risk Exposure among young children (Vol. 4). Department of Health: Nelson Mandela Foundation.
- HSRC. (2009). From Social Sciences to Social Sciences: Same- Sex Sexuality, HIV and AIDS and Gender in South Africa. In V. Reddy, T. Sandfort & L. Rispel (Eds.). HSRC Press.
- Human-Rights-Monitor. (2001). *Human Rights Forum: Harare, February 2001*.
- Human-Rights-Watch. (1995). *Violence against women in South Africa*. New York: Human Rights Watch.
- Institute-of-Medicine. (2010). *Preparing for the Future of HIV/AIDS in Africa*. Washington: National Academy of Science.
- Jejeebhoy, S., & Botts, S. (Eds.). (2005). *Sex without consent, young people in developing countries*. London: Zed Books.
- Jejeebhoy, S. J., & Botts, S. (2003). Non- consensual sexual experiences of young people: a review of the evidence from developing countries. *Population Council Regional Working Papers* 16.
- Jewkes, R. K. (2006). Beyond Stigma: social responses to HIV in South Africa. *The Lancet*, 368(9534), 430- 436.

- Jewkes, R. K., Jonathan, B., Levin & Loveday, A., & Kekana, P.-. (2003). "Gender Inequalities, Intimate Partner Violence and HIV Preventative Practices: Findings of a South African Cross- sectional study.". *Social Science and Medicine*, 56, 125-134.
- Jewnarain, D. (2008). *Young children's responses to AIDS*. M. Ed, University of Kwa-Zulu Natal.
- Kalichman, S. C. (2003). *Inside story on AIDS*. Washington, D. C: APA Life Tools.
- Kambarami, M. (2006). Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe. *African Regional Sexuality Resource Centre*.
- Kauffman, C. A., & Stavrou, S. (2004). "Bus fare please": the economics of sex and gifts among young people in urban South Africa. *Culture Health and Sexuality*, 6(5), 377- 391.
- Kauffman, K. D., & Lindauer, D. L. (Eds.). (2004). *Aids and South Africa*. New York: Palgrave MacMillan.
- Kehily, M. J. (2002). *Sexuality, gender and schooling: shifting agendas in social learning*. London: Routledge Falmer.
- Kehily, M. J. (2004). *An introduction to childhood studies*. Maidenhead: Open University Press.
- Kelly, P. (1998). *Coping when you or your friend is HIV- positive*. New York: Rosen Publishing.
- Kent, A. A. (2004). Living Life on the Edge: Examining Space and Sexualities within a Township High School in Greater Durban, in a context of the HIV Epidemic. *Transformation*, 54, 59- 75.
- Kwee, M. G. T. (2000). Constructivism and the Clinical Practice of Narrative Rebiographing. *ProQuest Psychology Journals*, 5(2), 133- 152.
- Leclerc- Madlala, S. (2000). Silence, AIDS and Sexual Culture in Africa. *DIDS Bulletin, University of Kwa- Zulu Natal*.
- Leclerc- Madlala, S. (2002). Youth, HIV/AIDS and the importance of sexual culture and context. *Social Dynamics: a Journal of African Studies*, 28(1), 20- 41.
- Leedy, P. D., & Ormrod, J. E. (Eds.). (2005). *Practical research: planning and design* (8 ed.). New Jersey: Pearson Education Inc.
- Lesnik- Oberstein, K. (2010). Childhood, queer theory, and feminism. *Sage Publications*, 11(3), 309- 321.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. California: Sage Publications.

- Lindlof, T. R. (1995). *Qualitative communication research methods*. California: Sage Publications.
- Lorber, J. (1994). "Night to His Day": The Social Construction of Gender. *Paradoxes of Gender*, 13- 36.
- LoveLife. (2011). Love them enough to talk about sex. *Love-Life*.
- Luke, N. (2005). Confronting the "Sugar Daddy" Stereotype: Age and Economic Asymmetries and Risky Sexual Behaviour in Urban Kenya. *International Family Planning Perspectives*, 31(1), 6- 14.
- MacPhail, C., & Campbell, C. (2001). "I think condoms are good but, aai, I hate those things": condom use among adolescents and young people in a South African township. *Social Science and Medicine*, 52(1613- 1627).
- Magnani, R., Karim, A. M., MacIntyre, K., Brown, L., & Hutchinson, P.
- Magnani, R., Karim, A. M., MacIntyre, K., Brown, L., & Hutchinson, P. (2003). *Transitions to adulthood in the context of AIDS in South Africa: the impact of exposure to life-skills education on adolescent knowledge, skills and behaviour*. Washington, D. C: Population Council.
- Magnani, R., MacIntyre, K., Karim, A. M., Brown, L., & Hutchinson, P. (2005). The impact of life skills education on adolescent sexual risk behaviours in Kwa- Zulu Natal, South Africa. *Journal of Adolescent Health*, 36, 289- 304.
- Maree, K., & Nieuwenhuis, J. (Eds.). (2007). *Qualitative research designs and data gathering techniques*. Pretoria: Van Schaik.
- Marstan, C., & King, E. (2006). Factors that shape young people's sexual behaviour: a systematic review. *The Lancet*, 368, 1581- 1586.
- Mbanjwa, B. (2010, 09/06/2010). Report paints grim picture of HIV, *Daily News*.
- McPhee, A., T. (2000). *Aids*. USA: Grolier Publishing.
- Mendick, H. F. (2004). *Telling choices: an explanation of the gender imbalance in participation in advanced Mathematics courses in England*. Goldsmith College: University of London, London.
- Mendick, H. F. (2005c). Only connect: troubling oppositions in gender and Mathematics. *International Journal of Inclusive Education*, 9(2), 161- 180.
- Meursing, K., & Sibindi, F. (1995). Condoms, Family Planning and Living with HIV in Zimbabwe. *Reproductive Health Matters*, 5, 56- 67.
- Meyer- Weitz, e. a. (1998). The socio- cultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. *AIDS*, 10(2).

- Mitchell, C., & Pithouse, K. (Eds.). (2009). *Teaching and HIV and AIDs*. South Africa: Macmillan.
- Morgan, D. (1997). *Focus groups and qualitative research*. London: Sage Publications.
- Morrell, R. (1998). Of Boys and Men: Masculinity and Gender in Southern African Studies. *Journal of Southern African Studies*, 24(4), 605- 630.
- Morrison, K., & Smith, M. (2004). *Myths and mysteries....about HIV and Aids*. Oxford Melbourne: Heinemann Educational Publishers.
- Mouton, J., & Marais, H. C. (1998). *Basic concepts in the methodology of the social sciences*. Pretoria: Human Sciences Research Council.
- Mthiyane, N. (2007). *Factors affecting success in Mathematics and Science amongst African girls: a case study of three high schools in rural KZN*. PHD, Kwa- Zulu Natal, Pietermaritzburg.
- Nair, Y. (2010, 01/12/2010). HIV- AIDS time bomb explodes, *Post*.
- Nasr, I., Sivarajasingam, V., Jones, S., & Shepherd, J. (2010). Gender inequality in the risk of violence: material deprivation is linked to higher risk for adolescent girls. *Emergency Medical Journal*, 10, 1- 4.
- Nattrass, N. (2004). *The moral economy of AIDS in South Africa*. United Kingdom: Cambridge University Press.
- Nayak, A., & Kehily, M. J. (2008). *Gender, youth and culture: young masculinities and femininities*. Hampshire: Palgrave Macmillan.
- Ndinga- Muvumba, A., & Pharoah, R. (2008). *HIV / AIDS and society in South Africa*. Pietermaritzburg: University of KwaZulu Natal Press.
- Nelson, S. (2009). *AIDS and society*. New York: AlphaHouse Publishing.
- Neuman, W. L. (Ed.). (2000). *Social Research Methods: qualitative and quantitative approaches* (4th ed.). Needham Heights: Allyn & Bacon.
- Nolen, S. (2007). *Stories of aids in Africa*. London: Portobello Books Ltd.
- O'Lincoln, T. Breaking the Chains. Women's Liberation, Sexual Politics and Socialism. *Socialist Action*, 1985- 1986.
- Orr, N., M., & Patient, D. (2008). *Choices, choices: all about HIV and AIDs*. South Africa: Jacana Media (Pty/ Ltd).
- Paechter, C. (2000). *Changing school subjects: power, gender and curriculum*. Buckingham: Open University Press.
- Paechter, C. (2001). *Gender, reason and emotion in secondary Mathematics classrooms*. London: Routledge.

- Paechter, C. (2006). Masculine femininities/feminine masculinities: power, identities and gender. *Gender and Education*, 18(3), 253- 263.
- Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). *Teenage pregnancy in South Africa- with a focus on school- going learners*. Pretoria: Department of Basic Education.
- Patitu, C. L. (2000). *An introduction to educational research*. University of Durban-Westville.
- Peltzer, K., & Promptussananon, S. (2005). HIV/ AIDS Knowledge and Sexual Behaviour Among Junior Secondary School Students in South Africa. *Journal of Social Sciences*, 1(1), 1- 8.
- Pettifor, A. E., Rees, H. V., Kleinschmidt, L., & Steffenson, A. E. (2005). Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a national representative household survey. *AIDS*, 19(14), 1525-1534.
- Piot, P. (2007). Written Testimony to the Senate Committee on Health Education, Labor and Pensions. <<http://data.unaids.org/pub/speech/2007/2007/122>.
- Punch, K. F. (Ed.). (2010). *Developing effective research proposals* (2nd ed.). London: Sage Publications.
- Rajab, D. (2010, 05/09/2010). Time to rethink role of our women, *Sunday Tribune Herald*, p. 4.
- Ramazanoglu, C. (1989). *Feminism and the contradictions of oppression*. London: Routledge.
- Reddy, S. (2011). Choosing to be unsafe: Young Adult's Sexual Decision- making within the context of HIV and AIDS. *Journal of Educational Studies*, 10(1), 1- 13.
- Reddy, S., & Dunne, M. (2007). Risking it: Young heterosexual femininities in South African context of HIV/AIDS. *Sage Publications London*, 10(2), 157- 170.
- Richardson, D. (2000). *Re- thinking sexuality*. London: Sage Publications.
- Roberts, S. T., & Kennedy, B. L. (2006). Why Are Young College Women Not Using Condoms? *Psychiatric Nursing Journal*, 20(1), 32- 40.
- Rose-Innes, O. (2006). Sociocultural aspects of HIV/AIDS. The South African Culture. *Health and Place*, 24.
- Rosen, H. (Ed.). (1998). *Meaning making as a metaframework for clinical practice* (Vol. 2). New York: Brunner/ Mazel Publishers.
- Routh, K. (2005). *Aids: 20th century issue*. USA: World Almanac Library.

- Rwenge, M. J. R. (2003). Poverty and Sexual Risk Behaviour among Young People in Bamenda, Cameroon. *African Population Studies*, 18(2), 91- 104.
- Schutt, R. K. (Ed.). (2006). *Investigating the social world: the processes and practices of research* (5th ed.). Thousand Oaks: Sage Publications.
- Shefer, T. (2001). Reflections on contemporary local research on heterosex among young people in South Africa. *University of Western Cape*.
- Silverman, D. (Ed.). (2006). *Interpreting qualitative data* (3rd ed.). London: Sage Publications.
- Simons, R. (2009). *AIDS and poverty*. New York: AlphaHouse Publishing.
- Skidmore, D., & Hayter, E. (2000). Risk and sex: ego- centricity and sexual behaviour in young adults. *Health, Risk & Society*, 2(1), 23- 32.
- Soanes, C., & Stevenson, A. (Eds.). (2004) *Concise Oxford English Dictionary* (11th ed.). United Kingdom: Oxford University Press.
- Spector, M., & Kitsuse, J. (2000). *Constructing social problems*: Transaction Publishers.
- Susser, I. (2009). *Aids, sex and culture: global politics and survival in South Africa*. United Kingdom: Blackwell Publishing.
- Teva, I., Bermudez, M. P., & Buela- Casal, g. (2009). Sexual Sensation Seeking, Social Stress, and Coping Styles as Predictors of HIV/STD Risk Behaviours in Adolescents. *Youth & Society*, 42(2), 255- 277.
- Tsui, E. K., Leonard, L., Lenoir, C., & Ellen, J. M. (2008). Poverty and Sexual Concurrency: A Case Study of STI Risk. *Journal for Health Care for the Poor and Underserved*, 19(3), 758- 777.
- UNAIDS. (2010). *UNAIDS Report on the Global Aids Epidemic*.
- Unger, R. K. (2001). *Handbook of psychology of women & gender*. Canada: John, Willy & Sons.
- Van Dyk, A. (2008). Perspectives of South Africa school children in HIV/ AIDS and the implications of the educational programmes. *African Journal of Aids Research*, 1, 79- 93.
- Van Roosmalen, E. (2000). Forces of Patriarchy: Adolescent Experiences of Sexuality and Conceptions of Relationships. *Youth & Society*, 32(2), 202- 227.
- Varga, C. A. (1997). Sexual decision- making and negotiation in the midst of AIDS: youth in Kwa- Zulu Natal, South Africa. *Health Transition Review* 2(Supplement 3), 45- 67.
- Varga, C. A., & L, M. (1996). Sexual non- negotiation. *Agenda*, 22, 31- 38.

- Vogelman, L., & Eagle, G. (1991). Overcoming endemic violence against women in South Africa. *Social Justice*, 18(1- 2), 209- 229.
- Walcott, C. M., Meyers, A. B., & Landau, S. (2008). Adolescent sexual risk behaviors and school- based sexually transmitted infection/HIV prevention. *Psychology in the Schools*, 45, 39- 51.
- Watch, H. R. (1995). *Violence against women in South Africa*. New York: Human Rights Watch.
- Weeks, J. (Ed.). (2003). *Sexuality* (2nd ed.). London: Routledge.
- Wentworth, W., & Wentworth, C. (Eds.). (1997). *The social construction of culture and its implications for the therapeutic mind- self*. New York: Teacher's College Press.
- Whiteside, A., & Sunter, C. (2000). *Aids: The challenge for South Africa*. Cape Town: Human & Rousseau Tafelberg.
- WHO. (2010). *Achieving Sustainable Health Development in the African Region*. Brazzaville
- Willis, R. (2002). *The AIDS pandemic*. England: Stanborough Press.
- Winston, R., Carletide, Z., McLeod, N., & Mustafa, B. (2012). The Next Generation: Young Women on Feminism. *Sage Publications*, 20(3), 262- 270.
- Wolf, N. (2012). My feminist perspective? Knowledge is power. *The Guardian*, 1- 13.
- Wood, K., & Jewkes, R. K. (2001). *Dangerous love: reflections on violence among Xhosa township youth*. Pietermaritzburg: University of Natal Press.
- Wood, K., Maforah, F., & Jewkes, R. K. (1998). "HE FORCED ME TO LOVE HIM": PUTTING VIOLENCE ON ADOLESCENT SEXUAL HEALTH AGENDAS. *Social Science and Medicine*, 47(2), 233- 242.
- World-Book-Encyclopedia. (2005). The World Book Encyclopedia *The World Book Encyclopedia* (Vol. 15, pp. 650). Chicago: Scot & Fetzer Company.
- World-Book-Encyclopedia. (2007). The World book Encyclopedia *The World Book Encyclopedia* (Vol. 7, pp. 69). Chicago.
- Yin, R. K. (1993). *Case study research: Design and method*. Newbury Park CA: Sage Publications.
- Youdell, D. (2005). Sex- gender- sexuality: how sex, gender and sexuality constellations are constituted in secondary schools. *Gender and Education*, 17(3), 249- 270.

APPENDIX: 1

Request to the principal to conduct research at the school

The Principal
Bester Secondary School
Phoenix

4068
1 November 2011

Dear Mr. -----

Re: Consent for learners to participate in research study

I am currently studying for a Masters Degree at the University of Kwa-Zulu-Natal (Edgewood Campus). It is the requirement of the faculty to undertake a research study. My research topic is: Understanding the risky sexual behaviour of female secondary school learners within the context of HIV and AIDS in South Africa. This letter seeks your permission to allow your female learners to participate in this research study and to allow all interviews to be conducted at the school. I am the sole researcher in this study. All information gathered during the research study shall be treated in the strictest of confidentiality. The names of the learners and the school will not be divulged at any stage of the research. Pseudonyms will be used in the final thesis. Learners have the prerogative to terminate participation at any time during the research. I look forward to your response.

I thank you.

Yours Faithfully

M.D. Maharaj
ST.NO. 8218182

Permission Granted: _____ (principal) Date: _____

My supervisor's details are as follows

Dr. Shakila Singh
Senior Lecturer
School of Education
University of Kwa-Zulu-Natal (Edgewood Campus)
Private Bag X03
Ashwood
3605
South Africa
Tel. 031- 2607326
Fax. 031- 2603697
Email. singhs7@ukzn.ac.za

APPENDIX: 2

Consent letter to parents

01 November 2011

Dear Parent/ Guardian

Re: Consent for learners to participate in research study

I am currently studying for a Masters Degree at the University of Kwa-Zulu-Natal (Edgewood Campus). It is the requirement of the faculty to undertake a research study. My research topic is: Understanding the risky sexual behaviour of female secondary school learners within the context of HIV and AIDS in South Africa. This letter seeks your permission to allow your child/ward _____ in grade _____ to participate in this research study to be conducted at the school. I am the sole researcher in this study.

All information gathered during the research study shall be treated in the strictest of confidentiality. The name of your child/ward and the school will not be divulged at any stage of the research. Pseudonyms will be used in the final thesis. Your child/ward has the prerogative to terminate participation at any time during the research.

I look forward to your response.

I thank you.

Yours Faithfully

M.D. Maharaj

St. No. 8218182

Permission Granted: _____

Signature : _____ (parent/guardian/gatekeeper)

Date: _____

APPENDIX: 3

Letter of informed consent for participants

1 November 2011

Bester Secondary School

I, _____parent/guardian of _____in grade_____ hereby grant permission to Mrs. M.D.Maharaj to conduct group and individual interviews with my child/ward. I have been informed of the research study and I understand that my child/ward is under no obligation to participate in this study. I am also aware that my child/ward may withdraw at any stage of the interviews. I am also informed that all information gathered will be treated in the strictest of confidentiality and that all data will be only used for the intended study.

Yours Faithfully

Parent/Guardian

Date: _____

APPENDIX: 4

Individual Interview Questions

1. How old is your boyfriend? What does he do?
2. Are you sleeping with your boyfriend? Why? Why not?
3. How long have you known your boyfriend for?
4. From your knowledge/experience who generally initiates the sexual advance?
5. Do you and your friends talk about issues related to sexual activities? Elaborate.
6. What activities do you engage in during the weekend?
7. What do you understand by the term “risky sexual behaviour”?
8. Is it cool to have many boyfriends? Elaborate.
9. What protective measures do you and your boyfriend use? Why? Why not?
10. Do you insist on the use of a condom? Why? Why not?
11. Are you aware of the repercussions of having unprotected sex? What do you know?
12. What are your views on teenage pregnancies?
13. Are you afraid of being infected/ affected by the HIV- virus? Why? Why not? Do you know of anyone who had/ has HIV/ AIDS? Explain your experience.
14. Where do you live? Describe your living conditions.
15. Are the elders in your community aware of the sexual behaviour of the young women? What are their feelings about this kind of risky behaviour? Are they good role models?
16. Has the school or the media educated you on sexual safety?
17. How has poverty affected and influenced your life?
18. Some cultures believe that young women are objects of male sexual satisfaction. What are your thoughts on the matter?

19. In your opinion who can assist/ what can be done to protect young girls from engaging in risky sexual behaviour?

APPENDIX: 5

Focus Group interviews

1. Do you and your friends talk about issues related to sexual activities? Elaborate.
2. What do you understand by the term “risky sexual behaviour”?
3. Is it good to have many boyfriends? Why? Why not?
4. What do you do during the weekend? Where and with whom?
5. Who is generally the dominant person in the sexual relationship?
6. Why do young women engage in risky sexual behaviour?
7. What precautions do you and your friends take during sex?
8. Do you insist on using a condom? Why?
9. Do finances play a big role in young women’s risky sexual behaviour?
10. What age group of men/ boys do you prefer? Why?
11. Are you aware of sexually transmitted diseases? Name them. Are you afraid of being infected?
12. What are your views on teenage pregnancies?
13. What is the role of love, marriage and long term relations in determining your sexual behaviour?
14. What does the community feel about this risky behaviour?
15. Has the school, educators and media taught you enough about sex and sexual safety? What do you know?
16. Describe the physical build of you house and community?
17. Some communities are in favour of multi-sexual partners. Why is this so? What are your views?