

**SCHOOL-GOING YOUTH, SEXUALITY
AND HIV PREVENTION IN NORTHERN
KWAZULU-NATAL: A GENDER PERSPECTIVE**

BY

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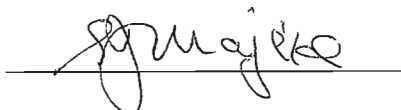
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Professor Mandy Goedhals

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DECLARATION

Submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy in the Graduate Programme in
Gender Studies
University of KwaZulu-Natal, South Africa.

I, Sisana Janet Majeke, declare that this thesis, entitled "School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: a gender perspective" is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. I confirm that an external editor was used and that my supervisors, Professors Catherine Burns, Robert Morrell and Mandy Goedhals, were informed of the identity and qualifications of my editor. Professors Burns and Morrell left the University of KwaZulu-Natal in 2009, and Professor Goedhals is therefore the sole signatory as supervisor. This thesis is being submitted for the degree of Doctor of Philosophy in the Faculty of Humanities, Development and Social Sciences at the University of KwaZulu-Natal, South Africa. None of the present work has been submitted previously for any degree or examination in any other university.



Sisana Janet Majeke

16 MARCH 2011

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Professor Mary Mandeville Goedhals

16 March 2011

Date



Editor: Professor Margaret Lenta

16 March 2011.

Date

DEDICATION

This thesis is dedicated to God almighty for his love, my loving mother, Elsa and my late father, Obed Shongwe, my daughter Nomfundo and my son Lunga, my grandson Bayanda, my sister-in law Mrs Vuyi Shongwe and her daughters: Siphhelele, Sindisiwe, Bongiwe and Hlengiwe, my sisters Ntombinkulu, Thandi, Gcino, Thuli, Zodwa and my late sisters, Mrs Dolly Mthombeni, Mrs Thembi Dlamini, Mrs Cash Nomali Mncwabe, Miss Nomusa Shongwe and my late brothers, Mr Isaac Boyi Shongwe and Mr Sipho Speech Shongwe for their care, understanding, support and encouragement.

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ABSTRACT

The incidence of HIV cannot be separated from social relationships. Therefore different forms of social relationships are bound to have different impacts; different identities may result in varied degrees of spread of HIV (Kirumira, 2004:158). Gender issues are increasingly being recognised as having a critical influence on the HIV epidemic in southern Africa. Gender inequalities fuel the HIV and AIDS pandemic, rendering females more vulnerable to HIV infection than males. This is shown clearly by HIV prevalence which is reported to be higher among young females than young males (Human Science Research Council, 2005:33).

This thesis concerns a three-phase study that I conducted amongst a group of school-going boys and girls in Northern KwaZulu-Natal. The purpose of the study was to conduct a gender-based life building skills programme to expose and sensitise school-going youth to the complexities of gender, sexuality and cultural issues, sex education, the language of sex, rights issues, gender equality and mutual respect, sexual decision-making and HIV prevention.

I conducted the first or orientation phase, using a quantitative approach, to determine baseline data prior to conducting the intervention phase of this study. Phase Two was the intervention phase, conducted to collect data during the gender-based skills building intervention programme. Action research is the qualitative research method that guided the intervention programme, involving the youth in a process of gradual change. Phase Three was undertaken using a quantitative approach, to collect data from all the learners who participated in this study. This phase aimed to evaluate the impact of the intervention programme.

The baseline study found that boys demonstrate their manhood by becoming sexually experienced. They do so at an earlier age than females, thus making them more vulnerable to sexually transmitted infections (STIs) including HIV infection. The results of this multi-phased study confirmed existing knowledge about gender, sexual risk-taking and HIV transmission and generated some surprising findings.

There was an increase in condom use of more than 90% of learners who reported they were sexually active after the intervention. There was an increase in one-partner relationships. After the intervention, girls better understood their sexual rights and were better able to negotiate for condom use with their partners. Gender power imbalances remained but boys understood better that girls had rights. They continued to believe in the importance of being heterosexually active as a key constituent of their masculinity but it appears that they will be more mindful of girls' desires and rights. Recommendations for various stakeholders, collaboration programmes, curriculum issues and for further research have been highlighted.

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LIST OF ACRONYMS

HIV: Human immunodeficiency virus

AIDS: Acquired Immunodeficiency Syndrome

ARV: Antiretroviral

PCP: Pneumocystis carinii pneumonia

TB: Tuberculosis

VCT: Voluntary Counselling and Testing

PMTCT: Prevention of Mother-To- Child- Transmission

STIs : Sexually transmitted infections

STDs : Sexually transmitted diseases

WHO: World Health Organization

UNAIDS: The Joint United Nations Programme on HIV and AIDS

UNICEF: United Nations Children's Fund

MDGS: Millennium Development Goals

HSRC: Human Science Research Council

PPASA: Planned Parenthood Association of South Africa

S. A.: South Africa

KZN: KwaZulu-Natal

D C: District Council

DOH: Department of Health

DOE & C: Department of Education and Culture

G. I: Gender Issues

G. I. S.: Gender Issues Score

WHP: Women's Health Project

CHAPTER ONE: INTRODUCTION TO THE STUDY

BACKGROUND TO THE STUDY

In 1988, as a health professional working in the field, I first encountered HIV and AIDS. I heard rumours from people around my home who were saying that HIV and AIDS was a disease brought to this country by people from overseas in order to reduce the African population. Others saw AIDS as a disease resulting from a curse or a punishment from God or witchcraft and it was named '*ingculazi*'.

Since 1999, the impact of HIV and AIDS on South Africa and especially on KwaZulu-Natal has become the dominant theme in my life. Gugu Dlamini, for example, , a 36-year-old woman was beaten to death on 28 December 1998 after publicly disclosing her HIV positive status over radio and television on World AIDS Day that year. She was attacked by a mob in her home in KwaMancinza, an area in Eastern KwaZulu-Natal province. They accused her of bringing shame on the community by revealing her HIV status (McNeil and Donald, 1998:1). In my professional work as a midwife I had the experience of seeing people becoming sick and dying of AIDS. Currently I see the numbers of HIV-infected women increasing dramatically. I realize that my work as a midwife, nurse-counsellor and researcher is no longer as fulfilling as it used to be. It has become depressing over the last decade because of the numbers of young and old people who are dying as a result of AIDS. I am one of many midwives and nurses, because of this grave health concern, who is prepared to contribute to HIV preventative educational work. Further, my concern about the vulnerability of youth to HIV and AIDS has supported my desire to explore gender-based approaches to skills-building HIV prevention interventions.

The need to target youth in my educational work became more and more obvious to me. Prevention of HIV infection is the goal of many interest groups, as well as being my own. Gender power relations are part of socialisation from early childhood and this prompted me to target young people in my work on gender identities and HIV prevention.

I am now (2008) a lecturer at the University of KwaZulu-Natal, in a province that is the epicenter of the HIV and AIDS epidemic in South Africa. This thesis, I hope, will

be a small contribution to preventing this epidemic from claiming the lives of young people and most of all young women, as HIV infects more women than men. I am a mother, an isiZulu-speaking woman who was born, raised and socialized according to socially-structured and gendered expectations based on Zulu culture in KwaZulu-Natal. In pursuing this PhD study, my aim is to address the needs of young people through a research-based intervention which will help young people to understand themselves, their relationships, their sexuality and their sexual decision-making patterns. This research may also contribute to addressing gendered norms that foster HIV infection in this population. Thus this study may have implications for reducing HIV infections.

Throughout the programme of research on which this study is based, I was registered at what was then the University of Natal. In January 2004, it merged with the University of Durban-Westville to become the University of KwaZulu-Natal. References in the text will therefore be to the University of Natal until the end of 2003, and thereafter to the University of KwaZulu-Natal.

MOTIVATION FOR THE STUDY

My research arose from my experience as a nurse-counsellor involved in a study conducted in one of the Primary Health Care (PHC) clinics in the Durban Functional region of KwaZulu-Natal (KZN), now known as Ethekewini District (Figure 3: see Chapter 3, Methodology). In 1999, I was employed by the Medical Research Council (MRC) as a nurse-counsellor to conduct voluntary counselling and HIV testing of pregnant women. This pilot study was conducted as part of the MRC project to test the effectiveness of single-dose Nevirapine, an antiretroviral drug that was subsequently found to diminish mother-to-child transmission of HIV (PTMCT). These women received voluntary counseling on an individual basis in a comprehensive approach to HIV counseling, testing and subsequent treatment.

Most women felt that they could not make decisions on matters pertaining to their own and their babies' health status, such as HIV testing, without the permission of their male partners. Power inequalities related to gender in heterosexual relations were one of the major impediments. These inequalities also play a major role in the spread of HIV infection. One example of the inequalities influenced my views and pursuit of this

research: a pregnant teenager sought consultation for counseling and testing (VCT). She told me of her background: she was 17 years old, pregnant for the first time, and single. She had run away from home when she discovered her pregnancy because she was afraid of her parents. She was staying with her male partner in an informal settlement house near the clinic area. Having more than 20 years experience as a nurse and midwife and almost a year as a nurse-counsellor and researcher in the HIV and AIDS field, I realized as I was counseling, interviewing and observing her that there were many clues that this woman had an abusive male partner. She stated that she wanted to be tested for HIV, but that she was unable to sign the consent for HIV testing without the permission of her male partner. She was fearful of increasing tension in their relationship which might result in violence from her partner. She promised that she was going to come back after discussing and obtaining his permission to be tested for HIV. The following week, she came to the counseling room wearing dark sunglasses. She sat down, took her glasses off and narrated the story as follows:

Buka iziyingi ezingasemehlweni ami zivuvukele. Ngishaywe ubaba walengane engiyikhulelweyo ngesikhathi ngicela imvume yakhe yokuhlololwa isandulelangculazi. Uthe kusho ukuthi senginelinye isoka, akasangethembi. Futhi kumele ngiyeke ukuza kulomtholampilo ngoba akafuni ukuzwa lutho ngokuhlolwa kwesandulelangculazi.

[Look at the area around my eyes; it is swollen. I was beaten by the father of the unborn baby when I requested his permission to have an HIV test. He accused me of having another boyfriend; he no longer trusts me. He told me to stop coming to this antenatal clinic because he does not want to hear anything about HIV testing] (My translation¹).

I listened attentively to this young woman while she told me of how her partner had reacted to her request. I then asked her whether they were using condoms during sexual activity. She answered with her eyes full of tears:

¹ All translations within this thesis have been made by myself.

Cha. Ngamcela ukuthi asisebenzise i-condom ngaphambi kokuthi ngikhulelwe. Wenqaba wathi akasoze ayisebenzise yena leyonto. Wathi kusho ukuthi sengiqome enye indoda esengiyifundise ukuthi ngisebenzise i-condom. Waqala laphe ukungishaya, manje usephinda okwesibili.

[No. I requested that we should use condoms before I fell pregnant. He refused and said he will never use that thing. He said it means that I have fallen in love with another man that has taught me to use condoms. That is when he started to beat me; now this is the second time].

I comforted her and gave her tissues to wipe her tears, and after a short time she was quiet. I then asked her how she had managed to come to the clinic that day. She said: *“Ngize ngoba engekho ekhaya. Usebenza emini kulelisonto, ubuya sekuhlwile ntambama, futhi ubenginike imali yokuthenga ukudla esitolo”*. [I came because he is not at home. He is working the day shift this week; he comes back late in the afternoon when it is dark and he gave me the money to buy food from the shop].

I then asked her what she was going to do about her situation. She replied:

Ngizomhlonipha ngenze lokho akushoyo ngoba ngabaleka ekhaya futhi ngaphuma esikoleni sengizokwenza ibanga leshumi. Ayikho into engingayenza ngoba angisebenzi futhi uyena ongondlayo. Usethathe ubuntombi bami ebenqiziqhenya ngabo njengentombi futhi sengizothola ingane yakhe. Ngizobekezela, ngimlinde aze athathe isinqumo sokuyokhokha ilobolo emndenini wami, ukuze ngikwazi ukubhekana nabazali bami. Futhi nguyena nowenza izinqumo njengendoda, yize nomangazi ukuthi unezinye izintombi.

[I am going to respect him and do what he says because I ran away from home and dropped out of school before doing my Standard 10 (Grade 12 or matriculation). There is nothing I can do because I am not working and

he is supporting me. He has taken away my virginity that I was proud of as a girl and I am pregnant with his baby. I am going to persevere, wait for him until he makes a decision to pay 'ilobolo' (bridewealth payment), to my family for me to be able to face my parents. And he is the one who makes decisions as a man, even though I know that he has other girlfriends].

Gender-power imbalances and gender-based violence were evident in this relationship. The response of this teenager indicated her dependence on her male partner, even though he was violent. These influences are pervasive in some areas of KwaZulu-Natal.

What happened in this encounter is similar to the findings of Johnson and Johnson (1993: 20), which addresses the problems of pregnant women who seek voluntary counseling and HIV testing but experience problems from their partners' negative responses. Leclerc-Madlala (1999: 25) finds that in KwaZulu-Natal in 1996, women were often blamed for spreading HIV infection and confronted rejection and increased violence from their male partners when they revealed their HIV-positive status.

As a Zulu woman from the province of KwaZulu-Natal, I understood the situation of the pregnant teenager, because respect for men is one of the characteristics of womanhood that our mothers taught us about from childhood. We were told to respect our parents, brothers, and even more, our partners. I explained to the pregnant girl that we were taught that males have the final say, especially on sexual matters and women are often told not to question a male's decisions. These norms however must be reconsidered amidst the HIV epidemic. She also said:

Mina nomndeni wami sisonta esontweni lakwaShembe elivumela abesilisa ukuba bathathe amakhosikazi amaningi njengokuthanda kwabo futhi lokho kuhambisana nesiko lesiZulu. Kodwa akuvumelekile kwabesifazane ukuba bathandane nabesilisa abaningi.

[My family and I belong to Shembe church and their religion allows men to have as many wives as they choose and this is part of Zulu culture. But it is not acceptable for women to be in love with many men].

This teenager took it as a norm that men have multiple partners. Religion and culture, including being Zulu, are part of a person's socialization and play an important role in the beliefs, gender stereotypes, inequalities and sexual norms of a particular culture.

Despite the traditions of patriarchy, the AIDS pandemic is rendering it necessary that a greater degree of gender-balance be achieved in relationships so that partners can avoid unsafe sexual behaviour. Of primary importance is the need to recognize that culture is dynamic, shaped by the times we live in, but capable of being modified when it is recognized that health and rights are affected. Despite the new South African Constitution, which decrees gender equality and offers protection from exploitation and abuse to vulnerable groups such as women and children, cultural change is slow, despite the evolving needs of society.

In the example described above, I made the young woman aware that she was responsible for her choices and the decisions that she made. She could make decisions that she would be proud of or ashamed of for the rest of her life. I reminded her that she was responsible for enjoying or enduring the consequences of each choice she made.

Towards the end of our conversation I made her aware that she would have to make the decision as to whether she would spend the rest of her life in this type of a relationship. Alternatively, she could find a way to protect herself and her loved ones from sexually transmitted infections, including HIV and could seek her parents' help. I hugged her and told her to take good care of herself. She also hugged me and said: "*Ngiyabonga*", [thank you] as we parted. Our discussion gave her an opportunity to reveal her feelings and be reminded about her rights as a woman. However, one thing that disturbs me is that sexual behaviour cannot be transformed by simply giving people information, because people do not change their behaviour in response to 'being told'.

There were other scenes like this, where the power of men over women was revealed during counseling and HIV testing sessions. Most women would not consent to have the HIV test because they wanted to consult their men. Such attitudes became a

daily problem for me as a nurse-counsellor and made me see that gendered power inequalities in Zulu culture play a major role in spreading HIV. I began to ask what could be done to save the younger generation from these inequalities and to create respect in both men and women for their partner's views.

My study was also motivated by the history of feminism and key feminist theoretical concepts in the module that I studied, in the year 2000, in the Centre for Gender Studies at the former University of Natal, Durban, before registering for my PhD study. These theories and stories revealed the harmful influence of a patriarchal system for women's self-esteem and the struggle of women across the world to challenge gender-power inequalities. Reading in this area drew me towards the debate around the causes of patriarchy and the possibilities for challenging it. Other studies in KwaZulu-Natal (KZN) have raised these issues, but much work remains to be done.

In January 2001, I began to think about finding a group of young men and women with whom I would interact and whom I could sensitise about gender-based HIV prevention issues within a framework of participative action research. My first impulse was to create this group at the antenatal clinic, but because of difficulties in making contact with men and maintaining regular contact with the women who attended, I decided to form groups in rural and peri-urban high schools. My research would focus on the transfer of gender-based skills and would enable young people to make informed decisions relating to HIV prevention.

Gender does not only refer to 'women' but also includes men. I realized the importance of my intervention's including both boys and girls since all are at risk of HIV infection. In addition, I realized the importance of working on issues of femininity and masculinity as these are implicated in unequal gender relations and are integral to high HIV risk and approaches to prevention. Later in this introduction, I will address the issue of why I decided to target both girls and boys.

GENDER AND THE HIV AND AIDS EPIDEMIC IN SOUTH AFRICA

South Africa has a population of approximately 47.4 million (Statistics South Africa, 2006:1) and currently has the highest number in the world (an estimated 5.3 million) of people living with HIV and AIDS (Department of Health, 2004:6; the Joint United

Nations Programme on HIV and AIDS (UNAIDS), 2004 :190). By the end of 1999 approximately 3.6 million South Africans were estimated to be HIV positive and over half of them were women (Roche, 2000:1).

The HIV situation has been compounded by the legacies of the past, where under colonialism and apartheid, there were enormous economic differences between black and white populations. This, and the need for black men to migrate to the urban areas for employment, leaving behind their families, rendered the black population more vulnerable to HIV infection. HIV infection rates however, cannot be explained by simply referring to the 'history' of the country or to 'poverty'.

In South Africa, as in other developing countries, the HIV and AIDS pandemic threatens to erode the growth of the population, its economy and aspects of its social life. The first AIDS cases reported in South Africa occurred among homosexual men in 1982. In 1987, it was reported among heterosexuals, with a concurrent epidemic among children infected through perinatal transmission (Abdool-Karim, 2000: 11). The growing HIV and AIDS epidemic in South Africa is not just a problem of public health; it is also primarily a social and cultural problem.

The absence of a vaccine against HIV infection or a cure for AIDS, has influenced both the spread of the pandemic and the social response to it (Gilbert and Walker, 2002: 651). Initially HIV and AIDS was dismissed as a 'gay' problem, or a western conspiracy but now most people have encountered its deadly consequences amongst family members or people they know.

According to the South African Department of Health, the HIV prevalence among pregnant women reached its highest level (29.5%) in 2005. Among women aged 20-24, almost one in three was infected with HIV (UNAIDS and World Health Organization (WHO), 2005:21). Among pregnant women in their late teens (15-19 years), HIV levels have remained at 15% to 16% since 2000, while among their 20-24-year-old counterparts levels have remained between 28% and 31% between 2000 and 2004 (Department of Health, 2005:2).

Attempts to intervene in the spread of HIV and AIDS in South Africa have not been successful for a number of reasons. One of these is the inadequate political will which characterized the Mbeki administration and caused the government to fail to

respond to epidemic in South Africa. Although the state acknowledged that AIDS cases had been diagnosed in South Africa since 1982, its response to the reduction of the spread of HIV and control of the disease was slow and it did not launch any educational campaigns until several years later (Gilbert and Walker, 2002: 659).

My experience of the 2000 World HIV and AIDS Conference held in Durban further shaped my thinking about HIV and AIDS because while I was focusing on gender imbalances as a leading cause of HIV and AIDS, I realized that there was tension in the South African government about the very existence of HIV in relation to AIDS. President Mbeki and his team called into question the scientific evidence of HIV in relation to AIDS upon which the entire 2000 World HIV and AIDS Conference was based.

Controversial debates took place between South African leaders, dissidents and medical scientists over whether or not HIV causes AIDS (Newsletter of National Primary Healthcare Network, 2000: 17, Press reports Sunday Times April 08, 2001: 1). Valuable time and resources were spent on this debate, while South African citizens, including young people who were already living with HIV and AIDS, were suffering and dying because of a lack of proper preventative methods, including proper teaching about the nature and prevention of the disease as well as safe sexual practices such as the female condom, antiretroviral therapy and above all, adequate funding.

Other factors which slowed down the country's response to the pandemic included the inability to merge the "paradigms of the medical and the political, the scientific and the social" (Marais, 2000:10). There has tended to be a simplistic focus on changing individual behaviour patterns, because of the early perception of HIV and AIDS as an individual rather than a community health issue (Campbell, 2003: 1; Marais, 2000: 11). What was needed, in fact, was awareness of a number of factors that influenced the sexual behaviour of individuals, such as gender inequalities, cultural norms and values.

A major challenge facing those who seek to ameliorate the problem of HIV and AIDS in South Africa is to assess the extent of the pandemic and profile those who are infected as well as the people impacted upon by the disease. Reliable figures are difficult to obtain and many of the figures used to describe the pandemic are based on extrapolations of small data sets. Reliable, but limited, sources of data are the annual surveys conducted by the Department of Health. Data is obtained from public antenatal

clinics and used to determine the percentage of HIV-positive pregnant women who are attending the clinics. Based on these figures, the estimate at the end of 2001 was that 4.74 million South Africans were living with HIV and AIDS, compared to 4.7 million at the end of 2000 (Health Systems Trust (HST), Soul City and University of Natal, 2002:15).

UNAIDS and WHO (2002:23) support this view and estimate that approximately one in nine, or over five million South Africans are living with HIV/AIDS. UNAIDS and WHO (2002:23) further report that there may be indications that preventative measures are having some impact on the HIV prevalence rates among adolescents as these appeared to have dropped slightly since 1998. This could be due to large-scale information campaigns and condom distribution programmes. In contrast to this view, according to the UNAIDS and WHO report (2005:4), “South Africa’s epidemic, one of the largest in the world, shows no signs of relenting”.

In addition the Human Sciences Research Council (HSRC) (2005:33) reported that the HIV prevalence estimates for South Africa increase with age from 3.3% in children aged 2-14 years to 16.2% in youth and adults 15-49 years of age. The HSRC further reported that HIV prevalence increases more dramatically among young females than young males. It peaks at 9.4% in females, a higher level than 3.2% , the rate for males, in the 15-19 age group. It also peaks at 23.9% for females in the 20-24 age group, and at 33.3% for the 25-29 age groups. By contrast HIV prevalence in males of the same ages appears to be at lower levels: 6.0% for males in the 20-24 and 12.2% in males in the 25-29 age groups. In individuals from the age group 35-39 onwards, HIV prevalence was reported to be higher in males than in females (Human Sciences Research Council, 2005:34).

HIV and AIDS is a pandemic that, as I have shown, tends to be more prevalent in certain age and gender groups. Gender issues are increasingly being recognized as having a critical influence on the HIV epidemic in southern Africa (UNAIDS, 2000:5).

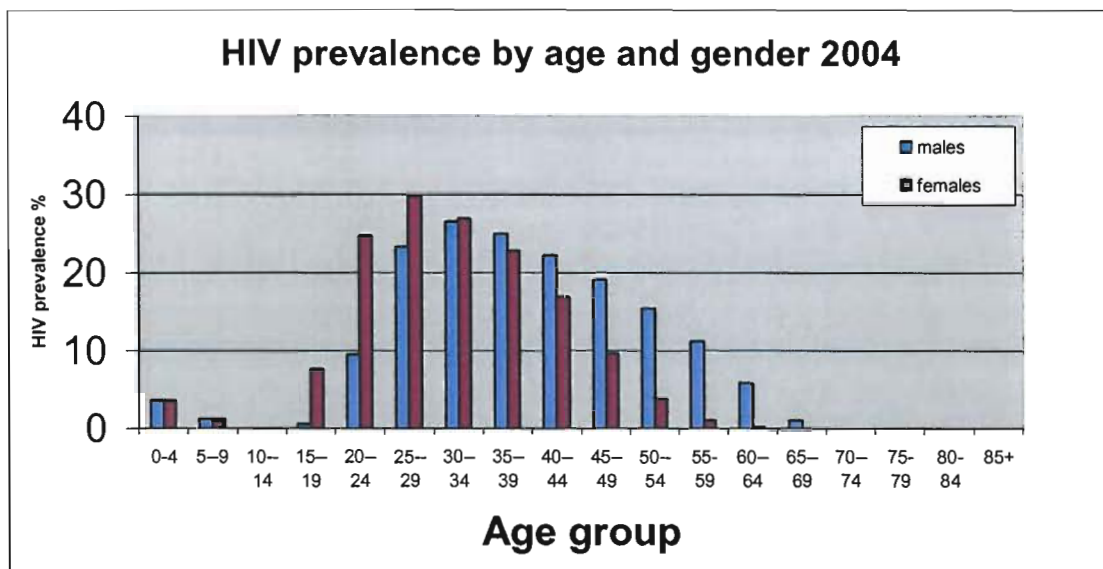


Figure1. Estimated prevalence of HIV by sex and age, 2004 (Dorrington, et al., 2004:9)

The Human Sciences Research Council (HSRC) (2005:33) reported that the HIV prevalence estimates for South Africa increase with age from 3.3% in children aged 2-14 years to 16.2% in youth and adults 15-49 years of age. The HSRC further reported that HIV prevalence increases more dramatically among young females than young males. It peaks at 9.4% in females, a higher level than 3.2%, the rate for males in the 15-19 age group. It also peaks at 23.9% for females in the 20-24 age group, and at 33.3% for the 25-29 age groups. HIV prevalence in males of the same ages appears to be at lower levels: 6.0% for males in the 20-24 and 12.2% in males in the 25-29 age groups. In individuals from the age group 35-39 onwards, HIV prevalence is higher in males than in females (Human Sciences Research Council, 2005:34; cf Dorrington, Bradshaw, Johnson and Budlender, 2004:9).²

South Africa, following the new political dispensation which came into effect from 1994, has been divided into nine provinces: KwaZulu-Natal, Gauteng, Western Cape, Eastern Cape, Northern Cape, North-West, Free State, Mpumalanga and Limpopo. Striking inequalities in HIV prevalence exist among the provinces as outlined below.

² As shown in Figure 1: Estimated prevalence of HIV by sex and age, 2004 (Dorrington, et al, 2004:9)

HIV AND AIDS EPIDEMIC IN KWAZULU-NATAL (KZN) AND GENDER

The Department of Health (2004:6) reported that KwaZulu-Natal had the highest rate in the country (37.5%), across all age and gender groups, higher than the other eight provinces of South Africa. In 2005, the South African Department of Health (2005) statistics indicated that among young women (less than 20 years old) who attended antenatal clinics, the prevalence of HIV infection was 15.9%. KwaZulu-Natal has 16.5% HIV prevalence, followed by two other provinces, Mpumalanga, 15.2%, and Free State, 12.6% that also have the higher HIV prevalence in South Africa (Human Sciences Research Council, 2005:35). By contrast the lowest HIV prevalence levels were recorded in the Western Cape, 1.9% and Northern Cape, 5.4% (Human Sciences Research Council, 2005:35). KZN is the current epicentre of the HIV and AIDS epidemic in South Africa, with an HIV prevalence rate approaching 40% in some areas (UNAIDS and WHO, 2005: 21; HIVAN, 2002:1).

The spread of HIV has been sustained by factors such as social and political agendas, denial, poverty, and gendered behavioural disparities. These factors in combination shape the course of the epidemic and its outcome. The rapid progression of HIV to AIDS has been attributed to poverty and related factors such as malnutrition and recurrent infections (Deschamps, Fitzgerald, Pape and Johnson, 2000: 2516). Studies from Uganda (Morgan, Mahe, Mayanja and Whitworth, 2002: 194; Morgan, Mahe, Mayanja, Okongo, Lubega and Whitworth, 2002: 598) have shown that the progress to AIDS and death are more rapid in people living with HIV and AIDS in developing areas than those living in wealthier countries. In contrast to the above view, some data suggests that the highest prevalence is not always amongst the poorest, for example, East African data has shown higher rates of HIV in wealthier urban people (UNAIDS, 2002:8).

Heterosexual sexual practices are the chief cause of the spread of HIV among the youth in KZN as well as other parts of South Africa. This is unlike the situation in developed countries where HIV was mostly transmitted through homosexual encounters and shared needles amongst drug users (UNAIDS, 2003:5). However there is a gradual change of the mode of HIV transmission in developed countries: in the United Kingdom there is a growing concern regarding the increasing heterosexual HIV in sectors of population such as migrants (UNAIDS, 2003:5). Despite high levels of awareness and the

known risk levels of heterosexual youth to HIV infection, the following characteristics of sexual risk-taking among young KZN men and women have been well documented: high levels of sexual activity, multiple sexual partners, commercial sex, non-use or inconsistent use of condoms, and coerced sex. (Akande, 2001:239; Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries, 2002:72; Varga, 1997:7; Harrison, Xaba, Kunene and Ntuli, 2001:69). It is estimated that over 60% of all new HIV infections occur amongst people 15 - 25 years of age, with women being infected earlier than men.

A number of factors influence the pattern of the epidemic and have contributed to the higher prevalence of HIV in women and girls in KZN. Amongst these are poverty, the female anatomy, and cultural factors including gender-power inequalities. Gendered inequalities often encourage women's dependency on men in all aspects of life and place women at higher risk of HIV (Global HIV Prevention Working Group, 2003:8). The lower status of women in Zulu society and within relationships means that women often live under social norms that encourage men's having multiple sexual partners (Akande, 2001:239; Harrison, Xaba, Kunene and Ntuli, 2001:69; Hunter, 2005:212). Zulu society limits open discussion of sexual matters, and discourages sex education for children and teenagers, especially girls. It frequently occurs that girls have sex with older men, which makes KZN's young women more vulnerable to HIV infection since older men are more likely to have had several partners and to be infected (Harrison, Xaba, Kunene and Ntuli, 2001:69; UNAIDS, 2002:27; Shisana and Simbayi, 2002:58).

It is characteristic of the socio-cultural dynamics of a patriarchal system, and in particular of Zulu society, that the gender and sexual roles, of boys and girls are prescribed according to norms and values. Male domination was demonstrated in a study conducted by Thorpe (2002) in two Durban township schools in KZN. In these schools, girls generally agreed that power was vested in boys, who dominated discussions during workshops. (Thorpe, 2002:61). Women in KZN lack the confidence to express their feelings, the power to negotiate on sexual matters or safer sexual practices. This is due to the fear, not only of facing violent behaviour from their partners, but of risking being abandoned or labeled as sexually experienced or promiscuous (UNAIDS, 2004:68; Global HIV Prevention Workshop group, 2004:13). However, cultural norms are always

in a state of fluidity and there are certain characteristics of the Zulu culture that appear to be changing. This will be discussed later in the literature review of Chapter 2.

It has been shown that HIV prevention approaches which focus on teaching skills alone are limited in their ability to influence the spread of HIV. These approaches only increase the youth's awareness of HIV and AIDS, but do not necessarily translate into the avoidance of risky sexual practices (Abdool Karim, Nkomakazi, 1992:340; Akande, 2001:239; Harrison, Xaba, Kunene and Ntuli, 2001:69). Such approaches do not accomplish their aim partly because they ignore gender issues.

In support of this view are the findings of the South African National Youth Survey examining the sexual activity of young people aged 12-17, commissioned by the Kaiser Family Foundation in 2000. This survey reveals that 90% of young people reported that they had heard of AIDS, but their awareness failed to translate into changes in their sexual behaviour. Further, the survey indicated that more than half of the sexually active teens believed they would not be infected with HIV by their sexual partners and that one in five had sex with more than two people. One of the boys in rural KwaZulu-Natal stated that even though he had two girlfriends, he used a condom only if one of them was untrustworthy (Love Life, 2001:1).

Motivation and design of strategy

Research-based evidence of the extent of HIV infection in KwaZulu-Natal among young heterosexual African males and females convinced me of the need to do two things. One was to extend and deepen school-going young people's understanding of HIV and issues of sexuality. The other was to intervene to contribute to increasing gender awareness and provide young people with the skills and knowledge to avoid HIV infection within the context of gender. I decided to conduct a three-phased study that focused on sensitising school-going youth about sexuality and gender-based skills through an intervention programme based on participatory action research. Schools became the setting of choice in which to conduct this study, as they are places where young people are found for learning purposes. I conducted my research in schools where a setting was available and where I could conduct sessions of a gender-based intervention programme with groups of

young males and females (Morrell, Moletsane, Abdool Karim, Epstein and Unterhalter, 2002: 12).

Schools are convenient research sites because they provide a compulsory educational 'home' for young people up to 16 and beyond. The transition since 1994 from apartheid to democracy has encouraged schooling. The South African Schooling Act, 1996 (Act 84 of 1996) made education a priority as it states that education for learners between the ages of 7-15 or learners reaching and completing Grade 9, whichever occurs first, should be compulsory (Education Policy, 1996:2). The implementation of this Act 84 of 1996 has enabled large numbers of young people to be educated.

Gender roles are established in everyday life, from childhood, with parents and other family members as the primary sources of socialization of children. Thereafter, schools became increasingly important as young people spent many of their waking hours in these institutions. According to Epstein and Johnson, (1998: 59) "Schools are complex spaces and were seen as the most suitable settings for conducting this study because schools act as centres that reinforce or amplify society's stereotypes". Boys and girls continue to be treated differently in schools, in a similar manner to the position in their families. Whyld (1983: 50) asserts that boys take the initiative and make treating girls and boys difficult for teachers. Hence schools were seen as the most appropriate places in which to examine social constructions of the notions of gender and to motivate a mindshift.

PROBLEM STATEMENT

HIV and AIDS appear to be concentrated in the most disadvantaged groups in South African society, for example, young people living in resource-poor and impoverished contexts. Young boys and girls, like adults, are at risk as they also contract HIV primarily through unprotected sexual activity. Heterosexual sexual activity between men and women has been reported to be major cause of the transmission or spread of HIV infection (UNAIDS, 2004: 2). Campaigns designed to deal with HIV and AIDS, up to the year 2002, when I began to collect data for this study, largely focused on preventive measures that were reported to be more cost-effective than antiretrovirals (ARVs), as

well as care of people living with HIV in South Africa (Creese, Floyd, Alban and Guinness, 2002:1636). Although health workers were increasingly aware of the spread of HIV and AIDS from 1994 onwards, the South African government refused to consider ARVs for South African people living with HIV and AIDS. The potential toxicity of the ARVs and cost implications were cited as the reasons hindering universal access in the public sector (WHO, 2002:10; Castro, 2002:20). In addition, the official line, emanating from the President himself, was that there was no connection between HIV and AIDS, a piece of mistaken education which had great influence over many, particularly the young. The government's stance on ARVs has however changed from 2004. There is nevertheless no vaccine (at this point, 2010) to protect people from contracting HIV infection and no cure for AIDS. Hence the focus of this study is on HIV prevention. It has made sense to target young boys and girls, as the age of sexual debut is early, as I shall show in Chapter 4.

The logic is that the only way that the epidemic can be successfully counteracted is by keeping people HIV negative and this requires that we start with young boys and girls, either before they have sex or just as they are starting to be sexually active. Such approaches have provided those interested in gender equality interventions with an opportunity of addressing gender inequalities implicated in HIV risks.

THE IMPORTANCE OF INCLUDING YOUNG MEN IN HIV AND AIDS PREVENTION AND GENDER EQUALITY INTERVENTIONS

Young men, like girls, are also vulnerable to HIV infection. In addition, women's situation cannot be addressed without considering the roles and influence of men. According to Piot (2001: 1), "The time is ripe to start seeing men as a part of the solution." Piot's view was supported by the UNAIDS (2000: 5) global theme for 2000, "Men make a difference." This theme encouraged men to be engaged as partners in combating AIDS and it gave a recognition to the responsibilities of men in controlling the pandemic (Roche, 2002: 2).

A balance must be achieved between recognizing how men's behaviour contributes to the HIV epidemic and their potential to make a difference. Men's involvement in the fight against HIV/AIDS can change the course of the epidemic (Piot,

2000: 1). Cultural beliefs and society's expectations about 'manhood' that encourage men to be the initiators of risky sexual behaviour place them and their partners at risk of HIV infection (Roche, 2000: 2).

In the research project which this thesis documents, I worked with both young women and young men. The purpose of targeting young men and women was to challenge traditional concepts of masculinity and create a shift in gender perceptions. I attempted to question features of their patriarchal culture and promote a model of shared gender-respect and equal responsibility in sexual decision-making. The goal at all times was the reduction of HIV risk-related behaviour to address the issues of HIV prevention.

FOCUS AND SIGNIFICANCE OF THE STUDY

I focused on exploring young boys' and girls' perceptions of gender, sexuality, sexual and reproductive health rights versus more traditional perspectives, HIV and AIDS and their sexual practices. The study also aimed at improving the understanding of HIV and AIDS and HIV prevention in the context of gender among the study population during the three phases of my study. The three phases are the orientation phase, the intervention phase, and the evaluation phase which will all be discussed in Chapter 3. The main aim was to examine gender-based life-coping skills and examine HIV prevention interventions from a health perspective.

The study was conducted in peri-urban and rural areas among the youth in a number of high schools of northern KZN. During the data collection process, I was working in the Department of Nursing Science at the University of Zululand and had easy access to the local high schools. As a Zulu woman who understands the value systems of Zulu culture, as well as having worked for more than 20 years as a health professional in KZN, I found it easy to gain access to these schools and to gain the confidence of learners. Only one of the sites approached regarding participation declined access. The school was in the city, located within the District Council Number 26 (Figure 3). Chapter 3: Methodology, provides details and discussion of this case.

I saw the need to conduct a gender-based HIV prevention intervention in this study as vital. In this study, 'sensitising youth' refers to the process of creating a mindshift among youth by exposing them to the programme within the complexities of a

gender-based skills-building process, going beyond revealing facts about HIV and AIDS, discussing linkages among complex concepts like gender inequality, patriarchy and cultural aspects related to HIV and AIDS. The project was designed to sensitise them concerning gender-based life building and coping skills, such as assertiveness, negotiation skills, the importance of gender-equality and mutual respect in life.

The young people who participated in this study were exposed to the gender-sensitive intervention and encouraged to apply the knowledge and understanding they gained about gender and sexuality issues. Topics addressed included HIV and AIDS; gender-based life building and coping skills in their lives, particularly in their relationships; and sexual decisions to protect themselves and their partners from contracting HIV.

By giving prominence to the gender aspects of the programme and approaching the participants as gendered beings, it was possible to stimulate debate among boys and girls and increase their awareness of the social and cultural constructions of gendered identities, masculinity and femininity.

In this study, the term 'youth' is used to refer to young people, learners from 13-19 years of age as targeted population of my study. The term 'young people' is similar to the term 'adolescents', which refers to a specific developmental stage of those who are no longer children but not yet adults. It includes the period from puberty into young adulthood, characterised by transition, physical and emotional development (WHO, 1997: 4; Harrison, 2003: 17).

As a result of my experiences as a professional nurse, midwife and nurse-counsellor and mother, as well as my formal involvement in post-graduate Gender Studies courses, I committed myself to research into gender-based responses to HIV prevention and the empowerment of young women and men in the area of gender equality and respect. I hoped to assist in promoting a culture where women are respected as equal partners with men in decision-making and HIV prevention.

I have aimed in this study to address the complexities associated with rights, different and sometimes conflicting cultural prescriptions of gender roles in the new South Africa. In the practice of virginity testing, for example, I will illuminate different attitudes related to this practice and examine the tension and confusion surrounding the

practice. This study addresses the controversial issues of youth sexuality from a culturally-sensitive focus and proceeds by examining how boys and girls perceive issues of gender, sexuality and HIV and AIDS, as outlined in Chapter Five.

THE COMPLEXITIES OF GENDER-SEXUALITY ISSUES, CULTURE AND VIRGINITY

The striking feature of the HIV epidemic is its ability to reinforce already existing socio-culturally constructed inequalities of gender, social status, race and sexuality (Patton, 1994: 2). I decided to register for a PhD and conduct this study as part of my doctoral work to determine what boys and girls know and believe about gender, sexuality issues and HIV and AIDS. The purpose of the study was to address notions of inequalities that the study participants may have acquired as part of their socialization. The aim of my study was to work with youth regarding the prevention and reinforcement of existing social and cultural gender inequalities during the AIDS pandemic, and to make a contribution towards the reduction of existing inequalities in the study population.

The study was divided into three phases and the learners who participated were from four high schools in northern KwaZulu-Natal. The first phase was carried to determine baseline data. The second phase consisted of the intervention programme, divided into nine workshops focusing on gender-based HIV prevention. The third or last phase was done after the intervention phase, to assess any changes in the baseline data reported by boys and girls in the first phase. Details of how these schools and learners were selected and also how the three phases of the study were conducted and their objectives are outlined in Chapter 3.

In the three phases, I examined how cultural 'norms' are constructed by assessing boys' and girls' understanding of the following issues: complexities of gender, sexuality issues, sexual and reproductive rights, culture, virginity, HIV and AIDS and the contribution of cultural norms in social constructions of masculinity in young males and of femininity in young girls. The influence of patriarchy, women's reproductive health, sexual decision-making, and heterosexual relations and practices were also examined. Some of these complexities, such as gender, culture and virginity will be examined in the following sections and in Chapter 2.

GENDER

The analytical term 'gender', refers to the norms, roles and behaviour constructed by society, based on the biological sex of individuals. This in turn determines how males and females are expected to behave and feel. In this study the term gender includes the socio-cultural constructions of female and male characteristics, including societal expectations of female and male roles in sexual relations and decision-making.

The terms 'masculine' and 'feminine' describe the cultural complexities of behavioural characteristics and personality attributes assigned on the basis of biological sex and incorporating the values of the society and the ways in which they are used (Whyld, 1983:9). Over time, historians and sociologists as well as anthropologists have shown that parents' expectations and the way they socialize their children are different, depending on the child's sex.

In most world cultures, parents have different expectations about how a girl or boy is expected to behave from conception, through childhood and continuing into adulthood. Furthermore, especially in patriarchal societies, parents often evince preferences for the sex of the child from conception and what they expect of their daughters is to be soft and respectful, in contrast to their sons, who are expected to be strong and brave. In addition, a male parent and a female parent generally have different understandings of gender and this varies between different cultures.

Regarding HIV and AIDS, the social expectations, roles, status and economic power of men and women influence the spread of HIV and impact of the epidemic. The promotion of cultural beliefs and values supporting mutually-responsible sexual behaviour and exploration of ways to reduce sex-role behavioral inequalities between young men and women is necessary to reduce the spread of HIV.

CULTURE

Culture refers to a complex concept constructed by society, and based upon the acceptable total of inherited beliefs and customs (Aunger, 2003: 73). Aunger states that these may include the appreciation and understanding of habits, values, norms, language, morals, art, music, knowledge and ideas that constitute the shared bases of social action

and behaviour of a particular group of people. Culture is socially constructed and periodically revised by society, fluid and capable of being contested in the course of interventions like my own. According to Auger (2003:73), in the social sciences the study and analysis of culture over the last century are acknowledged as complex issues, guided by the competing demands of different schools of thought. According to Auger (2003:7), "Culture has been variously defined as a social construction, a 'text', social behaviour artifacts or mental entities including ideas, beliefs, and values in people's minds. Indeed, in the history of anthropology, there has been a good deal of controversy about what categories of things can be included in the definition of this central concept."

Harrison (2003:19) explains that culture is a complex issue, made up of a range of characteristics that influence and determine the collective nature of how a particular group of human beings is expected to think, behave or act. Airhihenbuwa and Abregon (2000:7) view culture as "People's ability to understand and control their environment." Both views of culture, as a social force constructed by community, beyond the individual's control, and as a resource, are drawn upon here.

Northern KwaZulu-Natal, where this study was conducted, is situated in Uthungulu District near to where the King of the Zulus resides (see Figure 3.1). It consists predominantly of isiZulu-speaking communities that adhere strongly to the patriarchal notions of Zulu culture that promote male domination and prefer male rather than female offspring.

ZULU CULTURE

I was born and raised by my parents under the traditional values of Zulu culture in KwaZulu-Natal. I know that culture and society well. Examples of Zulu values are "*ubuntu*" meaning to be humane, and "*inhlonipho*" meaning respect; the latter will be outlined later. However, one of the negative aspects of Zulu society is that it operates within a patriarchal framework. Notions of this framework still permeate presentday Zulu society, even though modernization began long ago, around the 1880s. Like other cultures, Zulu culture changes subtly over time. Yet the definition of culture can harden and even ossify under social pressure. Certain elements of what people call culture can

remain while others fade away. Certain elements of culture do not easily disappear such as male control over property, which continues into today to be seen as a social good and an aspect of Zulu culture.

There is a need for a complete transformation of negative aspects of the Zulu culture, especially patriarchy. Gender norms and roles are beginning to change slightly over time, are no longer fixed. Change should also occur in gender roles and expectations that are still upheld by Zulu society. These include men's sense of entitlement over women's lives and bodies which still exists in Zulu culture. Women's sexual rights seem to be overlooked and violated despite our proclaimed democracy (Xaba, 2002:6). Gender inequalities are increasingly being recognized as having a critical influence on the HIV epidemic in Southern Africa (UNAIDS, 2000:5). At the XIII International AIDS Conference in Durban, Gupta (2000:2) described ways in which gender has shaped HIV risk. She argued that the gender-power imbalance, which is found to a varying extent in all societies, translates into a power imbalance in sexual interactions, which increases vulnerability to HIV infection.

In Zulu culture, the importance of types of respect known as *inhlonipho* or *ukuhlonipha* that females and males are taught is outlined in the work of Mchunu (2005:2). His study focused on how fathers over three generations raised their sons. Mchunu further documents some change in second and third generation men, who are more willing to compromise and allow some extreme *hlonipha* customs to be relaxed. For example, men of the current generation do not mind if their wives call them by their names whereas two generations ago this was seen to be very disrespectful (Mchunu, 2005:2). On the other hand, Mchunu reports that some sons in the second generation, known as *izinsizwa* still perceive themselves as superior to the women of their age and expect to be shown respect by those women (Mchunu 2005:8). Gender norms often determine not only what women and men are supposed to know about sex and sexuality, but also how they are supposed to behave in a sexual relationship. In Zulu culture, the importance of girls remaining virgins until they get married is emphasized, and virginity testing is done by elder women (Khuzwayo 2000:50). However, modern day virginity testing is claimed to be the re-invention of a past tradition (Scorgie, 1996:57). Many other authors have written about Zulu culture from a gender point of view including Leclerc-

Madlala (1997), Magwaza (2001), Mchunu (2005), and Hunter (2002). Their views will be explored further in Chapter 2.

The following section will highlight the intervention approach used in this study, as well as the purpose and objectives of the study.

INTERVENTION APPROACH FOR THE STUDY

The study centres on the intervention I conducted, aimed at equipping young Zulu males and females with skills such as negotiation, sexual decision-making and rights issues to promote HIV prevention within the context of gender. This intervention was developed prior to the initiation of the reviews of LOVELIFE³. The present study was based on the review of the interventions targeting young people available in South Africa from 2002.

THE PURPOSE OF THE STUDY

Young people derive their gendered identities from a whole array of influences besides Zulu culture, such as religion, rap music and the media. The purpose of the study was to expose and sensitise boys and girls to gender-based life-coping skills and to sensitise them about sexual and reproductive rights, negotiation and decision-making skills and HIV prevention. The aim was to encourage them to delay the onset of sexual activity or choose safe sexual practices.

The study was divided into three phases: phase 1 was the pre-test stage; phase 2 was the intervention itself; phase 3 was the post-test evaluation stage. Prior to the intervention phase of the study, in the first two weeks of August 2001, I conducted a pre-test to obtain baseline data. This helped to determine learners' knowledge levels, attitudes and perceptions towards complex issues and their sexual practices. Thereafter, from the last two weeks of August 2001 to the end of November 2001, I conducted a gender-based, skills building intervention based on the materials that I developed and other, modified materials that were used on other interventions, as I shall outline in Chapter 3 (Methodology). My intervention was also based on my experience as a Zulu woman and was rooted in this community of KwaZulu-Natal. It thus differed from other interventions

³ LOVELIFE is a national HIV prevention programme for South African youth, see details in Chapter 2.

in the literature. I drew on my own cultural experience with young people and my knowledge of their socialization. I did not receive any challenges related to my identity.

This intervention was followed by a post-test to assess any changes that occurred after the intervention phase in relation to the same indicators that had been assessed during the first phase. The post-test was done in the evaluation phase, which was the last phase of the study, conducted from September 2002 to November 2002. Further explanation of my approach is provided in Chapters 3 and 5.

OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Determine baseline data regarding the degree of youth's awareness, attitudes and perceptions of gender, sexuality issues, sex education, sexual rights, virginity testing, STIs and HIV and AIDS (first phase).
- Determine the roles of stakeholders⁴ as understood by young people, in HIV and AIDS and sexual practices in relation to HIV prevention (First and Third phases).
- Determine the sources of information about sexuality and gender issues, sex education, as well as STIs and HIV and AIDS, amongst high school learners of Northern KwaZulu-Natal (First, Second and Third Phases).
- Conduct gender-based life building skills intervention programme to expose and sensitise school-going youth to the complexities of gender-sexuality issues, sex education, the language of sex, rights issues, sexual decision-making and HIV prevention within the context of gender (Second or Intervention Phase).
- Assess the intervention programme by comparing the findings of the baseline data obtained in the first phase and those obtained in the third phase after the intervention.

⁴ These were understood to be parents, teachers, the Department of Education, and traditional healers.

RESEARCH QUESTIONS

- What are the attitudes, perceptions, knowledge and practices of boys and girls concerning gender, sex, sexual rights, sexual decision-making, HIV and AIDS, HIV prevention, and what were their sources of information?
- Which set of their community's role expectations and or prescriptions do young girls and boys know and adopt in their sexual decision-making?
- Are young girls and young boys who are aware of HIV and AIDS as a major problem and are armed with gender-sensitive life coping skills more likely to share and apply gender-based respect in sexual decision-making with the aim of protecting themselves and or their partners from HIV infection?
- Does an increase in HIV and AIDS knowledge influence the sexual behaviour, the number of their sexual partners, and influence them to adopt safer sexual practices such as use of condoms?
- What are the roles of stakeholders in HIV prevention within the context of gender?

CONCLUSION

I aim to document a three-phase HIV prevention intervention. In designing, implementing and analyzing the intervention, care has been taken to emphasise the Zulu context. This has involved examining the understanding of gender and sexual issues and the analysis of the responses of participants from a perspective that acknowledges that understandings are shaped by local surroundings, languages and cultures. The results of the study will make a contribution to the understanding of sexuality, behaviour and the prevention of HIV infection based on gender.

The chapters of this thesis are structured in the following way:

CHAPTER TWO: In Chapter 2, I will examine relevant literature and the theories which form the framework of this study, such as feminist and masculinity theories. In addition, I will review previous research on the complexities of gender and sexuality issues, sexual rights, culture and Zulu culture, including virginity testing. I will also review previous research studies on the patterns of HIV in South Africa and interventions in South Africa, designed to combat the HIV and AIDS epidemic.

CHAPTER THREE: Here I shall present the methodology and design used in this three-phase study. It includes a discussion of the setting, population and sampling technique used in this study. It further presents the process of data collection and analysis in the phases of this study, as well as the ethical issues that were maintained in this study. Limitations of the study are also outlined.

CHAPTER FOUR: In this chapter the socio-demographic profile and results of the baseline data that were collected during the first or introductory phase of this study is presented. High degrees of knowledge of HIV and AIDS among the participants was one of the major findings, although this knowledge was not linked to self-reported safer sexual practices. Many participants reported sexual activity at an early age in both sexes but more frequently in boys. Boys also reported higher numbers of sexual partners and low levels of condom use; in addition both boys and girls reported low levels of awareness of the risks associated with HIV infection.

CHAPTER FIVE: This chapter presents the design and process of the intervention phase. In addition, I describe the sessions during the intervention phase (see Table 5.1) and present the topics of each: terminology, for example, was the subject of the first of these nine sessions. The intervention phase was a two-way process of communication between myself as researcher, my assistants and the learners. As learners gained new knowledge about HIV, the researcher gained new knowledge about the sharing of health-related information and with the young boys and girls. Terminology concerning sexual

issues, and behaviour was conveyed by to the learners. For example, during the intervention phase, I, as researcher, learned that there are terms used by youth, while learners were excited by the opportunity to talk about sexuality issues. I did not know previously that condoms are mostly known to by boys as 'CDs'. The impact of this intervention phase of this study, in general terms, was found to be greater on girls than boys.

CHAPTER SIX: This chapter presents the results of the data collected during the third or evaluation phase, the last phase of this study. The findings confirmed low levels of abstinence and multiple sexual partners reported by the majority of boys, but very few girls. Boys' responses indicated that they were using power in sexual initiation and sexual decision-making. However, some findings were surprising: some boys reported abstaining from sexual activity; the age of sexual debut was reported to be similar for both gender groups. Further explanation and results will be presented later in Chapters 4, 5 and 6 as already indicated.

CHAPTER SEVEN:

In this chapter the major findings of the study will be summarised, in line with study objectives, research questions and the principal theories forming the conceptual framework of the study. Conclusions will be drawn from the main findings of the study. Chapter Seven will present recommendations based on the findings of the study with support from relevant literature and findings from other research studies.

Appendixes containing copies of the material used in the study follow the main body of the study. In order to avoid making this thesis undesirably bulky, the different sections of this material follow each other and do not begin on a new page.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

This chapter will review the literature and provide a theoretical foundation for the study. The literature review of this chapter addresses issues of youth, gender and gender-power inequalities. Constructions of youth sexuality to create 'feminine' girls and 'masculine' boys as well as the sexual behaviour and age of sexual debut of school-going youth and HIV and AIDS issues will be examined.

My themes will be further explored within the framework of theories related to Connell's (1987: 10) theory of gender and power, feminist theories, masculinity theories and theories related to vulnerability. The primary research question that informs this study is: are young boys and girls who have been exposed to gender-sensitive life coping skills more likely to apply gender-based respect and responsibilities in sexual decision-making with the aim of protecting themselves and their partners from HIV infection?

The next section highlights the principal theories guiding my research project and examines gender-sensitive literature. This section will further outline HIV-prevention interventions conducted in South Africa for youth.

PRINCIPAL THEORIES FRAMING THE RESEARCH PROJECT

The following theoretical models provide the theoretical framework which guided this study: Connell's (1987:90) theory of gender and power and feminist poststructuralist theory (Ritzer, 1992:505; Roseneil, 1995:2000), which are the major theories adopted as the framework of this study. R. W. Connell, an Australian sociologist, examined available theories on gender and power and combined them into one integrated theory (Connell, 1987:90). This theory of gender and power is based on philosophical writings concerning sexual inequality and gender-power imbalances (Wingood and DiClemente, 2000:539). Connell's theory was deemed suitable for this study as it satisfies the criteria of feminist poststructural theory that postulates that because gender-power inequalities are constructed by society, they are unfixed and could change.

CONNELL'S THEORY OF GENDER AND POWER

Connell's (1987:92) theory has three major social structures characterising the relationship between men and women: the sexual division of labour, sexual division of power and the structure of cathexis. He argues that the term 'structure' is similar to the term 'pattern' and refers to the intractability of the social world (Connell, 1987:92). It also reflects the experience of something that limits freedom. These patterns sustain the subordination of women to men. Identifying the dynamics which have the potential to transform these features amounts to identifying the conditions for changing the conditions of social practice (Connell, 1987:159). The first two structures, of division of labour and power, explain gender relations, while cathexis addresses the affective component (1987: 95).

The gendered division of labour consists of social structures which condition the relations between men and women. Some examples are the division of paid work in industry and unpaid work in house and childcare, unequal training, unequal promotion and unequal wages (Connell, 1987:96). The second social structure is gendered division of power, concerning the structures of authority, control and coercion (Connell, 1987:96). The third social structure, cathexis, involves the recognition that sexuality is socially constructed. Cathexis thus is about structures related to sexuality, which Connell (1987:112) refers to as structures that constrain and shape people's emotional attachments.

Connell (1987: 12) further explains that these three structures are interdependent and serve to explain the culturally-bound gender roles assumed by men and women. In addition, he emphasises that these three structures exist at two levels, the societal and the institutional levels. The three structures are evident in families, schools, industries, relationships and religious institutions where institutional changes occur gradually but more rapidly than societal changes (Wingood and DiClemente, 2000:541). The highest level at which the three social structures occur is the societal level. They are rooted in society through numerous historical and philosophical forces that consistently segregate power and decree social norms, including sexual norms on the basis of gender-determined roles. As society changes, these three structures evolve but the underlying fact of gender-power does not disappear (Wingood and DiClemente, 2000:540).

According to Hekman (1990:188), Connell's theory is a theory of political opposition which provides a strategy for feminists and deconstructs masculinity discourse and power.

Connell's social structures are applicable in my intervention among school-going youth. They are manifest as part of the risk factors that expose boys and even more, girls, to HIV at both institutional and societal levels. The inequalities which result from social and economic mechanisms occurring within the sexual division of labour and power, favour men. Women are more likely to experience adverse health outcomes, making young girls more vulnerable to HIV infection than boys. Zulu women are socialised to remain ignorant about sexual matters, submissive, shy and unable to assert themselves.

Connell's theory of gender and power supports the view that women's ability to protect themselves is often influenced by social, economical and cultural factors, including gender-determined sexual roles. The social and economic exposures are manifested in the phenomenon of women in unequal power relationships. Women tend to depend on their male partners because men usually bring more financial assets, such as money and gifts to the relationship. These three intertwined structures are manifest in young women who have older partners, and who have limited control over their relationships.

The structure of cathexis, in Connell's theory, addresses social norms and affective attachments that are maintained by social mechanisms and which produce biases with regard to how women and men should express their sexuality. These biases produce cultural norms that reinforce strict gender roles and stereotypical beliefs (Wingood and DiClemente, 2000:544). In Zulu culture, girls are encouraged to remain in monogamous relationships until they get married as opposed to the acceptable norm for boys who are expected to be sexually experienced and to have multiple sexual partners.

Feminist theories now work with definitions of gender that include boys and girls, men and women. Since my study includes boys and girls, I will draw on a variety of feminist theories in order to make sense of the data that I generate. For boys I will be drawing on newly emerging theories of masculinity pioneered by Connell, (1995), Connell, Hearn and Kimmel (2005), Morrell, (2001), Breines, Connell and Eide, (2000) and others. Drawing from feminist and masculinities theories will help to create a culture

where girls and boys see themselves as equals and learn to share equal respect and responsibilities in sexual decision-making.

FEMINISM

With some notable exceptions in Pacific and some African matriarchal societies, women have usually been afforded lower status than men in all spheres. Women were, and are sometimes excluded from decision-making processes to ensure that they remain subordinate to and dependant on men for survival (Mlungwana, 1996:9). However, the involvement of women in decision-making processes varies between cultures. Feminism is referred to as the theory of the political, economic and social equality of men and women. The political aspect of feminism is centred on equal voting rights, and equal salaries for equal qualifications (Knap van Bogaert and Organbanjo, 2009:116).

Feminism at the outset focussed on issues of identity, feminine qualities, gender roles and the freedom of women. They are encouraged to liberate themselves from oppression, stand up for their rights and make their own choices (Knap van Bogaert and Organbanjo, 2009:117). It is not easy to give a specific definition of feminism because it was developed by many feminists from various schools of thought, and can be divided into three waves. These three waves of feminism have common concerns raised on behalf of the women's rights and interests but each has had different focuses.

The first wave of feminism began in the west in the 19th century, focusing mainly on the injustices of male-dominated politics and the inferiority of women in society. Mary Wollstonecraft, John Stuart Mill, Susan Antony, Olympia Brown, Lucy Stone were, amongst others, considered feminists. Wollstonecraft, (1792:18) was the first female author to challenge the subordination of women in society. She argued that women were deprived of their natural right to education and encouraged to remain ignorant and to concentrate on their beauty to please men, as if they were created for men's satisfaction. She opposed the treatment of women like children. She assured women that they too could make a choice of the leaders of their country (Wollstonecraft, (1792:19). Mill was one of the Scottish feminists who brought the notion of women's suffrage to the British electors in 1865 (Knap van Bogaert and Organbanjo, 2009:116). The first wave of

feminism ended in the early 20th century after achieving the major victory of the amendment of the United States's constitution, granting women the right to vote.

The feminist trend emerged in Europe, as part of the discourse of the European enlightenment in the mid-nineteenth century (Andermahr, Lovell and Wolkowitz, 1997:76). Feminism challenges notions of power and gender by examining the restrictions placed on women in areas such as sexuality and decision-making which contribute to creating gender-power imbalances.

The second wave of feminism started in the early 1960s as a continuation of the struggle against patriarchy and female subordination and extended through the late 1980s. The aim of this wave was to offer an alternative to the male-dominated politics of the time. Traditionally, woman's life was defined by her biology nature and her ability to produce children. This wave focused on the equal education of women and men, encouraging women to understand aspects of their personal lives. This is the era when the essay called "The Personal is Political" was written by Carol Hanish (Ritzer, 1992:504). Feminists in this wave argue that women's roles are dictated by men and that males limit the achievements of women who are encouraged to liberate themselves through education. In this era the term 'the liberation of women' originated and the second wave to be known as liberal feminism. Key players in this wave were Lorraine Bethel, Charlotte Bunch and Angela Davis. Early second-wave feminists adopted the distinction between sex and gender, formulated by psychologists, such as Robert Stoller (1968).

Sex is a biological entity, referring to biologically-based phenomena. It is associated with the characteristics of an individual that are rooted in biology, including genital organs, chromosomes and genes that allow for differences in physical appearance and, therefore, for the two categories of female and male (Anselmi and Law, 1998:2). Linked to the understanding of the term sex as relating to biological make-up of the genitalia of the individual, it is vital to acknowledge that sex and gender are not synonymous terms.

Gender surpasses biologically-determined categories as it is a sociocultural based phenomenon, socially constructed by a society and based on cultural norms. Gender refers to the social and cultural factors that shape our reality and our sense of identity. Anselmi and Law (1998: 2) argue that gender is a social category of shared meanings

about the characteristics of maleness and femaleness, as well as the behaviour, attitudes, and feelings associated with these characteristics.

These distinctions between sex and gender define and differentiate the socio-cultural meanings of masculinity and femininity, from the base of biological sex differences of male and female on which they are constructed (Oakley, 1972 cited in Andermahr, Lovell and Wolkowitz, 1997:84).

FEMINIST THEORY

The term 'feminist theory' suggests a body of knowledge which offers critical explanations of women's oppression and subordination and challenges women's oppression. It offers analysis and explanations of how and why women have less power than men and how this imbalance could be challenged and gradually eliminated (Richardson and Robinson, 1993:50).

The following section examines feminist theory as one of the main theoretical bases that guide this study.

Feminist theory focuses on the place of women in society and the relation of women to each other and to men. It is that part of the scholarship on women that presents a wide-ranging system of ideas about human experiences and their understanding in relation to a woman-centered perspective (Ritzer, 1992:447). In this thesis three themes emerge in relation to feminist theory. Firstly, the woman-centeredness of some feminist theory is inspirational. Secondly, the feminist poststructuralist perspective that guided this study, regarding school-going boys' and girls' sexuality has been useful. Thirdly, the influence of feminist theory in analyzing the causes of HIV prevalence has been a central focus. HIV prevention and the local, KwaZulu-Natal (KZN), context where HIV and AIDS affect more women than men is of major concern.

WOMEN-CENTEREDNESS IN FEMINIST THEORY

Feminist theory's starting point is to examine the situation and experiences of women in society. It treats women as the central point for investigation as it seeks to see the world from the vantage point of women in society. It is critical and acts as an activist on behalf of women (Ritzer, 1992:447). The feminist perspective proposes that women's roles have

been different from, less privileged than and subordinate to, those of men. This has made women invisible in society and has acted as an indicator of gender inequality (Ritzer, 1992:450).

Women have been allocated roles very different from those of men. Girls, wives and mothers have been expected to be passive compared to assertive boys, husbands and fathers, especially in decision-making. The Greek philosopher Aristotle portrayed women as men's natural inferiors in terms of reason (Kimmel, Hearn and Connell, 2005:36). By contrast, the liberal English philosopher Mill developed dialogue with his wife and argued that equal education for both sexes would disprove men's claim to superior intelligence (Mill and Mill, 1970: 7; Kimmel, Hearn and Connell, 2005:37).

First wave feminist theories were primarily defensive as they fought for women's rights, arguing that women should receive the privileges of citizens; they questioned men's superiority to women. They asked "if God and nature had made women so clearly inferior to men, why were such strong social inducements necessary to retain their subjugation?" (Kimmel, Hearn and Connell, 2005:36).

Feminist theorists assert that women have occupied an inferior and subordinate position to men in most societies but women have indicated that they want to be included in the rights of citizens (Ritzer, 1992:451, Charfetz and Dworkin, 1986:51, Kimmel, Hearn and Connell, 2005:36). For example, during the French revolution, Mary Wollstonecraft, (1985: 426), in her "Vindication of the Rights of Woman" demanded the recognition of the common humanity of both sexes and appealed to men to be satisfied with the fact that men and women were created as equals.

Twentieth-century liberal feminists continued the struggle of seeking for women the privileges already enjoyed by men. They lobbied for equal treatment of boys and girls and wrote children's books featuring cooperative boys and resourceful girls (Kimmel, Hearn and Connell, 2005: 37). They welcomed men into their organisations and encouraged women to enter previously male-dominated occupations. However, they have been criticised for merely including women in male-dominated institutions and accepting a restrictive narrow model of equality without questioning the masculine norms that violate women's rights over their bodies.

The current versions of liberal feminist theories are more sophisticated in their analysis. They offer models for inquiries into the gendering of the state, law, civil rights, professions, and media and offer ideas for combining traditionally masculine and feminine personalities in individuals (Kimmel, Hearn and Connell, 2005:38). Maccoby, (1998: 189), represents a recent version of the liberal view that encourages freedom of choice for both sexes and allows for a varied play of feminine and masculinity difference across the life cycle. She sees youth “growing up apart in groups segregated by sex and adults experiencing convergence in sex and work” (Maccoby, 1998: 189). Other feminist theorists seek to deflate gender dualism by viewing gender as developmental across the life course. Masculinity might be defined by boys as development from childishness to maturity rather than as opposition to a denigrated femininity (Kimmel, Hearn and Connell, 2005: 38). The second phase of this study, based on the principles of the feminist theories, exposes young boys and girls to gender-based skill building in the intervention programme with an aim of promoting HIV prevention in gender perspective. The following section will outline feminist poststructural theory as the major theory forming the theoretical framework of my study.

FEMINIST POSTSTRUCTURAL THEORY

Feminist poststructural theory emphasizes the importance of culture and discourse in the constitution of gender. It is part of third wave feminism that arose in the early 1990s as a result of dissatisfaction with maternalist approach that maintained the stereotypes of feminine identities and practices and is continuing today. It involves a transformation in the social world and takes as its subject postmodern society that seeks to deconstruct the notion that a woman represents a set of attributes such as motherhood (Ritzer, 1992:505; Roseneil, 1995:200). Barrett (1992: 200) argues that feminist poststructuralist theory as a critique of maternalist assumptions within feminist social science has been one of the most important contributions towards feminist theories.

The usefulness of this study of feminist poststructural theory is that it helps to establish that the status and meaning of women is a complex issue within feminist scholarship. Feminists working within a post-structural framework take ‘instability’ as

their point of departure, acknowledging that women are always constituted historically and socially within discourses (Harding, 1986:646)

Post structural feminists' understanding of gender goes beyond the general belief of other feminists that focuses on the relations between men and women. They challenge such an approach as having a limited interpretation of gender that assumes a fixed opposition between men and women and excludes the meaning of gender in relation to other social constructions such class, race and sex.(Manicom,1992: 457).

“For example, in much colonial and early Union official discourse, the construct of “African woman” was invested heavily with female sexuality and patriarchal propriety; whereas mid-century state discourses around the question of the appropriate form of labour force organization (whether migrant or urbanized) constructed “African women” more in terms of racial and cultural identities” (Manicom, 1992: 458).

Post-structural feminists argue that there is no given meaning of women and no natural defining feature of women that can explain gender difference without considering ideological racial and class versions of womanhood (Manicom, 1992: 454). They provide a broader view of gender and other social practices such as race and class, which were socially constructed phenomena though used as fundamental organising principles in the past. This theory highlights the way discourse practices are arranged in a hierarchical network which promotes female oppression (Weedon, 1987: 10).

Feminist poststructuralist theory is also transformative as it asserts that socially constructed structures, including those of gender inequality, are not fixed but subject to change. Connell's theory of gender and power (Connell, 1987:95) and feminist poststructuralist theory provide the basis for developing my culture-specific and acceptable gender-sensitive strategies of HIV prevention. This body of theory also aided in my realisation that change from male domination could be made through the process of negotiation. I focus on that aspect of feminist poststructuralist theory that allows for more fluid identity formation. This opens up questions that could be fruitful in an HIV context such as: could the disease be strengthening gender inequalities in Zulu and other

societies? Could “scientific” and “educational” institutions be part of the problem that they are supposedly devoted to eradicate, that of sexually transmitted infections including HIV. There is scope for further research in this area since it was not part of my study.

Feminist theories offer a number of approaches to the attainment of gender equality depending on their perspectives on men and masculinity. Understanding of these concepts has altered long-standing assumptions about the division of people into categories of ‘men’ and ‘women’ as well their traditionally assigned gender roles.

MASCULINITIES AND THE NEW MASCULINITY STUDIES

In the mid 1980s a group of scholars, mostly sociologists, began developing gendered theories of masculinity. They positioned this work as pro-feminist and aligned themselves with the goal of the liberation of women and gender equity. These sociologists were later loosely described as the founders of Critical Men’s Studies (Connell, Hearn and Kimmel, 2005: 6).

Robert Connell is an Australian sociologist whose work had a major influence on the development of theories of masculinity. He developed a theory of masculinity which sought to consider psychological insights and social forces, and managed to combine various intellectual influences of materialism and feminism (Morrell, 2001:7). Connell argues in his 1987 book titled on *Gender and Power* that men are automatically endowed with power, and demonstrates that gender is a concept of power (Morrell, 2001:7). In his 1995 book on masculinities, Connell (1995:79) shows that men enjoy ‘patriarchal dividends’, and the advantages they gain from the subordination of women; not all men share this power equally. He argued that not all men were abusive or exploitative; some men oppress women while other men subordinated other men.

Connell shows that there are different masculinities and that masculinities are fluid and should not be viewed as being fixed. He shows there is a hegemonic masculinity, where men dominated other men, and which created cultural descriptions of what it means to be a ‘real man’ (Morrell, 201:7). Connell, Hearn and Kimmel (2005: 1) indicate in their book that the field of gender research has historically focused on issues relating to women, mainly developed by women. However, in recent decades, the study of gender has expanded and has included studies of gender issues about men and

masculinities. The recent interest in masculinities developed across various fields such as sociology, anthropology and cultural studies and social psychology as part of the social sciences, the humanities, education studies, political science and other fields (Breines, Connell and Eide, 2000: 24; Connell, Hearn and Kimmel, 2005: 1). It reflects a growing public interest in boys' and men's identities, conduct and problems and their origins. A large body of research has emerged (Connell, Hearn and Kimmel, 2005: 4).

The idea of a male sex role was the first step in the studies conducted on men and masculinities. This idea became popular at the beginning of the liberal-feminist discussions of the 'female sex role', which criticised cultural stereotypes but expressed optimism about change (Breines, Connell and Eide, 2000: 23). The concept of masculinities has followed the 'male sex role' and 'masculinity' is preferred to other terms that are commonly used, such as manhood and manliness (Connell, Hearn and Kimmel, 2005: 4). According to Connell, Hearn and Kimmel, (2005:4) 'masculinities' refers to ways of accounting for the positions of women and men in society and ways of describing the nature of men and the patterns that differ according to cultures. Morrell, (2001:9) asserts that there are no rules or procedures of developing masculinities: boys and men are not given a chance to choose images that are pleasing to them but their tastes and bodies are shaped by discourses of gender that they learn from birth.

Disciplines such as psychology, sociology, anthropology and history view masculinity as an internalised gender identity that belongs to males, reflecting a particular culture's norms and values (Connell, Hearn and Kimmel, 2005: 5; Breines, Connell and Eide, 2000:24). Masculinities are socially and historically constructed and learned from messages transmitted by agents of socialisation such as family, school and mass media. Males try to conform to social stereotypes of how a 'real man' is expected to behave in a particular society (Breines, Connell and Eide, 2000:24; Connell, Hearn and Kimmel, 2005: 5; Morrell, 2001:7). Patriarchy is the main structure of gendered power which limits men's capacity to consider the rights of others, particularly females. This makes them unable to engage in negotiations of gender-power equality, especially in decision-making; however this is not fixed, but has the capacity to change with time (Breines, Connell and Eide, 2000:23). It is essential to acknowledge that in addition to gender relations, there are other social factors such as race and class that are significant when

determining how men understand their masculinity, how they position it and exercise patriarchal power (Morrell, 2001:10). The focus of this study is on gender relations and so I have written little about literature that makes some suggestions about how other factors such as ethnicity, race and class influence men's understanding and constructions of masculinities.

Male writers such as Bly, (1992) Farrell, (1993) and Keen, (1992) blamed feminism for wanting to disempower men, and called for men to maintain patriarchy, assert themselves and stand up for their rights (Morrell, 1998:7). Despite these arguments, theoretical and research-based work on men and masculinities now constitutes a formidable corpus of work. This work shares a number of conceptual features; one of the major ways in which boys are distinguished from girls is through their socialisation by the members of their families and society. Socialisation theory explores the social learning experiences that mould people in general but particularly young boys and girls for the role expectations of maleness and femaleness (Ritzer, 1992:461). From infancy through childhood and adulthood, boys are socialised by their fathers, older boys, and mothers, to have qualities that are regarded as natural for boys. These include being hard and strong, reluctant to cry and assertive. Girls are socialised to be submissive, emotional, loyal, weak, childlike, sensitive, compassionate, and chaste until they are married (Moynihan, 1998:1074).

Kimmel, Hearn and Connell (2005:180) contend that men make, define and change their masculinity. Person (1980:605) argues that men's gendered identities often centre on their sexuality. Evidence suggests that genital sexual activity is a prominent feature in the maintenance of masculinity, but is a variable feature in feminine gendering.

Human sexualities are practices that are diverse, and culturally informed (Whitehead, 2002:162). I will draw from Hunter and Davis, (1994:24) who suggest that constructions of masculinity and male role identity must be viewed within a social and cultural context. African males are expected to meet culturally specific requirements such as promotion of the family name and to conform to dominant gender role expectations such as being successful, competitive, aggressive and initiators of heterosexual relations (Hunter and Davis, 1994:24).

In South Africa and other African countries, heterosexual transmission is the major mode of HIV transmission, as sexuality is usually manifest as heterosexuality. This does not mean that same sex practices do not exist covertly in South Africa and other African countries. In the 1980s the focus of attention on AIDS was either on homosexual men or on women. It has only been since the late 1990s that there has been a realization that men must be involved in the fight against AIDS. It has become clear that gender-power inequality is at the heart of the pandemic and that constructions of masculinity need to be taken into consideration (Kimmel, Hearn and Connell, 2005:106; Bujira, 2000: 25; Foreman, 1999: 50 and Tallis, 2000: 30).

The findings of previous studies into HIV prevention show that South African men talk of their right to have unprotected sex, which they describe as more natural (Kimmel, Hearn and Connell, 2005:186). They reported that they have strong sexual desires and claim that regular intercourse is essential for a man's good health (Panos, 1999:17). Numerous studies (Kimmel, Hearn and Connell, 2005:107) have found that both young and old men reported the importance of having sex with many female partners, as central to the construction of masculinity. The way in which men are driven by their construction of masculinity, irrespective of whether it is driven by biological or cultural factors, is of major concern. Particularly males' preference for unsafe sexual activity with multiple female sexual partners renders, other people, but more particularly girls, vulnerable to HIV infection.

VULNERABILITY

Vulnerability refers to a lack of power, opportunities or skills to make and implement informed decisions about one's own life. This vulnerability results in the increased likelihood of exposure to HIV infection. (Mann and Tarantola, 1996:441; Tallis, 1998:9). In this study, the term 'vulnerability' will refer to girls' and boys' susceptibility to contracting HIV.

VULNERABILITY FRAMEWORK

I have found the work of Mann and Tarantola helpful in analyzing vulnerability. They consider the vulnerability framework (1996:441) on three interdependent levels: personal /individual, programmatic and societal. Personal vulnerability provides a suitable framework for discussing HIV prevention in this study, since both boys and girls are vulnerable to HIV infection and need jointly to reduce their exposure to HIV in order to prevent infection.

The following section outlines the theoretical framework of the study, which is based on the theories outlined above, including Connell's (1987:53) theory of gender and power, feminist poststructural theory (Ritzer, 1992:505, Roseneil, 1995:200, Weedon, 1987:10), new masculinity studies(Kimmel, Hearn and Connell, 2005:180, Morrell, 1987:7) and a vulnerability framework (Mann and Tarantola, 1996:441) combined to create a new paradigm for understanding gender-power inequalities.

THEORETICAL FRAMEWORK OF THE STUDY

Figure 2 offers a diagrammatic representation of the principal theories guiding this study and the ways in which Conells's theory of gender and power, femininity, masculinity, and vulnerability overlap to generate a view of how these theories converge within Zulu culture, heterosexual relationships, and the HIV and AIDS epidemic. In the diagram, the model provides a framework for the understanding of gender inequality and directing further examination of this in sexual relationships. Theories of feminity and masculinity and theories related to vulnerability are linked in the model to offer a single view of social constructed femininity and masculinity amongst Zulu school-going boys and girls.

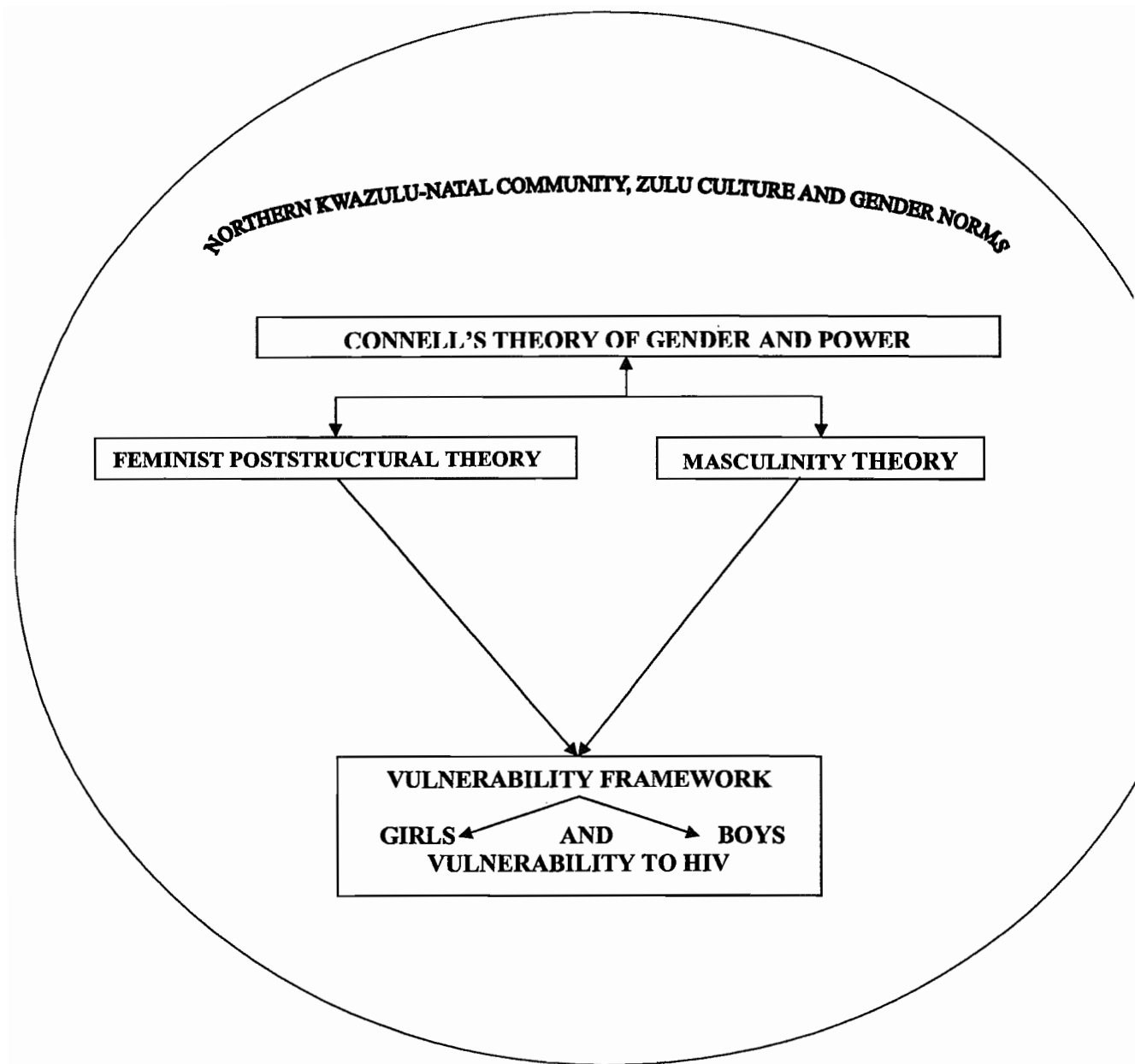


Figure 2: A DIAGRAMMATIC REPRESENTATION OF THE THEORETICAL FRAMEWORK OF THE STUDY

Figure 2 above shows a gender–power inequalities in the form of a triangle, with the flat top representing Connell’s theory of gender and power, one side representing feminist poststructural theory and the other side representing masculinity theory and the apex pointing at the vulnerability framework representing vulnerability of girls and boys to

HIV, all surrounded with a space in a circle representing the northern KZN community and Zulu cultural norms. This model of gender-power inequalities provides a framework for an historical view of the evolution of gender-based relationships among school-going boys and girls.

Recent literature (Kimmel, Hearn and Connell, 2005:180; Shisana and Simbayi, 2002:5; Gupta, 2003:3) suggests that relationships between males and females are heavily influenced by female subordination and male domination in sexual decision-making. These views, however, lack a comprehensive perspective on the unique power relationships between males and females in Zulu culture. They are shaped by the unique historical aspects of South African culture, the complexity of Zulu cultural norms and roles, and an understanding of male and female empowerment as a dynamic concept. In the model, feminist theories have been found to be structured around several fundamental dimensions: gender differences, gender inequality, and gender oppression (Ritzer, 1992:458).

The model of gender-power inequalities includes these concepts with the aim of understanding what shapes male-female relationships and sexual decision-making in Zulu youth. It acknowledges that these gender-power imbalances are not fixed but are subject to change as they are socially constructed. The main purpose of conducting the gender-based HIV prevention intervention programme among school-going girls and boys was to sensitise them to existing gender-power imbalances and encourage a mindshift towards a gender- equal respect in heterosexual relations.

The following sections will be based on this model that in turn, provides a framework for this study, driven mainly by a feminist poststructural theory perspective. The aim of this section is to examine and present a literature review of this study under the four themes including a number of culture-related issues, such as gender and identity, gender-power inequality and sexual decision-making, youth's sexual behaviour in relation to vulnerability to HIV and AIDS. We need to understand these themes in gendered terms, collectively. This section will further outline HIV prevention interventions conducted in South Africa for the youth.

GENDER, IDENTITY AND YOUTH'S VULNERABILITY TO HIV

This section will concentrate on examining gender as the main focus of the study. It will clarify the meaning and challenge categorical notions of sex and gender and constructions of youth's sexuality. This will assist in understanding the influence of gender-power inequalities as one of the impediments to HIV prevention.

Meaning of 'sex' versus 'gender' and youth's vulnerability to HIV

Gender, sex and sexuality were some of the terms discussed in the first session of the gender-based intervention programme conducted in the second phase of this study. The purpose of the first session was to address one of the objectives of this study: determining the perceptions of boys and girls regarding terms used in gender and sexuality issues. It was explained that 'sex' is a biological term, referring to the anatomical differences between male and female, and the reproductive practices which follow from them (Anselmi and Law, 1998:2). 'Gender', however, is a social construct, referring to the rules and norms which govern the behaviour of men and women. Whereas sexual differences between men and women will be the same in all societies, gendered differences may vary in different cultures. These matters will be further discussed in Chapter 5. Linked to the understanding of the term sex as relating to biological make-up of the individual's genitalia, the following section will briefly outline how the anatomy of girls' genitalia increases their vulnerability to HIV infection relative to the vulnerability of boys.

Biological make-up and increased girl's vulnerability to HIV than boys

While the gender-power imbalance between girls and boys is one of the factors that fuel the pandemic, biological factors also cause HIV infection rate to be higher in girls than boys. A girl's anatomical make-up predisposes her more to HIV infection than boys, because there is larger mucosal surface area exposed in the female genitals than in the male genitals. There are higher levels of HIV in semen than in vaginal fluids; the fact that women are recipients of seminal fluid, and more of it is exchanged during sexual intercourse than vaginal fluids, make girls more physiologically susceptible to STIs including HIV, than boys. In addition, girls often have untreated STIs, which make them

more likely to contract HIV (UNAIDS, 2002:10). Abdool Karim (1998:18) shows that although the root of young girls and women's vulnerability lies in the imbalance of power between boys / men and girls/ women, biological and sexual practices play an important role in increasing HIV infection in girls and women. Socio-economical factors related to the presence of poverty and unemployment also contribute to girls' higher vulnerability to HIV infection than boys.

Gender and identity

The way we view ourselves and the way that others view and treat us, is often influenced by our gendered position in society. In traditional Zulu communities, boys are socialised by their parents, family and community members to believe that girls are inferior to them and should be under their control. By contrast, girls are socialised to over-respect boys and act submissively towards them. In addition, in traditional Zulu community heterosexual relationships roles are assigned by community to males and females.

Typically men initiate, dominate and or control decisions about when, where and how to have sex with women. Women are expected to respond submissively to male sexual initiatives. The resulting unequal power relation particularly the girls' inability to negotiate sexual issues, increases a girl's vulnerability to HIV infection.

The South African population in 2004 was estimated at approximately 47 million, and an estimated 5.3 million people were living with HIV/AIDS by the end of 2003. This is said to be the highest number in one country in the world (Department of Health, 2004:6; UNAIDS, 2004:190). Fifty-one percent, approximately 23.8 million, of the population is female, and the overall growth rate of the population for 2004 to 2005 was about 0.9%, with the rate for females slightly lower than that for males (Gray, Govender, Gengiah and Singh, 2005:264). These figures show that women constitute the majority of the South African population, but their growth rate is less than that of males. This could be influenced by gender-inequalities, the biological make up of women and social, cultural and economical factors that promote their vulnerability to HIV and AIDS.

The provincial estimates show that KwaZulu-Natal has the largest share of the national population (20.6%), followed by Gauteng (19.2%) and Eastern Cape (15.0%), while the Northern Cape remains the province with the smallest share of population

(1.9%) (Gray, Govender, Gengiah and Singh, 2005:264). It has also been acknowledged that the pandemic in South Africa is gendered, because women comprise approximately 56 percent of people living with HIV/AIDS, with the largest group of women in the age group of 15 to 34 years (Roche, 2000:1; Whiteside and Sunter, 2000:2). The findings of the above studies show that gender inequality is one of the many factors that contribute to the promotion of the spread of HIV infection.

Gender is only part of our identity. In addition to gender, we are also known by other social categories: race, social class, ethnic group, religion and age. These categories of identity may be related to gender. In order to understand the impact of gender and other social categories on identity and the HIV and AIDS pandemic, it is important to recognise that gender, sex, ethnicity, race and class are based on history and culture and are related to positions of privilege and power in our society (Anselmi and Law, 1998: 6).

My study focused on HIV prevention in the context of gender and in relation to cultural identity, not on issues of race and class. The latter are beyond the scope of this study. However, since gender and power and feminist theories form the foundation of this study, the issue of gender and power in Zulu culture will be examined in the following sub-section.

Issues of gender, young women's bodies and reproduction

The purpose of this section is to examine the association of culture, gendered power inequalities and other social categories on identity and the HIV and AIDS pandemic. The work of Connell (1996:70) has shown that culture, social practices, body, sexuality and reproduction are interrelated. This section will also assist in laying the foundation of one of the research questions of this study: "Which set of their community's role expectations and or prescriptions do young people know, listen to, adopt and practice in their relations and sexual decision-making within the context of gender?"

South African, and particularly Zulu culture is male-dominated, with women accorded an inferior position and lower status in the community than men. Gender power-inequality and the inferior position of women, their bodies and their reproductive choices, are part of other factors that will be examined. Cultural norms and values are constantly shifting. These norms and values are conveyed from generation to generation through the

socialisation process and render young girls more prone to HIV infection than boys of the same age group. The very narrative of a coherent Zulu culture is a male narrative used to justify men's privileged position. However, Zulu culture, like other cultures, is not static, and can change.

Connell (1996:71) has explained that gender is a set of social practices that, amongst other things refers to bodies and what bodies do in relation to reproduction. These practices are not be a fixed set of biological determinants defined by bodily structures. Rossi (1985: 161) one of the feminist pioneers in sociology, argues that gender differentiation is not simply a function of socialisation or patriarchy but is also grounded in the fundamental purpose of reproducing the species.

The importance placed on fertility and the birth of children is likely to have a negative effect on the promotion of safer sex and may increase the susceptibility of girls to HIV infection. This is especially true in rural areas, in one of which I conducted the study, focusing on high school-going boys and girls in northern KZN. Traditionally, in South Africa, and particularly in KZN, biology was fused with culture to regulate young women's femininity and status in society, but it has changed now. In support of this view, Mager (1996: 13) argues "The gendering of girls was tightly tied to biology, more especially their capacity to bear children". Young women were rendered visible only through their fertile bodies and fertility or ability to conceive was, and still is a highly prized aspect of femininity. This remains the case, particularly for women living in rural areas (Preston-Whyte and Zondi, 1989:13, Morrell, et al., 2002: 13, Upton, 2001: 20, Harrison and Montgomery, 2001, 20).

Even today, as an African woman who is rooted in the Zulu culture in KZN, I know that the failure of a newly married girl to conceive causes her mother-in law to be concerned and to call the bride "*inyumba*" meaning unable to conceive. She may advise her son to marry another wife who will give birth to a number of children, particularly boys who will grow up and carry the family name. This view will be conveyed to young people and practices based on traditional Zulu culture are likely to shape their sexual behaviour, as young girls would be expected to prove their fertility and thus increase their vulnerability to HIV infection. Most boys use tradition and culture to justify their power

and control of women's bodies as well as their domination of sexual decision-making and girls generally agree that this power is vested in boys (Thorpe, 2002:63).

However, in this era of the HIV and AIDS pandemic, conceiving a child carries a risk of HIV infection (Morrell, et al., 2002:13). I challenge the exaction of proofs of women's fertility because it perpetuates notions of patriarchy and fails to take into account that marriage and sexual activity should be based on love, and not only on women's reproductive role. I realise that this may not be a universal understanding, and some would argue that the notion of love is itself culturally constructed. In Zulu culture, a woman is not encouraged to marry another man if her husband is infertile, or to have other male partners. She is currently still required to stay and support her husband, no matter what happens in their marriage. However if "*umakoti*", the bride, is infertile her life becomes miserable and her husband will be encouraged to marry another young girl who will give birth to children who will inherit their possessions.

The aim of applying my knowledge and practice of the Zulu culture in the above section is to clarify the background of the Zulu culture with the aim of assisting in understanding the cultural background of the boys and girls who participated in this study and also to determine their perceptions of sex and gender as part of the foundation of the first research question and one of the objectives of this study.

African women's struggle against gender inequality and female subordination takes complex forms. Analysts are just starting to evaluate the different kinds of agency and struggle emerging in African women's lives in the wake of HIV and AIDS. For example, the behaviour of women in Churches and in civic organisations such as Treatment Action Campaign (TAC) shows their ability to resist.

Zulu women's struggle is grounded in the culture with which I am familiar, and tends to be linked with sex roles, relationships and the research question of this study. Zulu women make an association between their bodies, reproduction and household activities, but this is capable of changing with time. Mikell (1997: 7) argues that "Nature or reproduction appears to have pushed women towards domestic activities" The same author, further argues that, on the contrary, men are encouraged to take on responsibilities requiring greater power, aggression and decision-making skills in the realm of culture, sexual matters, family roles, military tasks, economy and politics (Mikell, 1997: 7).

The reader must be aware that there are debates on different feminist views between Western and African feminists. Some African feminists contest the validity of a Western feminist approach and ask to what extent Western feminist constructs can be applied to African situations. African women argue that “what it means to be African women differs radically from the increasingly anti-naturalistic conception of women in industrialised Western countries” (Mikell, 1997: 8). Like many Westerners, Africans including Zulus tend to fuse nature and culture in their traditional conception of men and women’s roles.

Africans are aware that gender roles are changing as culture itself is not fixed but dynamic. For example, many African, including Zulu women now have employment outside the home, so they are no longer confined to the kitchen, and urban families are growing smaller. However, African women are often concerned that Western women seem to exaggerate the gender inequalities of African heterosexual relationships, and Western feminists are often troubled that African women take their reproductive task too seriously (Mikell, 1997: 8). Additionally, these Western feminists draw on the work of ‘black feminists’ like Patricia Hill Collins. In her body of work and that of many black feminists, Patricia Hill Collins (cited in Anselmi & Law, 1998: 6), opposes the reduction of individual identity to any particular social category. She treats these aspects of identity as interlocking facets of social oppression, arguing that the categorising of individuals into either black or white, male or female, poor or rich promotes false dichotomies that reduce complex identities to superficial characteristics (Collins, cited in Anselmi and Law, 1998: 6).

I concur with Collins’ view that using rigid binaries to try and make sense of the fluidity of identity can result in serious analytical errors and may promote the oppression of marginalised individuals. For example, young girls who are socially oppressed and powerless in terms of sexual decision-making are more vulnerable to HIV infection. Caution must be exercised in importing western feminist categories; but I also acknowledge the use of many of these categories, such as class, sex and gender systems which reinforced indigenous ideas and their power such as Christianity, with its patriarchal narratives and explanations, can form a patchwork quilt of patriarchies.

It is beyond the scope of this study to give the reader in-depth details or to elaborate on the extent and implications of this debate, which will not be examined further, because the focus of the study that I conducted was, not on the issue of race but gender-based HIV prevention.

GENDER-POWER INEQUALITIES, SEXUAL DECISION-MAKING AND HIV AND AIDS

This section will address issues of sexual decision-making and one of the research questions is: “Which set of their community’s role expectations and or prescriptions do young girls and boys know, listen to and adopt to the constructions of sexuality and practice in their relations and sexual decision-making within the context of gender?”

Studies conducted in South Africa and other countries have shown that certain personality characteristics are encouraged in girls and women living in patriarchal societies (Harrison, Xaba, Kunene and Ntuli, 2001; Taylor, et al., 2002; Varga, 1997). Such characteristics as passivity, submissiveness, compliance and dependency on men are harmful for women as they place them at a higher risk of contracting HIV than men. Some studies describe the role of gender inequalities in heterosexual relations and the impact of these factors on young girls’ level of risk and their inability to make sexual decisions and negotiate for safer sex (Harrison, 2002:43, Varga, 1997: 43, Varga and Makubalo, 1996: 4).

Young women find it difficult to exercise their sexual rights and this may be influenced by the ideology of ‘feminine girls’, who are socially constructed by society. Smith (1991:3) asserts that women need to assume the attributes and roles traditionally considered to be masculine, such as assertiveness, self-esteem, decision-making and independence, if they are to survive and remain healthy and safe. In support of this view UNAIDS (2002:26), argues that in many cases certain socio-cultural factors also limit women’s control over their sexual lives. These socio-cultural factors include cultural beliefs and practices, gender inequality and male dominance in heterosexual relations, sexual violence, stigma and discrimination, poverty, commercialisation of sex, and misconceptions about HIV and AIDS.

In many instances sexual intercourse occurs without negotiation between partners but is decided by the male partner who believes he has control over the female's body. A major United Nations study has shown that many women remain powerless and unable to make sexual decisions or to exercise control over the circumstances and this situation makes them more vulnerable to HIV infection (UNAIDS, 1998:4). Gupta (2000:5) claims that gender-power inequalities favour men and boys or men have greater control over girls or women, particularly in sexual-decision-making.

Some studies have shown that most women dare not ask their male partners to use condoms during sexual activity as they are afraid of being suspected of being unfaithful or abandoned by their male partners (Abdool Karim, 2001:1, Abdool Karim, Abdool Karim, Preston-Whyte and Sankar: 1992:10, Jewkes, Levin and Penn-Kekana: 2003:125). Cultural norms and practices related to sexuality such as refusal of condoms as well as difficulties in negotiating for regular use of condoms promote the risk of HIV infection. Multiple sexual partners and the importance of fertility in African communities may hinder the practice of safer sex. In addition, urbanisation and migrant labour exposes people to new cultural influences that may result in the erosion of certain African traditional values that could serve to protect young girls and boys from HIV infection such as abstinence from sex before marriage. Such factors pose a challenge for preventive strategies as efforts to reduce HIV and AIDS epidemic are directed at all South Africans, especially the youth. Areas for action include redoubled efforts to empower girls and women with the information, skills and methods they need to reject unsafe sex and negotiation skills.

Not all risky sexual encounters are coerced or occur as a result of male dominance and violence; some are consensual. Researchers exploring gender identities and femininity have suggested reasons for the occurrence of such behaviour (Morrell et. al 2002:13). These reasons will be examined in Section 2.5 of this chapter under the heading 'Construction of Femininity and Sexuality in Girls'.

I recognise that inequalities play a role in promoting the spread of HIV in complex ways. Women differ in their personalities, as do men and it is not always the case that boys have all the power and girls have none. An increasing number of research projects in

KwaZulu-Natal show that girls are not merely victims. High levels of unemployment and an inadequate welfare system have lead to widespread poverty which renders young people, particularly girls, more vulnerable to contracting HIV. The daily struggle for survival overrides any concerns people living in poverty might have about contracting HIV. The influence of poverty on girls' sexuality and sexual activity will be outlined in the following sub-section.

The impact of poverty on sex and sexuality; the agency of young girls

In addition to gender-inequalities, young girls are also anatomically and socio-economically more susceptible to STIs and HIV than boys of the same as group. Sexual activity is often associated with gifts, and some young girls' low socio-economic status pushes them to have sexual relationships with older men. (Leclerc-Madlala, 2001:3). Research findings (Abdool Karim, 2002: 13, Leclerc-Madlala, 2001:3, Leclerc-Madlala, 1997:12, Bassett and Mhloyi, 1991:2, Varga and Makubalo, 1996:13) have indicated that some young girls' low socio-economic status leaves them with no option but to agree to have sex with older men.

There are however different schools of thought regarding this. Hunter, (2002:1) and Silberschmidt (2001:3) argue that girls choose to exercise their sexual agency in a context of material deprivation. These girls receive gifts from the older men, who are called 'Sugar Daddies', in the form of small material items: clothes, cash, cell phones, and cars. Hunter (2002:1) quotes a 20 year old boy, Bongani, in Northern KwaZulu-Natal saying " Sugar Daddies work at the firms that pay a lot. The girls can never stay without *qoming*, (choosing a lover) them, because if they don't *qoma* they won't get things like money, cell-phones and clothes."

Young girls in such situations are more vulnerable to sexual abuse as they might face violent behaviour from their partners. In addition, they have little or no power to negotiate safer sex and run a high risk of contracting HIV infection, as older men are more likely to have had multiple sexual partners and are more likely to be HIV infected than younger men (Morrell, Moletsane, Abdool Karim, Epstein and Unterhalter, 2002:12, Shisana and Simbayi, 2002:58, UNAIDS, 2004:68, UNAIDS and WHO, 2004:4). Girls

and young women who become infected with HIV by 'Sugar Daddies' then infect boys and young men, who in turn infect other young women.

I have carefully reviewed the literature relating to gender and identity, gender-power-inequalities and sexual decision-making in relation to youth and HIV and AIDS above. This leads us to the following section, where literature on the next theme, that of sexuality, will be considered. A number of complex and culture-related issues in relation to youth and their vulnerability to HIV and AIDS will be considered.

SEXUALITY, YOUTH, HIV AND AIDS

In order to understand how HIV infections occur we must understand how young heterosexual people relate to one another and then to try and intervene to modify the processes which occur when young people develop sexual relationships.

Young people who were the population of this study make up a significant proportion of the population of South Africa. People below the age of 19 years constituted half of the South African population of 44.8 million in 2001 (Statistics South Africa, 2001:8). School-going youth was the population of the study that I conducted. Approximately 11.2 million learners were enrolled in public schools in 2002, with 4 million of these learners enrolled in secondary schools and 7.2 million learners enrolled in primary schools (Department of Health media release, 2005:1).

My study was conducted in 2002 as I will explain in the Methodology Chapter. In 2006, 12 million learners were enrolled in public schools, out of these 4.5 million learners were enrolled in secondary schools and 7.5 million learners were enrolled in primary schools (Media release, 2006:1). The total number of learners who were enrolled accounted for 5.7% of the total South African population, estimated at approximately 47.4 million (Statistics South Africa, 2006: 6). The estimated population of South Africa differs according to the specific years when the census is done. The above population statistics are significant as the study that I conducted in 2002 was among the school going youth.

Meaning of sexuality versus sex

My discussion of sexuality begins with the acknowledgement that there is a difference between sex and sexuality. The literature that will be reviewed will help to eliminate the confusion that exists about the meanings of these terms. These terms were discussed in the first session of the gender-based intervention programme conducted in the second phase of this study. This was done as part of addressing one of the objectives of the study, to determine the meaning of terms used.

In English the term “sex” is complex: sex was, and to an extent still is used to indicate whether a person is male or female. The term also refers to the act of intercourse (Devenish, Funnell and Greathead, 1992: 106). Sexuality on the other hand includes the social aspects of people’s lives, their feelings and attitudes, their physical body, as well as the way they walk, dress and behave. Sexuality also influences their beliefs and values, their relationships decisions, as well as determining sexual attraction (Devenish, Funnell and Greathead, 1992: 107). Anselmi and Law (1998:254) support the above views by claiming that sexuality refers to how people are regarded in terms of either female or male, the way they dress, their behaviour, attitudes and relationships.

The following sub-section will briefly examine the construction of girls’ and boys’ sexuality through the development or making of ‘feminine’ girls and ‘masculine’ boys. Such sexuality constructions are part of the cultural and gender norms and societal expectations socialised in young people at an early stage. While some constructions of sexuality have positive benefits, for example in Zulu culture, such as “*ubuntu*” referring to humanity, associated with good morals such as abstinence and being faithful to one sexual partner, “*inhlonipho*”, meaning respect, by contrast others are dangerous, such as promotion of gender inequality among young boys and girls, which influence them to engage in risky sexual behaviour and thus be more susceptible to STIs, including HIV infection.

CONSTRUCTIONS OF SEXUALITY, SEXUAL DECISION-MAKING AND HIV AND AIDS

The literature reviewed in this section will help to clarify the understanding of how young girls' and boys' sexuality is constructed. I will focus on baseline data regarding youth's awareness, and perceptions of the complexities of gender, sexuality issues, HIV and AIDS.

Constructions of sexuality are gendered and occur as part of the process of socialisation from childhood of girls and boys. Maker (1996: 15) asserts that gendering is constructed for young Africans from a cultural ideal pattern and individual lives are mapped out and divided into stages on the basis of biological sex and age. Similarly, in African culture the construction of youth's sexuality differs according to the constructions of femininity and masculinity.

Gender norms are contested and dynamic, not monolithic. In the case of the study that I conducted, youth are operating in contexts where there are many divergent gender norms operating: some dictated by 'traditional Zulu culture', others dictated by peers; others, by South African's human rights culture and existing AIDS discourses.

Gender norms are socially constructed by the community in relation to a particular culture. They often determine how men and women are supposed to behave in relation to sex and sexuality. Whitehead (2002:162) asserts that sexualities are never simple biological facts, although some people protest that they are. Amongst many others, she has argued that sexuality is diverse, confusing and culturally informed.

Gender-power disparities are linked to the theories of gender and power and masculinity forming the conceptual framework of the study. They are characterised by male-domination of sexual rights, in a way that limits young boys' and particularly young girls' ability to understand the complexities of gender relations and the expression of sexualities. It also influences their vulnerability to HIV infection and prevents them to achieve responsible decision-making about the ways to protect themselves from HIV infection (UNAIDS, 1998:3).

Constructions of girls' femininity

In Zulu culture, young people were traditionally made sexually aware at a young age. This was usually done, in the case of girls, not by their parents, but by older female relatives or siblings known as '*amaqhikiza*' who used to guide young girls. *Amaqhikiza* were elder girls/women who have known boyfriends who have given them what is called '*Ucu*' as a sign of having accepted their proposal for love and might then marry them. Boys would be educated by older men. Catherine Burns (1996:80) argues that in the past, Zulu society had different strategies for sexual control. The following sub-section will examine these different strategies for sexual monitoring and will look at other roles played by *Amaqhikiza* to guide girls' sexual practices.

Strategies of constructing femininity

This section focuses on the strategies that shaped the construction of femininity. It will draw mainly on feminist theories, as outlined in Section 2.2. These strategies were used to monitor girls' sexual activity to prevent pregnancy and also to prevent HIV. This section will also highlight how important these strategies were historically. They were obeyed, particularly when Zulu people were a rural people but are contested in the 21st century. In addition, literature reviewed in this section will clarify what implications these strategies have for my study.

The construction of femininity for girls was central to female bodies and their changes (Mager, 1996: 15). In Zulu society in KwaZulu-Natal, the body changes and sexuality of young girls' traditionally were carefully monitored by their mothers and *amaqhikiza* (Khuzwayo, 2000: 50). This happens from puberty until 21 years old or the early twenties if a woman is not yet married (Riley, 1988:1, Morrell, et al., 2002:15).

The role of *amaqhikiza* was to educate and guide young girls on love-related matters and on how to practice *ukusoma*, that is, non-penetrative thigh sex, with their boyfriends and/or their girlfriends as well. Burns (1996:81) supports this view by arguing that *amaqhikiza* would instruct young people on how to practice non-penetrative sex between the thighs of the woman partner, called '*ukusoma*' and also on other forms of sexual play as means of exercising sexual control to promote abstinence and unwanted pregnancy. The issue of *ukusoma* could be applicable to girl friends and their partners as

well in the 21st century because not all girls are heterosexual, but in the traditional and current Zulu culture it was and is still applied specifically to heterosexual girls. Other strategies that were implemented by '*amaqhikiza*' will be examined below.

Virginity testing

Virginity testing is one of the strategies employed by *amaqhikiza*, as part of their construction of girls' femininity.

The following section will be based on the gender and power and feminist theories forming the framework of this study. It will also lay the foundation of this study by addressing one of the research questions: 'What are the roles of stakeholders in HIV prevention within the context of gender?'

Are *amaqhikiza* part of the stakeholder group? In African, and particularly Zulu culture, they are stakeholders and have a role to play in the monitoring of young girls' sexual activity. They conduct virginity testing, known as '*ukuhlolwa kwezintombi*' by performing a physical examination to check if the young women's hymen, known as '*iso*' is still intact. That would prove that they were still virgins or were not sexually active. The aim of monitoring the sexual activity of girls was to delay the onset of sexual activity. Together with '*ukusoma*' it is expected to assist in preventing unplanned teenage pregnancies and is also assumed to be a strategy for preventing HIV infection. However, virginity testing is a controversial, gendered and debated issue. The procedure of virginity testing, as well as the awarding of certificates for the girls who are found to be virgins is explained by Khuzwayo (2000:50).

Some isiZulu-speaking people still promote virginity testing. I would like to indicate that I will revisit the controversial and gender politics of virginity testing as it will be examined later, in this section. Once a year, young women are called by the Zulu King to come together at Enyokeni Royal residence to celebrate one of the biggest socio-cultural gatherings called '*Umkhosi Womhlanga*' (Khuzwayo, 2002:73). One of the main aims of '*Umkhosi Womhlanga*' is to enable young women to undergo virginity testing aimed at promoting good morals in young girls, such as abstinence prior to marriage and also to prevent heterosexual transmission of HIV infection.

Although the practice of virginity testing for girls is believed to have originated in KwaZulu-Natal and remains most popular among Zulus it is increasingly practiced outside KwaZulu-Natal. Eastern Cape women's and children's rights organisations report the use of virginity testing among Xhosa communities where girls are examined by a committee of women and those girls who have remained virgins for two years are awarded certificates (George, 2007:13). Virginity testing is also practiced by certain African Kingdoms that offer gifts to young people who remain virgins. One example is the Buganda Kingdom's plan of stopping the spread of HIV by advocating virginity testing for girls and virginity monitoring for boys (Ssebunnya, cited in the *Sunday Tribune*, 2002:12). Ssebunnya notes that those who remain virgins into their early 20s will receive gifts to launch them into adulthood. The gift would be a few heads of cattle for men and it would be a refrigerator or a stove for women. In this way the African tradition will be used as a tool to stop the spread of HIV (Ssebunnya, cited in the *Sunday Tribune*, 2002:12). However, this forms part of the controversial and gender political aspects of virginity testing which will be examined in the following section.

The controversial and gendered politics of virginity testing

Virginity testing arguably violates gender equality. The provisions of the South African Constitution recognise that everyone has the right to bodily and psychological integrity, meaning that everyone has the right to make decisions concerning reproduction as well as the right to security in and control over their body. Virginity testing as presently practiced in South Africa impedes the free exercise of these rights (Leclerc-Madlala, 2001:3). The South African Commission on Gender Equality (CGE) opposes the practice and argues that virginity testing constitutes another form of the violation of women's rights (Leclerc-Madlala, 2001:3). In her research on this area, Leclerc-Madlala (2001:3) argues that virginity testing reinforces patriarchy as it serves to divert attention away from the need to explore the lack of male sexual responsibility. Burns (1996:81), supports the above stated views by arguing that the practice of virginity testing does not promote gender equality because it is only performed on young women and not on young men.

One of the girls in a KwaZulu-Natal protest march in July 2005 indicated her support of virginity testing (Scorgie, 2006:19):

“The commission on Gender Equality claim that they speak on behalf of all women but what about us? We want virginity testing to be made legal as it is part of our culture. (Nomagugu Ngobese, cited in Lindsay Barnes and Maokgodi Seabi, ‘Virgins oppose testing ban’, Natal Witness, July 15, 2005).

The underlying aim of virginity testing may be good, as it may promote abstinence until marriage, and help in the prevention of unplanned teenage pregnancies and could contribute to the reduction of HIV infection among young people in the communities where it is practised (Scorgie, 2006:20). It must however be doubtful that the prevention of HIV was a purpose, since the practice of virginity testing predates the pandemic. Some Zulu women promote virginity testing as a way of empowering the girl child to say no to sex, teaching her to take care of her body. The belief that virginity testing may provide a culturally appropriate solution to a myriad of problems, including the AIDS epidemic, is shared across various levels of the Zulu and other ethnic groups. Many rural women see virginity testing as the only way to re-instill and sustain self-respect, self-determination and pride (Khuwayo, 2000:11).

As a Zulu woman, I know that virginity testing for girls ‘*ukuhlolwa kwezintombi*’ is a Zulu cultural practice, that was done in the past and it is being revived with the aim of preserving girlhood, known as ‘*ubuntombi nto*’. However, I argue that it is a cultural practice that should be reassessed, as it promotes the deeply embedded notions of gender imbalances and violate women’s rights. This is because its purpose is to encourage girls to abstain from sexual activity until they get married, while boys are not monitored. After 1994, South Africa became a democratic country where the equal sexual rights approach is promoted, which according to Klugman (2001:15) promotes shared respect and gender equality, particularly in sexual decision-making, that could help to prevent HIV infection. I also believe that virginity testing is one of the cultural practices that promote women’s oppression and reinforces patriarchy for the reasons outlined below.

The inspection of girl's genitalia for the presence of hymen or '*iso*' that will prove that she is a virgin is done by an elder woman in the presence of her female relative/s who may be invited to observe. No privacy is provided for the girl being examined. By contrast, males are not tested for virginity or are tested on a very small scale. For example Khuzwayo (2002:12) documented that the testing techniques of males' virginity included older man observing the boy urinating in the air and the power with which a boy urinates will indicate whether he is a virgin or not. If urine shoots up straight in the air the boy would be considered to be a virgin but if urine sprays over a wide area it means that he is sexually active (Khuzwayo, 2002:12). Such virginity testing for boys is not invasive compared to the way it is done on girls and it is also subjective and inaccurate.

There is much less emphasis on socialising boys to delay the onset of their sexual activity. Instead, male sexuality is generally valued and encouraged by peers and older men: boys may initiate sexual activity from twelve years of age (Preston-Whyte and Zondi, 1992:10).

My question is, what will happen if a young girl who has preserved her girlhood gets married to a boy, who was '*isoka*', meaning having many sexual partners, and who did not practice '*ukusoma*' but was having unsafe sexual activity? Surely this will promote the spread of STIs including HIV.

The social forces operating on adolescent girls convey the cultural message that males are the more valuable and are expected to be more competent in sexual matters than girls (Anselmi and Law, 1998:256). I strongly concur with the views of Morrell and his co-authors (2002:15) who argue that virginity testing imposes solely upon girls and women the responsibility of halting the epidemic without taking into account the inequalities of gender power which place women at risk of contracting HIV infection during unsafe sexual activity, such as rape.

In addition, I argue that the results of virginity testing could have either positive or negative effects. If the results of virginity testing are positive, they could bring joy and pride and could have a positive impact on the girl and her family members because girls who pass the test are identified by a mark on their foreheads and they also receive a certificate. This identification of girls who are found to be virgins is good, but it also has a negative impact as they are exposed and made vulnerable to the risk of being raped by

HIV positive men. South Africa has one of the world's highest statistics for rape due to the spread of the false myth that having sex with a virgin cures HIV/AIDS. Girls who fail the test may be stigmatised, causing them psychological trauma and other psychological problems such as low self-esteem and depression.

If virginity testing was also done regularly on boys and was done publicly in the same manner as it is done on girls it would still be in conflict with their rights to privacy. It might be argued that if both boys and girls underwent virginity testing, it could in both cases delay the sexual debut, and help to prevent HIV infection. As a health professional, and a mother who also has a daughter and a son, I would be happy if the practice of both girls and boys virginity testing could be done by elders who are trained and know what they are looking for, with the informed consent of a boy or a girl older than 16 and with an awareness of privacy, anatomy and universal principles of hygiene and precautions against infection. These principles were reported to be lacking in the practice of virginity testing for girls before Clause 12 of the Children's Bill of Rights was passed by Parliament in December 2005 (Scorgie, 2006:21).

Morrell and his co-authors (2002:13) argue that girls do not thoroughly understand their sexualities and thus have little or no ability to resist the patriarchal discourses that allow men to determine the conditions of sexual activity (Morrell, et al., 2002:13). I tend to agree with their views and argue that even if young girls know about their sexuality and their sexual rights, they lack not only the knowledge but also the assertiveness to negotiate safer sexual practices with their male partners who dominate sexual decision-making.

In Zulu culture, young women were given minimal opportunities to air their views. They displayed their femininity through body signs: degrees of nakedness and firm breasts, type of dress or attire (Magwaza, 2001:25, Mager, 1996: 15) Although Mager is writing about Xhosa society, there is a similarity between the two: Xhosa culture has cultural values and norms that are similar to those of the Zulu culture (Magwaza, 2001:25 and Mager, 1996:15). George (2007:13) reports that virginity testing for girls is also being practiced in provinces outside KwaZulu-Natal, such as the Eastern Cape which have a large Xhosa community. Most boys use tradition and culture to justify their power and control of women's bodies as well as their domination of sexual

decision-making. Girls generally agree that this power is vested in boys (Thorpe, 2002:63). Even though culture has changed, this notion still exists, this means that girls are exposed to risky sexual behaviour and are more vulnerable to HIV infection than boys.

Constructions of boys' masculinities

Having outlined how the bringing up of 'feminine' girls and their sexuality occurs as well as some factors that increase their susceptibility to HIV, it is vital to recognise and acknowledge that boys are also vulnerable to HIV infection, but in a different manner. The following section will draw on masculinity theory as one of the theories on which boys' sexuality is grounded. I shall briefly examine how masculinities and the construction of boys' sexuality are promoted by culture and gender norms and roles that also serve as factors that make them vulnerable to HIV infection.

Boys are also at risk of HIV infection but in a different way to girls in a patriarchal society. The socialisation process is not obvious, automatic and singular but it is fluid and subject to change, as it is contested and shaped by different kinds and routes of socialisation. Gender roles, the roles that society expects boys and girls to play, differ from culture to culture. In Zulu culture boys are expected to be strong and brave, not to cry and to initiate relationships and to make decisions at home. Zulu girls are traditionally expected to be submissive and to respect boys as their partners and were also expected to have no say in sexual matters. However, the latter has changed slightly. This facet of traditional culture has come under attack in an age of democracy that discourages any forms of discrimination and a society where gender equality is promoted. However, there is a clash of 'norms': the Zulu norms versus the modern democratic norms.

Youth may be able to enforce gender roles among their peers and are influential in stressing the importance of conforming to set gender roles. For example, Zakwe (2005:144), in his article on the raising of a Zulu man, states that he was about five years when he realised that he was 'a man'. He explained that he was taught by his peers that he was not supposed to confide in a woman over male-related issues but should sort his problems out with men. He was told that men and women are different for a reason, "It was a God-given right for men to be different and therefore dominate women" (Zakwe 2005:144). He was told to adapt to a set of rules, behave in a certain manner and do

things to prove his manhood. He argues that it was important to be part of the group and he conformed to the peer group norms (Zakwe, 2005:144).

Peer and socialisation pressures and the desire of young people to conform to youth culture, pushes boys to initiate full sexual relations with multiple partners and encourages them to prove their masculinity in non-negotiable contexts. This renders them vulnerable to contracting HIV infection. The previous section emphasised the girls' risk, but I do not mean to disregard the risk run by boys (Varga, 2001:3). In the rural areas and in certain religions, such as the Nazareth church, males are encouraged to be polygamous, have multiple sexual partners as part of their African, and more particularly, their Zulu culture. In Zulu culture, a male with many girlfriends is known as '*isoka*' and is highly respected as being a 'real man' (Zakwe, 2005: 145).

If a male has multiple sexual partners, he is at greater risk of contracting sexually transmitted infections including HIV, and can also infect his sexual partners. Hence the effects of being '*isoka*' in the era of HIV and AIDS tragically plays out at the many funerals in areas where men who used to be known as '*amasoka*' are buried by their friends who used to envy them for their ability to attract women (Hunter, 2005:217).

After having outlined the section above that examined constructions of girls' and boys' sexualities and the complexities of the Zulu culture, the next section will examine previous studies as well as the sexual behaviour of young people in relation to HIV and AIDS.

YOUTH, SEXUAL BEHAVIOUR, AGE OF SEXUAL DEBUT, HIV AND AIDS AND PREVIOUS STUDIES CONDUCTED ON YOUTH IN SOUTH AFRICA

This section will have its foundation in the theories forming the framework of this study as outlined Section 2.2. It will also assist in providing the background to the two research questions of this study 'What are the sexual practices of boys and girls in relation to sexual decision-making and HIV prevention?; 'Does an increase in HIV and AIDS knowledge influence the sexual behaviour, number of sexual partners, and safer sexual practices, such as use of condoms during sexual activity?'

This section starts by briefly outlining factors that are likely to shape the behaviour of boys and girls in sexual activity. Thereafter I shall focus on the findings of the previous studies conducted on the youth's sexual behaviour and the age of sexual debut.

When young people are sexually active they are vulnerable to sexually transmitted infections (STIs), including HIV, if they engage in risky sexual behaviour. Factors likely to shape boys' and girls' engagement in risky sexual behaviour at an early age are developed socially and we need to understand them collectively in gendered terms. In addition to gender-based factors there are other specific developmental issues, such as raised hormonal levels, that influence boys' and girls' engagement in risky sexual activity.

The youth's developmental stages as well as biological factors such as fluctuating hormone levels play a role in their behaviour (Harrison, 2005:20). Social, economic and cultural factors including gender norms, roles, gender-inequalities and stereotypes also contribute to their behaviour. Numerous factors that influence sexual decision-making and behaviour must be taken into consideration when developing HIV prevention interventions.

Young boys and girls in adolescence are characterised by rapid development and transition from childhood to adulthood. This transitional stage means that they are faced with life challenges and normative demands typical of their age and requiring guidance and counselling (Lens, Herrera and Lacante, 2003: 122). Youth is characterised by an increase in hormonal levels that turn young people into sexual beings. High levels of hormones further influence them to experiment with various things, including risky sexual behaviour. They perceive this behaviour as being a sign of their independence, personal control and responsibility. They find themselves faced with new situations and demands for an autonomous lifestyle, with little or no adequate preparation (Sunmola, Dipeolu, Babalola and Adebayo, 2003: 38). Young boys and girls have not yet acquired new capacities to handle the challenges and thus expose themselves to risky behaviour.

Both boys and girls are required to make decisions about their futures, including education, occupations, sexual and family life. There is a Nguni idiom often used in the isiZulu language which says "*Umthente uhlababa usamila*" (Reddy et al., 2003: 7),

referring to a type of strong grass with sharp thorns capable of pricking and injuring people from the time they are being developed. This isiZulu expression is often used to caution the youth not to engage in risky behaviour while still young because it has serious complications and may impact on their lives. Increased sexual awareness is part of the characteristics of development of the youth. While this is a normal process, it is often characterised by experimentation, which has the potential of exposing the youth to the complications of risky sexual behaviour, the consequences of which persist into adulthood. This is grounded in the Vulnerability Model as outlined in the theoretical framework of this study in Section 2.2.

The youth of South Africa, like in other countries, are often exposed to risks which may promote unprotected sexual activity that lead to unplanned teenage pregnancies and sexually transmitted infections, including HIV (Reddy et al., 2003: 51). Most of these risk behaviours are preventable, hence the focus of the study I conducted was on sensitising the girls and boys to gender-based life building skills.

The HIV epidemic is gendered. While it infects both young boys and girls, girls have consistently been found to have higher prevalence rates of HIV infection than males. A research study on age and gender differences in HIV infection, conducted in rural KwaZulu-Natal (KZN) in 1992, demonstrated that HIV infection is about four times higher among young females than among young males, especially between the ages of 15 and 25 years (Abdool Karim, Abdool Karim, Singh, Short and Ngxongo, 1992b: 1540). A study conducted in Kenya in 1998 supports the findings of the KZN study, revealing that the prevalence of HIV infection among women aged 15 to 19 was 23% whilst it was only 3.5% among young men of the same age (UNAIDS, 2002:26).

Young people tend to become sexually active and experience the complications of unprotected sex at a young age (UNAIDS, 2002:69). Youth's engagement in sexual activity is not explained by biology but by gender, socialisation and sexual identity. Around the world, the timing of sexual debut differs.

The timing of sexual debut can be explained by social interactions and value systems, all of which are gendered. My study will look for explanations as to why South Africa has a young age of sexual debut and high HIV infection levels.

The following section will examine the findings of the previous studies conducted on the youth's sexual behaviour and age of sexual debut.

Young people begin sexual activity at a relatively early age. Some begin before the age of 15, they have multiple sexual partners and they do not use condoms regularly enough to ensure their protection from HIV infection (UNAIDS, 2002:70).

The age of one's first sexual experience is an important indicator of sexual risk and is a key indicator for monitoring responses to the HIV epidemic among boys and girls (Gregson, et al., 2002:1897, Harrison, 2005:259).

A research study was conducted in a rural subdistrict of KwaZulu-Natal in 2003, among 314 young men aged 15 to 24, of whom 62.7% were sexually active (Harrison, Cleland, Gouws and Frohlich, 2005: 259). The findings of this study (Harrison, et al., 2005: 260) revealed that 13.1% of 15 to 24 year old men had experienced sexual debut before the age of 15. Of these men, 3.5% of them reported having had their sexual debut at 12 years and or younger. Some of the reasons for early sexual debut stated by young men included peer pressure and needing to assert their masculinity (Harrison, Cleland, Gouws and Frohlich, 2005: 259).

The Medical Research Council (MRC) was commissioned by the National Department of Health of South Africa to undertake a 'youth risk' behaviour survey in 2002. A total of 10 699 learners participated in the survey of which 54% were females and 46% were males, enrolled in Grades 8 to 11 in public secondary schools in the nine provinces of the country (Reddy et al., 2003: 27). The results of this survey revealed that 41% of learners reported having had sex. For 14%, the age of first sexual activity was younger than 14 years. Significantly, more male learners (50.1%) admitted to this than female learners. The numbers for females varied in the provinces from 9.9% in North West province to 19.1% in Gauteng. Among the learners that reported to having already had sex, 54% had had more than one sexual partner, with significantly more male (66.4%) than female learners (38.1%). Seventy percent reported having had sex in the past three months, with no variation by gender but some in the provinces, from the lowest, 62% in the Free State, to the highest, 77.8% in KwaZulu-Natal (Reddy et al., 2003: 27).

Among those learners who reported having had sex, only 29%, with no variation by gender, reported having used condoms consistently. This rate varied between provinces, 38.8% being the highest, amongst North West province learners to 14.5%, significantly lower than the national average, for learners in KwaZulu-Natal. Sixteen percent of learners who have had sex reported having been pregnant or made some one pregnant. Overall, the national prevalence of learners who reported that they had received education regarding HIV and AIDS was 72% (Reddy et al., 2003: 54).

The findings of the survey show that for males the prevalence of early sexual debut was significantly higher than for females in areas such as that of having had sex, initiating sex at 13 years or younger, or having two or more sexual partners. These findings indicate that both boys and girls are at a high risk of contracting STIs, including HIV.

The findings of other school-based research studies support the findings outlined above. The study of the sexual behaviour of rural youth conducted with 387 boys and 514 girls attending two high schools in a rural area of Southern KwaZulu-Natal revealed that 30% of learners reported being sexually active, while 70% were abstaining (Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries, 2002:71). Of the above learners, 18% of the males reported having started sexual activity at 10 years of age, compared to 1.4% of the female learners. In addition, 33.5 % of males reported that they always used condoms, compared to 10.1% of the female learners. Of the sexually active learners, 53.8% reported having a single partner, 32.6% reported having multiple sexual partners, and 13.6% of learners did not answer the question (Taylor, et al., 2002:71).

The findings of the studies outlined above indicate that there were significant gender differences concerning sexual practices of school-going youth, at least as the different gender groups reported. The majority of boys reported that they were sexually active and that their sexual activity began considerably earlier than females. In addition to multiple sexual partners and low rates of consistent condom use, some learners reporting to have been pregnant or having made some one pregnant. Both boys and girls, but particularly girls, are susceptible to risky sexual behaviour that increases their vulnerability to HIV.

The studies, outlined above, are similar in certain respects to the study that I conducted. They were also conducted in schools with both boys and girls participating in the study. I would like to make it clear that my study is not on the scale of these other studies. Taylor, et al's (2002:71) study was conducted in rural high schools in KZN, as was my study but neither of the earlier studies included the gender-based life skill building intervention that I conducted.

Research studies with different approaches and interventions have targeted the youth in South Africa. Most of the studies were aimed at determining the youth's knowledge of, attitudes and practices concerning HIV and AIDS. Some of the HIV prevention interventions have been conducted through the media while others were conducted in schools.

The following section will examine some of the HIV prevention interventions that are of relevance to the intervention that I conducted.

HIV PREVENTION INTERVENTIONS CONDUCTED IN SOUTH AFRICA FOR YOUTH

This section will start with an overview of HIV prevention interventions conducted for the youth in South Africa and will be based on one of the research questions: 'Does an increase in HIV and AIDS knowledge influence the sexual behaviour, number of sexual partners and safer sexual practices, such as use of condoms, during sexual activity?'

The research study that I conducted is in line with the national policy of expanding life-skills and HIV and AIDS education programmes. One such example is the *DramaAIDE* HIV and AIDS education initiative whose purpose is to create an awareness of HIV and AIDS and gender amongst learners in KwaZulu-Natal schools, using drama and performance (Dalrymple, 2000:1). Other examples of HIV prevention programmes that are conducted in partnership with the South African Departments of Health and Education include the following: Departments of Health's "Partnership against AIDS" initiative, "*Yizo Yizo*" television series, the television Life Skills programme entitled "Beyond Awareness", offered by Soul City and LoveLife.

This section will briefly describe some of these intervention programmes. Successes, strengths and weaknesses will be highlighted, especially for the life skills

programmes, Soul City and LoveLife as they have been evaluated. Furthermore, I have decided to select these HIV prevention intervention studies because they relate to the intervention that I conducted in this study. Lessons learnt from the HIV intervention research studies will be discussed later after reviewing these studies.

LIFE SKILLS PROGRAMME

This is a curriculum-based HIV/AIDS prevention programme in the formal schooling system. A programme of life skills has been developed as part of the Outcomes Based Education (OBE) “Curriculum 2005”, within the Life Orientation (LO) curriculum component. It provides learners with Life Skills and HIV/AIDS knowledge that equips them with the knowledge and skills to prevent HIV/AIDS. It was initiated in 2000 and targeted Grade 5 to 9 learners. In subsequent years it became mandatory for all grades and schools.

The Life Skills programme includes advocacy, educator training, care and support, monitoring and evaluation (Smith, 2002:5). The life skills intervention has an advantage of being delivered as part of the school curriculum and therefore reaching large numbers of learners during school hours and on a regular basis (Morrell, et. al, 2002:18). There have been some independent evaluations of the Life Skills programme. For example, Moroney (2002: 2) conducted a research project to evaluate teaching HIV/AIDS Education using the Life Skills Approach in two Durban area high schools. Her findings reveal that the programme was ineffective in the poorer and badly managed schools where the need for life skills was most pressing or needed.

The Life Skills programme, as with the other approaches that inform the interventions, such as the ‘Abstain, Be faithful to One Partner and Condomise” (ABC) as well as “Knowledge, Attitude and Practices or Behaviour” (KAPB) make school-going learners aware of HIV and AIDS. However, the Life Skills programme, as with the ABC and KAPB approaches, have limitations, such as the failure to include gender issues and to not translate the youth’s awareness of HIV and AIDS into behaviour change. The findings of many KAPB surveys demonstrate that most young people continue to engage in risky sexual behaviour even though their awareness and knowledge of STIs including HIV is high, thus lowering the interplay of factors that influence sexual decision-making

(Abdool Karim, Abdool Karim, Preston-Whyte and Sankar, 1992:82; Morrell et al, 2002:13).

SOUL CITY

Soul City is one of the two television series produced by the Johannesburg-based Soul City Institute for Health and Development Communication, a non-profit organization. The second television series, for younger viewers, is “Soul Buddyz” (Soul-City, 2005:2). Soul City is South Africa’s longest-running HIV/AIDS prevention intervention programme. According to David Jammy, head of Curious Pictures, a Johannesburg television production company, Dr Garth Japhet originated the concept behind “Soul City’s” in 1990. He was a medical doctor working in one of the clinics in Alexandra, a township north of Johannesburg, when HIV was becoming more common (“Soul City”, 2002:2). Dr Japhet teamed up with Dr Shereen Usdin to develop Soul City “a health education programme, which addresses common problems while exploring the cultural barriers that sometimes prevent healthy choices. The idea was to create television drama series, in conjunction with a corresponding radio series and print material” (Soul City, 2002:2).

The objective of Soul City is to bring about social change, largely in the health field; it also includes other health related matters such as economic issues and personal relationships. Soul City has already produced three series and has print media, television and radio campaigns broadcast in nine of South Africa’s 11 official languages (Soul City, 2002:2). Soul City covers the Life Skills programme and a wide range of health promotion areas, in addition to HIV and AIDS and its prevention.

The initial episode of Soul City focused on issues facing adults, youth and children, such as HIV and AIDS, maternal and child health, alcohol abuse and smoking. In 1999 “Soul Buddyz” was launched as the second educational programme of Soul City, tailored for children aged 8 to 12 years. Soul City Edutainer has also inspired similar programmes, such as *Yizo Yizo* a television drama that started in 1999, produced by the Bomb Shelter Company in Johannesburg, addressing issues facing students and teachers in township schools such as rape, murder, HIV and AIDS. In 2002 the South African Broadcasting Corporation’s education division commissioned *Tshatsha*, a series tackling

issues facing young people in the Eastern Cape; other such programmes are *Takalane Sesame*, a children's programme (Soul City, 2005:3).

Soul City is donor-funded and is one of the biggest multi-media edutainment programmes, currently funded in part by the Department of Health, the Department of Social Development and other government departments (Coulson, 2006:7). It is also dependent on international donors such as the European Union and the United Kingdom's Department for International Development (DFID) as well as corporate sponsors, including British Petroleum and the Old Mutual (Soul City, 2005:2).

Soul City would appear to have more strengths than limitations. One of the main strengths is its broad comprehensive subject matter. Furthermore, it targets both the youth and adults and conducts community-based interventions (Coulson, 2006:7). It also has print version that distributes information on HIV and AIDS.

One of the most valuable strengths of Soul City is its ability to develop a theoretical model known as "social and behaviour change model". UNAIDS (1999:5) reports that theory-led campaigns tend to be more successful and provide better evaluative data. In Soul City's model, the role of the individual is found at the centre of a set of concentric circles that represent the community, the social and political spheres. Advocacy is proposed as one major method to help exert change at all three levels of this model of "social and behaviour change" (Coulson, 2006:6). Soul City uses qualitative research techniques to evaluate its impact on the orientation of health services. The qualitative part of the research helps them to understand the target audience much better. Thili Shongwe, senior research Officer at Soul City, indicated that women reported that, "In our culture, women are supposed to endure abuse" (Soul City, 2005:2).

Soul City has won an award for its research methodology, television programmes and print material. Its programmes are now being exported across to SADC countries, including Mozambique, Namibia, Zimbabwe, Lesotho, Botswana, Malawi, Zambia and Swaziland (Cassidy, 2008:3; eAfrica, 2005:2). A study on achieving Millennium Development Goals (MDGs) for health, funded by the WHO indicated that a sustained change in behaviour is occurring among young people in South Africa, with regard to safer sex practices. South Africa's Department of Health in 2007 reported a fall in the number of under 20s infected with HIV, from 16.1% in 2004 to 13.7% in 2006 and a

similar fall occurred among 20-24 year old” (Cassidy, 2008:3). I used information from these resources to develop material for the intervention phase of my research study.

However, Soul City has been criticised for not having documented information on how extensive this impact is on service delivery as a whole (Coulson, 2006:8). Another major limitation of Soul City is its failure to include complexities of culture and gender sensitive issues in the interventions for HIV prevention. It is vital that the complexities of culture, gender relations and the status of women in relation to men in society and the influence of gender-power inequalities on sexual negotiation and decision-making should be included, since these may promote or hinder safer sexual practices aimed at prevention of HIV infection.

LoveLife

LoveLife has been South Africa’s largest national HIV prevention programme aimed at the youth. It promotes a healthy lifestyle, HIV and AIDS-free living among South African teenagers (Steward-Buchanan, 2005:2). LoveLife was launched in 1999, initially as a five-year strategy designed to reduce the rate of HIV infection by 50% amongst the youth aged 15 – 20 years old (Coulson, 2006:4). The major funding for LoveLife through to the 2005 period was from the United States-based Henry J Kaiser Family Foundation, the South African Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria. It also received funding from the Anglo American Chairman’s Fund, the South African Broadcasting Corporation, the Independent Media Group and approximately 20 other private corporations (Coulson, 2006:4, Steward-Buchanan, 2005:1).

LoveLife started Phase 1 with a series of billboards titled “Foreplay” followed by the payoff line “Talk about it”. The talk show LoveLife *JikaJika* and the toll-free telephone help line, which dealt with sexual matters amongst young people, were launched in Phase 2. In Phase 3, a second television series called *Scamto* was launched and a lot of the print media publications were printed to inform South Africans about the epidemic. LoveLife’s *LoveTrain* was implemented during the last phase. It travelled around the country and made stops in Cape Town, Durban and other smaller towns to spread the message (Coulson, 2006:14).

LoveLife has a number of strengths, including that of combining high-powered media HIV and AIDS awareness and education with the development of adolescent-friendly reproductive health services and other outreach and support programmes for hard-to-reach youth in poor communities (Coulson, 2006:3, Steward-Buchanan, 2005:2). The LoveLife HIV prevention programme is similar to the study that I conducted. It also was divided into different phases that including a skills building intervention phase. The study I conducted also included complex cultural and sexuality issues in all three phases. In contrast to the intervention that was conducted in my study, gender issues were not included in LoveLife campaigns, even though its campaigns targeted both girls and boys.

In 2004 LoveLife has come under increased criticism because the results of Phase 3 found that the mass media message in the billboards campaign was confusing to the youth (Coulson, 2006: 19). A panel convened by Global Fund in December 2005 advocated no additional funding for LoveLife because of the panels' concerns that LoveLife's programme did not meet its impact targeted goal to reduce HIV prevalence among adolescents by 50%. The panel found that there was an apparent lack of progress in slowing the epidemic between 2001 and 2004 (Makgetla, 2006:1). One of the research questions of the study that I conducted was: 'What is the ability of HIV prevention interventions to change youth's sexual behaviour?' The question is posed against the backdrop of continuing high levels of HIV transmission, as well as contradictory evidence about the changes in youth sexual behaviour, such as the rise of abstinence, increased use of condoms, and continuing levels of sexual violence in South Africa. The critiques seem to provide a negative answer to this study's research question, such as what was claimed by the panel of LoveLife reviewers, who indicated that there is an overall lack of progress in slowing the epidemic in South Africa among the youth, in 2001 to 2004 (Eleventh Board Meeting, 2005:24).

HIV PREVENTION RESEARCH STUDIES CONDUCTED IN KZN SCHOOLS

Studies have been conducted in KZN schools to integrate gender equality and HIV prevention interventions. Gender equality awareness and getting learners to commit to respect fellow human beings equally will promote free sexual decision-making and negotiation for safer sex. Morrell, Moletsane, Abdool Karim, Epstein, and Unterhalter

(2002:11) claim that integrating gender and HIV reduction interventions in schools offer opportunities to transform gender disparities and are more likely to achieve sustainable behaviour change. I strongly agree with their view and the intervention that I conducted was aimed at sensitising boys and girls to gender-based life skills with the aim of encouraging HIV prevention in the context of gender.

A study was conducted in 1999 by Harrison, Xaba and Kunene (2000:2) in two high schools in rural KZN. It explored gender and sexual decision-making among rural adolescent women in the era of HIV and AIDS. The findings of their study revealed the extent of male pupils' control in the domain of love and sex, where they had full control in the initiation of relationships and decision-making in sexual relations (Harrison, Xaba and Kunene, 2000:2). This study is similar to the first phase of the study that I conducted among the high school-going youth of KZN, which explored young people's understanding about of culture, gender and sexuality issues. Some of the HIV prevention programmes stated above formed the foundation of the study that I conducted. Most of them targeted the youth, particularly those that were conducted amongst the school-going youth and especially DramAidE, because it examined the HIV epidemic that affects young people and women more than men. By contrast, the methodologies that they used in their studies were different from those that were used in the study that I conducted among the school-going youth of Northern KwaZulu-Natal.

HIV PREVENTION RESEARCH STUDY CONDUCTED IN KZN SOCCER FIELDS

The Shosholozza AIDS project is another example of a gender-sensitive intervention. It was not school-based but targeted young African men who play soccer in KwaZulu-Natal. It focuses on attitudes to sex, encourages men to communicate with their partners about sexual practices and to, know and tell their partners about their HIV status. It uses soccer as a vehicle to target and involve men in HIV prevention interventions. Its decision to target men was based on the failure of programmes which targeted women and expected them to negotiate safer sexual practices with their partners to prevent HIV infection. These failed because most women lacked power in their relationships to make decisions on sexual rights (Makhaye, 1998: 93).

The targeting of men in the Shosholozza AIDS project was similar to the rationale of targeting both young men and women in the study that I conducted. As I have already indicated, I found that gender inequality played a significant role in decision-making. I found that women were powerless in making decisions, even those pertaining to their well-being and HIV testing without their partner's permission. Although it is essential not to overstate gender inequalities as one of the factors shaping the HIV epidemic, it needs to be balanced with other contributing factors such as the women's agency. Gender-imbalances must be understood in order to understand the impact of gender-power imbalances on the HIV and AIDS pandemic. Tallis (2000:59) argues that when one talks of gender-inequality, one is analysing the inferior position and status of women in relation to the superior position and status of men.

The HIV prevention interventions that have been outlined above show that much has been done with the youth to reduce the HIV epidemic in South Africa and particularly in KZN, where most of the HIV prevention programmes have targeted school-going youth. My assessment is that these HIV prevention interventions managed to increase the awareness of youth regarding HIV and AIDS. However, their high levels of knowledge did not translate into changes in their sexual behaviour as there is an overall increase in the HIV rates among the youth (Abdool Karim et al, 1992:82; Morrell et al, 2002:15; UNAIDS, 2002:72; UNAIDS, 2004: 10; Shisana and Simbay, 2002:15).

This assessment relates to my study where one of the objectives was to assess the baseline data including school-going youth's awareness of HIV and AIDS. It differs from the other interventions listed above, as its main purpose was to conduct a multi-session intervention programme to expose learners to gender-based life building skills in relation to HIV prevention.

As a follow up to the outlined HIV prevention programmes, the following section will look at what I have learned from these interventions, in relation to their successes and why these campaigns and interventions in some instances have not been successful.

WHAT LESSONS CAN WE LEARN FROM THESE INTERVENTIONS?: SUCSESSES AND WEAKNESSES

This section will review the literature to clarify lessons learned from the interventions and campaigns conducted so far in South Africa for the youth. I shall further address one of the research questions “Can HIV prevention interventions change the youth’s sexual behaviour?” The HIV prevention programmes that have been examined in the previous section have shown that programmes for young people do inform them as to their danger, even though they rarely change sexual behaviour. The HIV prevention programmes or campaigns which have been carried out in South Africa such as LoveLife, Soul City, life skills, as well as others that were targeting school-going youth, had some success as well as failures. I will summarise the main successes in order to reflect on gender interventions, how such successes and failures informed the approach of my study and try to answer the question of why these interventions in some instances have not been successful.

The main success of most HIV prevention programmes, such as those mentioned above is the one shown by findings of most KAPB surveys which demonstrate that these interventions have managed to produce a high level of awareness and knowledge of STIs and HIV and AIDS among the youth. However, that knowledge has not translated into behaviour changes: most of the youth continue to engage in risky sexual behaviour (Abdool Karim et al, 1992:82; Morrell et al, 2002:15; UNAIDS, 2004: 10). The study that I conducted therefore tried to go beyond simply generating or transmitting knowledge and involved participants in a programme of gender-based life skills in relation to HIV prevention.

Research studies reveal that the majority of the South African young girls, and more especially boys, are sexually active, and tend to have early sexual debut, multiple sexual partners and lack or inconsistent use of condoms (Reddy et al., 2003: 54; Taylor, et al., 2002:71; Thorpe, 2002:63; Selikow, Zulu and Cedras, 2002:24). However, while this is true, certain significant changes in sexual behaviour, such as increases in levels of abstinence have been reported by findings of other previous studies and surveys (HSRC, 2005:50; Makhaye, 1998:94).

A number of theoretical models which aim to reduce HIV risk behaviour have been proposed and are used for HIV prevention interventions. These theories have been grouped into two approaches according to the level of change achieved. Some approaches explain the individual level change in HIV risk behaviour and others refer to community level change (Peterson and DiClementia, 2000:4; Campbell, 2003: 183; Airhihenbuwa and Obregon, 2000:9; Ncama, 2004:53).

These theoretical models may assist in addressing two of the research questions in the study that I am conducting: Firstly, 'What is the ability of the HIV prevention intervention to change youth's sexual behaviour?' Secondly, 'Does an increase in HIV and AIDS knowledge influence sexual behaviour among boys and girls? Does it affect the number of sexual partners, and introduce safer sexual practices?'

The following section will examine the two theoretical approaches used for HIV prevention interventions where the aim is to reduce risky behaviour at the individual and community levels. I shall also discuss factors that shape failure to achieve change. In addition, as part of the process of determining factors that shape the failure of an intervention to achieve change, I shall ask whether the evaluation takes gender into account, if so how.

WHY DO HIV PREVENTION INTERVENTIONS FAIL

Research findings suggest that HIV prevention interventions that target individuals for risk behaviour change and are knowledge-based are likely to fail (Peterson and DiClementia, 2000:4; Campbell, 2003: 183). Such interventions fail because it is known that information alone cannot change people's behaviour (Morrell et al, 2002:15; UNAIDS, 2004: 12). Sometimes the information provided is difficult to understand and is irrelevant to the individual's needs and culture. The findings of KAPB surveys demonstrate that even if knowledge of STIs including HIV is high, many young people continue to engage in risky sexual behaviour (Abdool Karim, et al., 1992:9). In support of these findings, UNAIDS (2002:72) argues "even where knowledge has been substantially increased, 'knowing is not necessarily doing'. Many young people do not connect knowledge and risk perception with behaviour".

INDIVIDUAL LEVEL CHANGE INTERVENTIONS VERSUS THOSE PROMOTING COMMUNITY LEVEL CHANGE IN HIV RISK BEHAVIOUR

Interventions that produce individual change are inadequate in reducing risky sexual behaviour because they focus on a relatively narrow range of factors. Such factors determine sexual behaviour changes from an individual, linear and rational perspective but fail to produce the desired behaviour change (Airhihenbuwa and Obregon, 2000:8; Peterson and DiClementia, 2000:4; Campbell, 2003: 183; Fisher, Miscivich and Fisher, 1992: 16; Kirbi, 1992: 13; Morrell, et al., 2002:13).

The individual change level interventions do not take into consideration that sexual decision-making is influenced by a number of interrelated factors that are often beyond the control of an individual; for example, it may be based on the culture of the particular community. By contrast, HIV prevention interventions that promote community level change are more successful, as they aim to change the social context and cultural norms (Airhihenbuwa and Obregon, 2000:8; Campbell, 2003: 183; Kirbi, 1992: 13, UNAIDS, 2002:16). The authors cited recommend interventions aimed at community level behaviour change and community mobilization, which provide strategies on which success in the fight against HIV can be built.

HIV prevention programmes have maximum impact if they address the underlying factors that influence sexual decision-making. Most of the programmes outlined in the previous section have not been successful because they focus only on individual level change (Abdool Karim et al, 1992:82; UNAIDS, 2002:72).

Multiple theories to address the HIV risk behaviour and partnerships

Interventions often fail to achieve the desired aim of reducing HIV risk behaviour if they do not take into account that no single HIV prevention approach can be effective everywhere. Focused prevention programmes should include multiple components, developed in each case with the input from the targeted population, to address the specific needs of vulnerable groups and to take into account the numerous factors that influence behaviour change (UNAIDS, 2002:81). Recognition of multiple theories capable of addressing high risk behaviour, and partnerships between stakeholders are essential for effective HIV prevention interventions. Community level change requires

the systematic involvement of both youth and their community. Interventions should aim to break the silence around HIV and AIDS, as well as to eliminate stigma and discrimination, develop partnerships between society and government and involve all those affected by HIV and AIDS (UNAIDS:2002: 16).

Gender-inequality factors in relation to culture

Gender inequality is intertwined with culture and varies according to different cultures. HIV prevention interventions fail to achieve the desired HIV risk behaviour change if they do not consider the cultural context and do not take into account the role of gender inequalities. If they have a simplistic version of gender or think of gender as being about girls and exclude boys, they will fail. If boys are not theorized and involved in HIV prevention interventions, the results will be weak. In strongly patriarchal communities, such as that of Northern KwaZulu-Natal, where I conducted my study, the socialisation of boys often encourages them to prove their masculinities by having many sexual partners. They are encouraged to dominate women, particularly in sexual decision-making and this renders the women vulnerable to HIV infection (Zakwe, 2005:144; Hunter, 2005: 217).

In 'Summertown' (a pseudonym) the intervention that Catherine Campbell and her colleagues (2003: 183) conducted in the Gauteng province in South Africa, allowed her to explore the social constructions of sexuality. She highlighted many examples of community, cultural, and gender-related inequalities that rendered young people vulnerable to HIV. Campbell (2003: 184) further argues that the extent to which people have the ability to adopt new sexual behaviours and to safeguard their health is determined by the degree to which social circumstances support them in these challenges.

There are some HIV prevention interventions that targeted both boys and girls in KZN. One example is DramAidE, an organisation providing HIV and life skills workshops in schools through drama, using its programme 'Mobilising Young Men to Care'. DramAidE's belief was that realistic behaviour change will not occur without addressing gender and getting young men fully involved (Dalrymple, 2000:1; Thorpe, 2002: 61). The Shosholozha AIDS project is another example of a gender sensitive intervention, although it is not school-based but targets young Zulu men who play soccer.

Its decision to target men was based on the failure of programmes which targeted women only and expected them to negotiate safer sexual practices with their men to prevent HIV infection (Makhaye, 1998: 93). Other interventions that targeted school-going youth, similar to my study reveal the risks that boys and girls are faced with (Selikow, Zulu and Cedras, 2002:22; Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries, 2002:69; Harrison, Xaba and Kunene, 2000:2).

Millennium Development Goals

The 2006 Millennium Development Goals (MDGs) report (2006:14) from the United Nations, indicate that although HIV prevention efforts in some places are proving successful, but new infections, incidence of HIV continue to increase in South Africa.

HIV prevention interventions fail in changing behaviour and reducing HIV infection rates if they do not implement the recommended trends such as the eight Millennium Development Goals (MDGs) arising from the United Nations Summit of September 2000. These MDGs include the following goals: to reduce global poverty by half, reduce child and maternal mortality and improve maternal health, ensure environmental sustainability and develop a global partnership for development (MDGs Report, 2006:16). The total package is integral to success in HIV prevention and the alleviation of the impact of AIDS (UNAIDS, 2002:16; MDGs report, 2006:1). The MDG's sixth goal is about a worldwide commitment to halt and begin to reverse the global spread of HIV and AIDS by 2015. In addition the MDG goal three, like six, is relevant to my study it promotes gender equality and the empowerment of women by achieving primary and secondary-school education for all by 2015 (MDGs Report, 2006: 8).

Anselmi and Law (1998:237) advocate that a feminist model of power needs to incorporate a gender analysis of power and this sort of model would lead to the understanding of the dynamics of oppression and how internalised oppression of women creates barriers to equality between boys /men and girls/women. Feminist colleagues also question men's intentions when they focus on gender, and some worry about the patriarchal usurpation of women's studies initiatives (Canaan and Griffins, 1990 cited in Anselmi and Law, 1998:78). My study was influenced by the feminist framework, based

on the premise that girls are more vulnerable to HIV than their male counterparts in the same age group. The feminist framework is in line with the Millennium Development Goals (MDGs), particularly Goal 3 that promotes gender equality and the empowerment of women and Goal 6 that promotes reversing of the spread of HIV and AIDS and combating the epidemic by 2015 (MDGs, 2006:14).

CONCLUSION

Decisions about preventing HIV/AIDS are based on cultural and gender norms and roles that influence the individual's decisions in ways based on cultural expectations of society and sometimes beyond the individual's control. However, the intervention that I conducted in this study rests on the assumption that while an individual cannot change these expectations, s/he is constantly interacting with them and can change his or her own behaviour. Furthermore, social expectations are not fixed, but change with time, and there is more than one set of expectations. The big question is 'Which set of their community's role expectations and or prescriptions do young girls and boys know, listen to and adopt to the constructions of sexuality and practice in their sexual decision-making?' This is one of the research questions that the findings of this study will help to answer. I must acknowledge that the limitations of the HIV prevention intervention programmes that have been adduced to them over time, and have been outlined in this chapter, are new and were not yet reviewed when I started my study.

Because youth is our future, we need to ensure that they are protected from HIV infection by equipping them with all the relevant negotiation skills that will enable them to make informed negotiations and decisions about their own sexual values, health, and interpersonal relationships. The cultural practice of virginity testing for girls promotes gender imbalances that make women more vulnerable to HIV infection than men. This practice nevertheless is aimed at delaying sexual activity in both young boys and girls and may reduce risky sexual behaviour with the aim of preventing, not only unplanned teenage pregnancies, but also reversing the spread of HIV and AIDS by 2015 to achieve the target for MDG 6 to protect and save the youth and the nation.

Strategies such as sex education and sexual rights campaigns need to focus on conveying the culture of understanding of human and sexual rights, gender equality, self-

respect and respect for other people's rights as well as self control in sexual relations for the youth to be protected from HIV infection.

The following chapter will discuss the methodology of the study that I conducted.

CHAPTER THREE: RESEARCH METHODOLOGY

INTRODUCTION

This chapter describes the methodology used in this study. It includes a discussion on the sites and population of the study, the sampling technique and instrumentation, data collection and analysis, ethical issues, academic rigour and limitations of the study. In this study, the collection of data was divided into three phases, namely, the orientation, intervention and evaluation phases, and each had its own methodology, as will be outlined below.

WORK EXPERIENCE AS THE BASIS OF THE STUDY

This thesis is based upon my work experience as a Nurse-Counsellor over a two-year period from 1999 to 2000, when I was employed at the South African Medical Research Council (SAMRC) in Durban. The idea and motivation for conducting this study on gender-based HIV prevention intervention originated during this period.

In April 2000 I was employed by the Department of Nursing Science at the University of Zululand as the Co-ordinator of their Midwifery Programmes. This change in employment, from Durban South African Medical Research Council (SAMRC) to the University of Zululand occurred when I had already registered as a part-time student in the Centre for Gender Studies at the then University of Natal, Durban. In February 2000, as part of the theoretical background to my doctoral research, I studied the module Gender Theory and Politics, before registering for my PhD study. This module exposed me to the socially constructed notions of patriarchy and the struggle of women across the world to challenge these systems.

In addition, as an African and isiZulu-speaking woman concerned about the HIV epidemic, my health professional duties have convinced me to make a contribution towards the prevention of the transmission of HIV infection. I decided to do this through an action-oriented research project that involved the youth.

RESEARCH DESIGN

This study adopted both quantitative and qualitative approaches. A quantitative approach was used in the pre-test phase to determine base line data from participants prior to conducting the intervention phase. It was also used in the last, phase, which was the post-test or evaluation phase conducted after the completion of the intervention phase, in line with the seventh objective of the study. A qualitative approach was used in the second or intervention phase that forms the main focus of this study. It was in line with the sixth objective and purpose of the study as outlined earlier in Chapter 1. The theoretical framework of the study, as outlined in Chapter 2, guided the gender-based life building skills of HIV prevention intervention in the second phase, using action research method. Action research within a phenomenological design is a qualitative research method that guided the intervention phase of this study that involved the youth in the process of gradual change, as it will be outlined later in this chapter and also in Chapter 5.

The origins of phenomenology can be traced back to Husserl, “the fountainhead of phenomenology in the twentieth century” (Vanderberg, 1997:11). Husserl was a student of Franz Brentano who provided the foundation for phenomenology. Brentano is regarded as the first phenomenologists who stressed the “intentional nature of consciousness or the internal experience of being conscious of something” (Holloway, 1997:117). Husserl named his philosophical method ‘phenomenology’, the science of pure ‘phenomena,’ and he regarded realities as the absolute data from which to start (Kruger, 1998:28). Martin Heidegger is one of the students of Husserl who introduced the notion of interaction and exchange of ideas or discourse that exist between a person and her/his world and or environment or society surrounding that person. Heidegger’s phenomenology focussed on human experiences as they are lived (Taylor, 2001:653).

Heidegger and Husserl respectively explored the ‘lived world’ and their follower, Alfred Schults, extended their ideas by adding that “the human world comprises various provinces of meaning” (Vanderberg, 1997:7). Husserl’s philosophical phenomenology provided a point of departure for Schultz who focused on the ways in which ordinary members of society attend to their everyday lives (Schultz, 1970:315). The aim of phenomenological research is to describe the world as experienced by the participants in

the study in order to discover the underlying understanding or perceptions of a given phenomenon (Baker, Wuest and Stem, 1992:1355).

Phenomenology was chosen as a suitable design for this study because as a researcher I was concerned with the lived experiences of young people, boys and girls who participated in the gender-based life skills of HIV prevention intervention that was conducted in this study. The qualitative approach is associated with subjective descriptions of life experiences aimed at developing a greater understanding of the issues studied, such as gender issues in relation to HIV prevention that were considered in the intervention conducted in this study. The qualitative approach was also appropriate for this study because its purpose was to explore the perceptions of young people as participants and the meanings they attach to HIV prevention in the context of gender. I describe young people's experiences through descriptions which they provided, as they experienced the conditions being studied (Brink, 1999:119; Morse, 2002:18).

Polit and Hungler (1999:18) and Morse (1994:15) assert that qualitative research is used with an aim of producing an in-depth, probing type of enquiry used for phenomenon where little is known. My study, for example, was conducted among the learners of high schools in the Mthunzini District, which includes the rural and peri-urban areas surrounding the University of Zululand. Youth sexuality and the prevention of the spread of HIV infection in this district has not been researched in the context of gender power-inequalities.

Munhall (1998:336) explains that qualitative research refers to distinct modes of inquiry oriented towards obtaining, analysing and interpreting non-numerical data in order to understand the unique nature of human thoughts, behaviour, negotiations and meanings of specific and contextual features of the phenomena under study. This view is supported by Boxill, Chambers and Windt (1997:74), who describe qualitative research as an approach to data gathering, which comprises in-depth investigation of human perceptions, attitudes and experiences, as well as the associated processes and the contexts in which they occur.

The nature of this study, determined that qualitative action research design was the most suitable approach for the second or intervention phase of this study. Action research design, as will be discussed later in this Chapter, was aimed at enabling me as

the researcher to use a learner-centred approach that concentrated on obtaining data of a highly sensitive nature. The data collected constituted high school learners' perceptions, experiences and opinions in terms of gender, sexual decision-making, HIV and AIDS and HIV prevention.

As the researcher, I was therefore able to explore and focus on what was happening in the lives of individuals, what was important about their experiences and what alterations or changes could be made by determining their opinions about the prevention of HIV in the context of gender.

STUDY SETTING

Schools are learning centres which serve the broader needs of the community where boys and girls are educated on various issues including values and life skills. They may be good or bad influences on young people. Education provided to children in schools represents the main way of forming their aspirations for the future, while at the same time the school environment may re-inforce the gender-power related inequalities of the larger society (Harrison, 2003: 58; Mensch and Lloyd, 1998: 168). The association of schools with risky sexual behaviour is complex. The school environment may put young people at risk because it is the place where, specifically in the adolescent stage, that they negotiate their gender identities and explore their sexualities (Morrell, et al, 2002: 11).

I argue that by identifying patterns of risky behaviour that seem to re-inforce gender-power imbalances in heterosexual relations between school-going youth, we can at least cause them to question such patterns. The intervention conducted in this study was aimed at bringing about changes in young people's perceptions and attitudes that might, in the context of gender, assist in shaping their sexual decision making and willingness to undertake HIV prevention. Morrell, Moletsane, Abdool Karim, Epstein and Untehalter (2002:11) assert that schools are vital in publicising campaigns for promoting gender equity and for the reduction of HIV transmission. They further argue that school-based interventions offer an opportunity to transform gender relations in the greater community.

Schools were therefore chosen as the most suitable sites mainly because this study was focusing on a theoretical, gender-based intervention programme which would have

no clinical component. Schools were the only settings where young women and men could be targeted together on a weekly basis for three months. Though Youth clinics, hospitals, work places, churches, sports or play grounds, might have been available, it would have been difficult to find the same young women and men on a continuous basis for a period of three months. Schools also allowed me to obtain ethical clearance from the Department of Education, which is more difficult to obtain outside of an institutional setting.

Although there are many advantages in using schools as my setting, there were also disadvantages, such as the constraints of school hours: this intervention had to be conducted after school hours. Learners also constrained by public transport timetables forced us to adhere to a limit of two hours for each session of the intervention. The schools' timetables were another constraint: there were written examinations at particular times and sports on certain days. High school learners' hoped that the programme would involve T V drama, or debates with other schools: all this imposed limitations on my ability to gather data and work with the participants. Some learners thought that they might have an opportunity to be employed as HIV and AIDS counsellors: this was clarified and corrected at the time of recruitment.

Since I was new in the area, I had to find schools: I used the telephone directory to search for a list of high schools. I then contacted the secretaries of four high schools to make appointments to meet with the school principals.

RESEARCH SITES

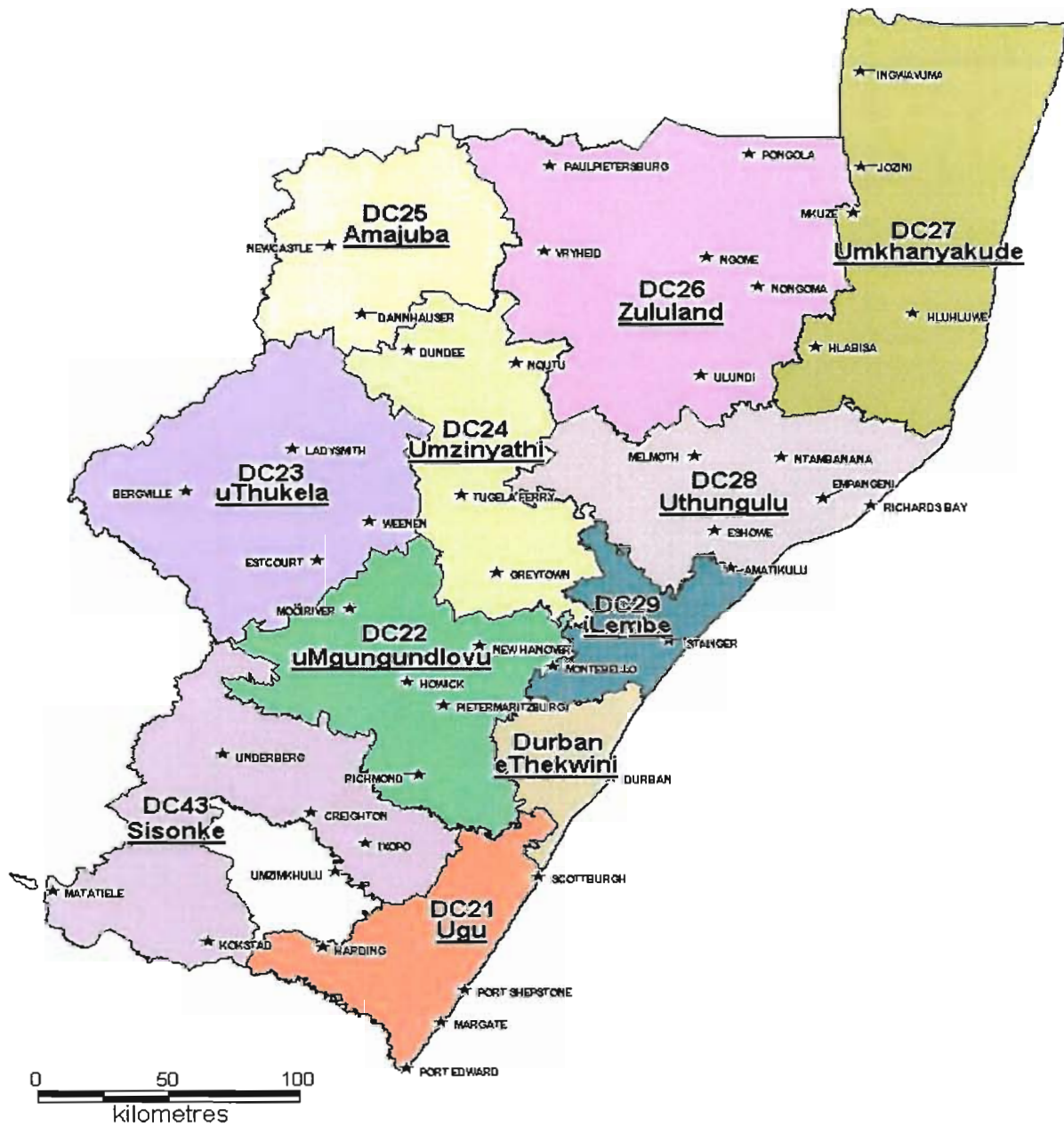
Convenience sampling was used to select high schools that were close to the University of Zululand, where I was then employed. This was to take into consideration my own time and financial constraints. Four high schools were identified between January and February 2001. They were in the *Mthunzini* District, part of *Uthungulu* District Council (DC), number 28 of KwaZulu-Natal health districts (Refer to Figure 3, a map of KZN health districts). Northern KwaZulu-Natal is approximately 200 kilometers from Durban, the largest city of KZN, across the '*Uthukela*' river that marks the boundary between Northern and Southern KZN., (See Figure3: Map of KZN Health Districts below).

KWAZULU-NATAL HEALTH DISTRICTS

Population - 9 070 457

Area - 92 440 Sq. km

Density - 98 People per Sq. km



One multiracial, historically advantaged white high school in the urban area of this district was identified, so that a representative sample should be arrived at. The administrative staff of this school was uncooperative and refused access to the principal. As a result no learners enrolled in urban schools participated in the study.

The high schools where permission was granted for my study to be conducted were situated in northern KZN, close to the residence of the royal family, in *Zululand* DC number 26 (see Figure 3). This area consists of rural, isiZulu-speaking communities who adhere to the patriarchal notions of Zulu culture. My reason for selecting four high schools was to reach out to as many learners as possible. It was not known how many learners would be interested in participating in the study and I wished to anticipate the possibility that some learners might decide to withdraw during the study, since participation was voluntary. I selected four high schools also to ensure that an adequate number of learners were recruited and retained so as to have a representative sample in rural and peri-urban areas. The representative sample was essential, especially for phases one and three where quantitative data was collected by means of self-administered questionnaires.

Appointments were made with the principals of these four high schools. Meetings were held in February 2001 in the high schools with the principals and selected staff members who were to act as liaison persons between myself as researcher and learners. I introduced myself and informed them of my profession, my area of employment and the plans I had to conduct the study. The purpose, ethical considerations, the proposed methodology, including the three phases, (the orientation or first phase, the intervention and evaluation phases), as well as the duration of the study were explained and discussed in these meetings.

The principals and their staffs were made aware that the study would only be conducted after the research proposal had been approved by the Higher Degrees and Research Ethics committee of the Faculty of Human Sciences, at the then University of Natal⁵ in Durban, where I was registered as a part-time student. I further explained to them that letters would be written to the school authorities, including principals and

⁵ The University of KwaZulu-Natal was formed on the 1st January 2004 as a result of the merger between the University of Natal and the University of Durban-Westville.

officials of the KwaZulu-Natal Department of Education and Culture, to request permission to conduct the study. In addition I explained that the study would be carried out after the Higher Degrees and Research Ethics committee of University of Natal had approved my proposal to conduct this study.

The principals and liaison staff welcomed the proposed study feeling that it was essential in this era of HIV and AIDS. Some principals even mentioned that “We get worried if we see learners who are pregnant because we are afraid of the possibility of those learners becoming HIV positive.” They also felt that all learners in their schools needed this study to equip them with life skills in relation to gender issues, sexuality, HIV and AIDS and particularly the prevention of the spread of HIV infection. Some indicated the need to extend this study to all learners as part of their guidance or life orientation classes, commonly known as “LO” which are included in the timetable as part of ‘Curriculum 2005. Curriculum 2005 is the brand name used to refer to the new South African national curriculum framework for schools that was intended to achieve full coverage of grades 1 to 12 by the year 2005. It is based on the concept of outcome-based education (OBE), introduced in Grade 1 in 1998 but implemented in 1999 due to delayed provincial governments’ budget constraints in the 1997/98 financial year (South African Education: 2004:6). The principals indicated that they were going to discuss the matter with members of their school governing bodies. The selected staff, ‘liaison teachers’ were approachable and were easily reached when necessary, through their school and mobile telephones.

The individual and community transformation approaches and various HIV prevention programmes, such as “abstain, be faithful to one partner, condomise” and “knowledge, attitudes and practices”, commonly known as ABC and KAP approaches, which had been tried with only partial success, were explained to the principals and liaison teachers as outlined in Chapter 2.

Pseudonyms have been used to represent the names of the high schools to ensure anonymity and confidentiality of information obtained from participants. ‘Thela High School’ represents one of the rural high schools, ‘Zintombi High School represents the second rural high school. ‘Drama’ High School and ‘Khono’ High School represent the peri-urban high schools. The first three were the historically disadvantaged high schools

of the area, whose buildings looked old even though they were well maintained. Khono High School was one of the new peri-urban high schools, offering technical subjects and skills. This was a suitable community in which to conduct this study. These young people had grown up in patriarchal societies, where gender socialisation of young women and girls may deprive them of their right to take control over their sexual health.

All the learners in these four high schools were Zulu and their mother tongue was isiZulu. Learners from other racial groups did not participate in this study. The sample included learners from Grade 8 to 11. Learners from Grade 12 did not participate in this study as none of them indicated an interest in participating in this study, possibly because they were busy preparing themselves for their final year's work and examination.

The most striking feature of the gender ethos which prevailed in the schools is its ability to reinforce gender stereotypes and to make schools masculine dominated environments. This is shown by the choice of leaders in these four schools. The former and the current principals and deputies as well as heads of departments were males. The exception to this was Drama High School, which was once headed by a female principal. Another important gender dynamic at the schools was that all the liaison staff were women. This seemed to be associated with the fact that women's traditional nurturing role was seen making them more suitable than men teachers, who were in leadership roles that included managerial skills. Whyld (1998:42) suggests that woman teachers are kept in an inferior position in the education hierarchy because the employers are reluctant to promote them and because they assume that married women may leave the school if their husbands are transferred.

Women in these schools often do not apply for higher level posts or jobs in another area. I shall argue that the different and unequal positions held by men and women teachers in the school education system are largely due to traditional gender power-imbalances and present patterns in the school. These patterns may have started to change following the affirmative action policy of the new constitution of 1996. This was evinced in 2005 when Phumzile Mlambo-Ngcuka was appointed Deputy President of South Africa, the first woman to occupy this position.

Thela High School is located in Vulindlela area and is adjacent to Zintombi rural High School. Thela High School is not far from the University of Zululand. It was

established in the late 1950s. The school boasts that one of its former principals was the Honourable Premier of KwaZulu-Natal in late 2001 and the whole of 2002. The municipal Ward Councillor at the time of data collection was a male as is the area's traditional leader. The school mainly serves learners from the rural areas or the outskirts of this municipality's boundaries, but it also draws learners from Uthungulu District Council number 28. It is a male-headed high school, and is a day school, attended by both girls and boys. The enrolment figures in 2001 were 645 learners from Grades 8 to 12.

Zintombi High School is located in Dlangezwara rural area, adjacent to Vulindlela. It is opposite the entrance to the University of Zululand, and approximately 0,4 km away from it. This school was established in 1969 and the first principal was a male, the former National Minister of Education. It falls under the jurisdiction of Umhlathuze Municipality and under Uthungulu District Council number 28. This school is under the jurisdiction of the same Municipal Ward Councillor and Inkosi as Thela Rural High School, because these high schools are adjacent to each other. Zintombi High School is a single sex-school boarding and day school attended only by girls from all over South Africa as well as *KwaDlangezwa* area. It is also a male-headed school, where the deputy is also male. It is not easy to assess this high school's socio-economic status. Because of the wide area it serves, it caters for learners who come from all walks of life and different backgrounds. The enrolment figures in 2001 were 795 girls from Grades 8 to 12.

Drama High School is a peri-urban high school located in Esikhawini Township. It is approximately 5 km away from the University of Zululand. This school was established in 1983 and the first principal was a female, who at the time of data collection was a member of the KwaZulu-Natal Legislative Assembly and the former KwaZulu-Natal Minister of Education. It also falls under the jurisdiction of Umhlathuze Municipality and under Uthungulu District Council number 28.

Drama High School is in a municipal ward that is currently under the jurisdiction of a male Councillor and, traditionally, under a traditional chief who is also male. This is a day school, attended by both boys and girls, in the peri-urban area of Esikhawini Township in northern KwaZulu-Natal. Some learners at this school were unable to pay fees because of the poverty of communities served by this high school, and a traditional reluctance to pay for girls' education. It was the only high school that had a female

former principal, but this did not make it any different from the other schools since at the time of data collection 2001 and 2002, it was a male-headed high school. The enrolment figures in 2001 were 1 295 learners in Grades 8 to 12.

Khono High School is another rural high school that is also located at Esikhawini Township, next to the Faith Mission Church. It is also not far from the University of Zululand, being approximately 5, 5 km away from it. This school was established in 1989 with the first Principala male, still there at the time of data collection. This school was established as a joint venture between the Education Department and Richard's Bay Minerals (RBM), a large company in the area.

Khono High School is supported in terms of buildings and equipment by Richard's Bay Minerals (RBM) Company. It adheres to principles of good conduct and discipline, offers a wide range of technical subjects and skills and achieves good results. It is also under the jurisdiction of Umhlathuze Municipality and under Uthungulu District Council number 28. It is under the jurisdiction of the same Municipal Ward Councillor and traditional chief as *Drama Rural High School*, since these high schools are both in Esikhawini Township. It is a day school and is the only technical high school attended by both young women and men, in the peri-urban area of Esikhawini Township and the whole of Zululand District of northern KwaZulu-Natal. Like the other three high schools, it is male-headed. The enrolment figures of its learners in 2001 were 969 learners in Grades 8 to 12.

SAMPLING METHOD

Purposive sampling, a type of non-probability sampling, was used to select the sample in this study (Brink, 1999:134). Various factors such as time and financial constraints constrained the use of any other kind of sampling.

The proposed research study was announced to the population of learners, including girls and boys. They were told that it was going to be conducted after school hours in a series of workshops and those interested were requested to indicate their interest to the liaison teachers. They were also promised that participation in this study would be safeguarded by anonymity, confidentiality. The age group would be 13 to 19 years. Those learners who met the selection criteria were required to submit informed

consent forms, signed by them and their parents or guardians, and outlining the study. Of these learners, 175 eventually took part in the study. The learners who did not show an interest in participating in the study were not given letters with informed consent forms since they had already indicated that they were not interested.

Purposive sampling was suitable for this qualitative study because it allowed participants to be selected, based on the judgment of the researcher regarding their suitability in age and their interest in the phenomenon being studied (Brink, 1999:134). I selected participants who were attending in one of the four high-schools. The sample was representative of high school learners: the participants were selected on the selection criteria outlined below. This was done to ensure that the quality of the data collected in this study would be high.

THE POPULATION AND SAMPLE SIZE

I chose to target youth because both young women and men are vulnerable to HIV infection and there is thus a need for them to be researched together. Zulu culture, highly gendered and male favouring, sits awkwardly with South Africa's new gender friendly constitution which promotes gender equality. Zulu culture generates gender-power inequalities and tensions within heterosexual relations. The theme of 'Zuluness' will be woven throughout this study and I will focus towards the end of Chapter 5 on Zulu linguistic and cultural features cited by the girls and boys during the intervention.

IsiZulu speaking boys and girls are likely to draw their identities and their subject discourses from the gendered Zulu culture in which they live, of which they are a part and to which they contribute. A consequence of this is that they receive, but do not necessarily accept, the messages of Zulu culture, but in their own gendered ways. The intervention that I implemented was designed to develop gender-based life skills in an approach that enabled me to interact with school-going girls and boys. I developed materials that made it possible to use combined methods such as focus group discussions, games and role-plays in this intervention, as will be outlined in Appendix 2.

Inclusion/ selection criteria

The youth that was included in this study had to meet the following inclusion or selection criteria: Girl or boy⁶ of 13 to 19 years of age, enrolled in one of the four selected high schools in Mthunzini District of Northern KwaZulu-Natal, irrespective of where their home area is located.

The participants had to show interest in participating in the study. They were given typed informed consent forms that they took and discussed with their parents/guardians at home. They then returned the informed consent forms signed by both themselves and their parent/guardian as proof that they were willing and were also allowed by their parents/guardians to participate in the study, which was conducted after school hours. The signed forms were returned to the liaison teachers who organised a meeting between the researcher and those learners who met the selection criteria. Participants had to be isiZulu speakers, because the study focused on the decision-making patterns of isiZulu speaking women, who found it difficult to make decisions on vital health matters such as HIV testing without their partner's permission which was the primary reason for conducting this study. The researcher's original question was "Does gender-power imbalances have any influence on youth's sexual decision-making and efforts to prevent the spread of HIV infection?"

There were a total of 3704 learners in Grades 8 to 12 enrolled at the four chosen high schools from which the entire sample was selected. The sample size of 175 participants, in the category 13 to 19 years old, was obtained during the orientation phase and maintained during intervention and evaluation phases of this study. The majority of participants, 108 (61.7%) were females; 67 (38.3%) were male. There were between 25 and 55 participants from each of the four high schools in Mthunzini District of Northern KwaZulu-Natal.

Overall, the sample consisted of 175 learners whose first language was isiZulu although English served as their medium of instruction as they were at high school level. Consequently, the questionnaires for collecting quantitative data in the first and the last phases, as well as instructions for collecting qualitative data during the second or

⁶ Though I am aware that the usages of 'girl' and 'boy' for post-pubertal individuals is controversial, I have decided to use these terms since the learners, recognising that they were still of school age, used these terms amongst themselves.

intervention phase of this study were in English. However, the research assistants and I had to give explanations of some of the English terms to learners since our mother tongue was also isiZulu. Very few learners required assistance with English terms since English was their medium of instruction. Further socio-demographic characteristics of the sample will be outlined in the next chapter.

RESEARCH PHASES AND DATA COLLECTION PROCESS

The data collection process was divided into three phases: orientation, intervention and evaluation, as shown in Table 3.1. Each had its own specific methodology. In the last or evaluation phase, I assessed the change that intervention programme had made in the participants' mindsets and sexual behaviour.

Table 3.1 Research phases and data collection process

Phases	Sample A single Group	Data collection Method / Instruments	Activities	Period of conducting each phase
First / Orientation Phase (quantitative)	175 girls and boys	Distributed Questionnaires	Baseline data collection (Pre-test)	First two weeks of August 2001
Second / Intervention Phase (qualitative)	175 girls and boys	Focus group discussions Games Role-plays	Intervention: gender-based skills building implementation	Last two weeks of August 2001 to the end of November 2001
Third / Evaluation Phase (quantitative)	175 girls and boys	Distributed the same Questionnaires as in first phase	Assessment of change after intervention programme (Post-test of the group as in first and second phases)	September 2002 To the end of October 2002

It was necessary, prior to conducting the intervention however, to conduct a baseline pre-test study. The data was collected using two instruments developed by the researcher, one for quantitative and the other for qualitative data. The collection of quantitative data initially took place during the orientation or pre-test phase using the questionnaire in the first two weeks of August 2001. Later, for comparative purposes, a further round of quantitative data collection was conducted in the evaluation or post-test phase, after the

intervention phase, using the same questionnaires as in the first phase⁷. Questionnaires are simple tools that also allow for testing for reliability and validity (Polit and Hungler, 1997), such as quantitative data, which was obtained during the pilot study prior to conducting orientation and evaluation phases of this study.

Data collection in the following section of this chapter was further subdivided into two main sections with different methodologies. The first section included research ethics, development of the questionnaire that was used as an instrument for quantitative data collection during the orientation and evaluation phases, as well as the pilot study. The second section focused entirely on the intervention phase that formed the main part of the action research of this study, academic rigour for qualitative approach and limitations of the study.

SECTION ONE

RESEARCH ETHICAL ISSUES

As a researcher I followed the injunctions of Brink, Morse and others and considered, and adhered to the fundamental principles of human research ethics throughout the study. These principles included respect for persons, and the protection of the participants' rights, mutual benefits shared between the participants and myself as researcher, and justice (Brink, 1996:39; Morse, 2002: 13).

The information pertaining to the study was explained to the KwaZulu-Natal Department of Education and Culture (DOE&C) and the school authorities, including school principals, by means of letters written to both groups, requesting permission to conduct the study. The information about this study was shared, on the initiative of the school principals, with their governing bodies. Information concerning the project and selection criteria were explained to the learners who had indicated that they were interested. I also explained to learners that, in addition to my professional nursing and midwifery experience, I am also a trained and experienced HIV and AIDS nurse-counsellor.

⁷ As shown in Table 3.1 outlining the three (3) Research phases and data collection process.

Learners whose close relatives or friends were infected with HIV were encouraged to discuss those issues with me privately on an individual basis. I also gave them my contact details and encouraged them to make arrangements to see me individually if they needed help with other personal issues. I further assured them that I would ensure that confidentiality and anonymity were maintained to protect their human rights. I explained to them that I would refer them to other experts if necessary.

Participants were discouraged from discriminating against those who happened to be infected with HIV but instead were encouraged to take care of them and support them. This was done as a precautionary measure to safeguard against stigmatisation of those learners whose close relatives or friends were infected by HIV. I gave a talk on “discouraging discrimination against people living with HIV and AIDS” to the whole group of participants, who afterwards broke into small focus group discussions. This was done on the first day, during the introduction section of the intervention phase in each high school. Two learners consulted me privately and discussed personal issues that were affecting them as individuals. I counselled them accordingly and they were grateful for that opportunity. One female learner indicated that she was afraid to discuss that information with any one, including her mother, as she was not sure how she would react. This kind of individual contact constituted an additional dimension characteristic of the intervention that I conducted.

All those involved—the Department of Education, principals, governors and participants—were offered information such as the identity and profession of myself as the researcher, the title and objectives of the study, the method to be followed, duration, the nature of the participation expected from each person during the three phases of the study, how the results would be used and the manner in which privacy would be maintained.

The purpose of the use of tape recorder, note taking and flip charts during focus group discussions, according to my planning and based on financial affordability, as well as the presence of at least two research assistants, was also explained. Participants were further assured that all information and records during the three phases of the study would be kept confidential. Tape recording was not used due to financial constraints since no funding was received for this study until the period when the report writing took place.

Anonymity was explained and maintained through out the period of research and writing the report by using numbers for participants and pseudonyms for schools, as well as in the eventual publication of the findings to ensure that data was not linked with their names or the names of the schools. All data and records were stored in a secure place and no one except the immediate research team had access to them. It was also explained that the learners had the right to decide whether or not to participate in the study and that they were had the right to withdraw from the study at any time, without penalty or prejudicial treatment.

The Higher Degrees and Research Ethics committee of the then University of Natal⁸, Durban Campus, approved the research proposal. Written permission was obtained from the KwaZulu-Natal Department of Education and Culture on behalf of the high school authorities, as well as by means of signed informed consent forms obtained prior to the study from learners who participated in the study and their parents/guardians.

INSTRUMENT DEVELOPMENT AND QUANTITATIVE DATA COLLECTION

The questionnaire was developed on a basis of reading in gender and anthropological literature as well as nursing and health care literature on HIV and AIDS. It was used to collect baseline data from participants during the first phase and was also used as an evaluation tool during the last phase. This was done to compare data that was obtained during the pre and post-test phases with the aim of checking for changes in the perceptions of participants.

The questionnaire, as an instrument for collecting quantitative data, had a space for writing the number of the respondent (to ensure anonymity) and instructions that guided participants on how to answer the questions. The questionnaire had closed- ended questions that required either a 'yes' or 'no' response. Spaces were provided for open-ended questions that required reasons for responses offered. The questions were written in simple English and were easily understood by participants. In addition, the two research assistants and I myself were available to clarify issues if necessary.

⁸ The University of KwaZulu-Natal was formed on the 1st January 2004 as a result of the merger between the University of Natal and the University of Durban-Westville

Self-administered questionnaires were conducted, with participants sitting at separate desks, answering individual questionnaire and were monitored by the researcher and research assistants. We were ready to give clarification to any queries raised by individual participants. The questionnaire (available in Appendix 1) gave participants the opportunity to express their own opinions and perceptions of HIV and AIDS and gender issues. It also had the advantage of giving participants time to think thoroughly about each question.

However, the self-administered questionnaire also had its disadvantages. For example, one of the disadvantages of the questionnaire of this study was its length, as it was too long and this might have impacted on the willingness or ability of participants to fill it in properly as attention lags when a questionnaire is too long. Part of the length was the result of my own belief that, since non-verbal cues to attitudes were necessarily absent from the written responses, respondents had to be asked to elaborate on 'yes/no' answers, and give reasons for their attitudes and perceptions.

The questionnaire was divided into four sections: Section A: socio-demographic data of the participants; section B: issues of gender, sexuality, culture and virginity; section C: relationships and sexual decision-making and section D: HIV, AIDS and prevention of transmission of HIV infections (see Appendix 1: Questionnaire with these sections). The quantitative data obtained using this instrument is related to objectives 2, 3, 6 and research questions 1, 3, 5, 6 and 7, as outlined in Chapter 1. The results of the data obtained in the first and last phases, through the use of this instrument will be presented in Chapters 4 and 6.

RELIABILITY AND VALIDITY OF QUANTITATIVE DATA

Validity is the ability of the instrument to measure the accuracy of what it is intended to measure (Burns, 2001:226). For example the questionnaire used to collect data during the orientation and evaluation phases was expected to determine the perceptions and attitudes of learners towards HIV and AIDS, gender, sexuality- virginity, culture.

Reliability is the ability of the instrument, such as this questionnaire to give the same results each time the same situation is measured in the same learners (Burns and Grove, 2001:227). Reliability, therefore, as noted by Selltiz, Wrightsman and Cook, cited

in Brink (1996:124), is concerned with the consistency, stability and repeatability of information and the investigator's ability to collect and record information accurately and repeatedly on the same participants.

In order to ensure validity and reliability, the questionnaire as the data collection instrument was piloted on learners from of the same four high schools. It was thus pre-tested and refined before use on the participants in this study. Furthermore, research assistants were trained, to ensure that they were able to interpret the questionnaire content. They were also able to give clarification to participants who required assistance. Therefore the pilot study, the first and the third phases of this study was designed to meet these objectives of validity and reliability of instrument design and quantitative data.

PILOT STUDY

The pilot study was carried out in the last weeks of July 2001, prior to conducting the orientation phase of this study. It was carried out over one day for each high school after school hours in closed classrooms in order to ensure privacy. Respondents completed the self-administered questionnaires. This was done to test the ability, of the questionnaire that was used to measure what it was supposed to measure. This was also done to eliminate ambiguities and identify the weaknesses of the developed tool and thus enhance the accuracy and validity of the data collected.

The developed questionnaire was tested on 17 learners who represented 10% of the sample. The group was composed of between 3 and 6 participants from each school, who met the researcher before the the pilot study was conducted on different days in each of the four high schools, prior to its use in the first phase. Ethical considerations were also observed in the same manner, as will be discussed below.

Discussions between participants during the self-administration of the questionnaires, which were distributed at the beginning of the session by the researcher, were discouraged. No discussions between participants ever happenThe questionnaires were collected at the end of the session of the pilot study by the researcher and the two research assistants, who were also trained during these pilot study sessions.The biographic data of the two research assistants, will be outlined later under the Orientation phase. The information obtained in the pilot study was used to modify the questionnaire,

though the data generated in this part of the study was discarded and was not included in the findings. The main changes in the questionnaire had to do with wording and question sequence. The pilot study participants did not participate in the actual study.

REFRESHMENTS

Refreshments were served to participants in the pilot study, and all the other three phases of the study as a gesture of hospitality, to relieve hunger and boost glucose levels of participants since these sessions were conducted after school hours. Refreshments were also given as a means of gaining access to the schools, building and maintaining relationships with participants.

THE ORIENTATION PHASE

An exploratory research design using a quantitative approach was used in this first phase. This was the orientation phase whose main aim was to introduce participants to the study. It was an exploratory phase, the objective of which was to obtain socio-demographics and biographic data. It also determined baseline data regarding the participants' awareness and perceptions of various issues, such as gender, sexuality, virginity, and other cultural issues, including relationships and sexual decision-making, HIV and AIDS and the prevention of HIV infection (Appendix 1).

This first phase was conducted in the first two weeks of August 2001, after school, over a single day in each of the four high schools and lasted between one hour and one and a half hours, including refreshments. It was conducted in closed classrooms to ensure privacy, and a total of 175 participants completed questionnaires. Ethical considerations were also prominent, as in the pilot study. Discussions between participants during the administration of the questionnaire were discouraged and the questionnaires were collected at the end of the session.

RESEARCH ASSISTANTS

The orientation phase and the other two phases of this study were conducted with the help of two research assistants, who assisted from the time of the pilot study and

throughout the three phases of this study. The pilot study provided them with an opportunity for training. They were given an opportunity to learn how to distribute, monitor and assist participants who had queries, as part of their training. This was part of their preparation for quantitative data collection in phases one and three of this study. They were paid for their assistance on an hourly basis out of the researcher's pocket since no funding or any financial assistance was received for the data collection during the three phases of this study.

To maintain their anonymity, the names of the research assistants will not be recorded and they will be known as research assistant A and B. Research Assistant A was 26 years old. She employed in a 'mornings only' position at the University of Zululand and was free after 13:00 on weekdays. s. She was from the KwaDlangezwa area and her home language was IsiZulu. She had matriculated at *Zintombi* Rural High School in 1993 and had a three-year Secretarial Diploma in Office Administration and a Degree in Bachelor of Arts (B.A.). She agreed to be a research assistant because sessions were conducted after school when she was already off duty.

Research Assistant B was 28 years old and was unemployed. She was from Esikhawini Township and her home language was also isiZulu. She had matriculated at *Mningi* High School in 1991 and had a certificate in Basic Sewing and a Receptionist's Diploma. She agreed to be a research assistant because sessions of this study were conducted after school and she was available at any time.

Refreshments were also served to participants of the first phase, during every session for same reasons as already stated. The first phase was completed successfully by the end of the second week of August 2001, with only a few interruptions due to sports, heavy rains and transport problems.

The intervention programme was conducted in the second phase of the study, using a qualitative approach and will be discussed later in section two.

The following section will be discussing the evaluation or third or post-test phase of the study that was conducted as the last phase, using the quantitative approach as the first or orientation or pre-test phase of the study.

EVALUATION PHASE

The third or last phase of the study adopted an evaluation research design, and is therefore called the evaluation phase, and used a quantitative approach. The evaluation phase was conducted. It lasted for two months, from September to October 2002. During this phase, the original same participants also completed self-administered questionnaires similar to those that they had completed during the orientation or first phase. These self-administered questionnaires were conducted with the help of the same two research assistants, in the same manner, with the same ethical considerations and in the same environment as explained above, in the first phase.

The third phase was conducted to determine the perceptions of participants regarding the same issues that had been addressed during the first or orientation phase of this study. Evaluation research design is an applied form of research that involves finding out how well a programme, practice, policy or procedure concerning any intervention that was implemented is working (Polit and Hungler, 1999:20). Brink (1999: 117) shows that three broad categories of evaluation research exist: the diagnostic, formative and summative evaluation research.

The summative evaluation was used in this last phase that was conducted nine months after completing the intervention phase to determine how useful the strategies utilised during intervention phase were. The purpose of this evaluation phase was to check for any changes in young people's perceptions on the same issues including sexual practices as already outlined in the first phase. It was conducted for the purposes of comparing data obtained during the first/ orientation phase and the last or evaluation phase of this study.

The aim of this evaluation or last or post-test phase of this study was to ascertain the youth's perceptions of about HIV vulnerability. It also assessed the individual's likelihood to choose actions or report their intentions to select safer choices and or report attitudes or behaviour changes.

The objective of this third or last or post-test phase was to assess the effectiveness of the various strategies used during the intervention phase to sensitise the youth about gender-based skills for HIV prevention. This was done in a series of workshops, by comparing the findings obtained during the first phase with those of the last phase.

The evaluation phase, like orientation phase, was conducted after school hours, over one single day in each of the four high schools, for one-hour to one and a half hours 30 minutes per session. It was again conducted in closed classrooms to ensure privacy, and where the same 175 participants completed self-administered questionnaires identical to those as those they had completed during the first phase. Ethical considerations were also observed and maintained in this phase, in the same manner as it was done in the pilot study and throughout the other two phases of this the study, as already explained above.

The questionnaires were distributed at the beginning of the evaluation session by the researcher and the two research assistants. Discussions between participants during self-administration of the questionnaire were discouraged and the questionnaires were collected at the end of the session of the third or evaluation phase.

Another area was used for those who had completed the evaluation phase questionnaire, where they had to wait to be served with refreshments and to be addressed by the researcher who also awarded individual participants with a certificate in as a token of appreciation for their attendance and participation in all the three phases of this study. I also gave learners, who participated in this study, copies of *Soul City: Living pPositively with HIV and AIDS*, which that came as a supplements to *Sunday Times* in 2001. These were written about contained basic information in isiZulu and English about HIV and AIDS basic information in isiZulu and English versions. These copies were given as a sign of appreciation to individual learners who participated in this study.

I further encouraged learners to use these *Soul City* (2001) copies for referral purposes and also to apply into practice the gender-based skills positively in their lives, especially in the area of their sexual health and their efforts to prevent HIV infection. In addition, I also encouraged learners to share HIV and AIDS information and skills gained from the intervention phase of this study with their peers, members of their families and their communities.

The evaluation phase lasted was conducted for two months, from September 2002 and was completed at until the end of October 2002, with few interruptions due to sports and transport problems and the end of the year examinations.

ANALYSIS OF QUANTITATIVE DATA

After the collection of data, I moved to UKZN, Durban, where the process of analysis of the quantitative data that was obtained during the first and third phases of this study was carried out. The process was done to make sense of this data and to come up with reasonable conclusions. Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS). Part of this was the Chi-square (χ^2) test which is a non-parametric test of statistical significance, that was done, carried out with the help of a statistician, to assess whether relationships existed between the two nominal variables levels of awareness – that which learners manifested in the orientation phase, and that of the evaluation phase (Polit and Hungler, 2001: 487). Polit and Hungler (2001: 488) claim that Pearson's value is the most commonly used correlation coefficient that was also used, with the help of a statistician, to designate the magnitude of relationship between two variables measured on an interval scale, and this was used to indicate the significance of the findings. (Polit and Hungler, 2001: 488). Data obtained from learners in response to the questions in Appendix 1⁹, were analysed using a Wilcoxon Signed rank test to determine and compare the HIV and AIDS knowledge scores obtained by learners in the pre-test or first phase and post-test or third phase. The results of this quantitative data obtained during the pre-test or orientation and post-test or evaluation phases will be presented in the following Chapters 4 and 6, respectively.

SECTION TWO

DESIGN AND PROCESS OF INTERVENTION OR SECOND PHASE

The intervention programme was conducted in the second phase and it was the major motivation for this research study. An action research, with a qualitative approach, within a phenomenological design¹⁰ was used mainly for this intervention phase

⁹ Refer Appendix 1: Questionnaire for first and third phases of the study Section D: HIV/AIDS and prevention of HIV infection.

¹⁰ As explained earlier under research design and latter in this section with reference to Schutz, (1970).

ACTION RESEARCH

Action research is social research in which, for example the young people who participated in the intervention phase were involved in a gradual process aimed at creating change and achieving transformation of attitudes and evaluated in the evaluation phase. Speziale and Carpenter (2002:14) assert that action research consists of four types: Cooperative enquiry, community-based action, participatory research and action science or enquiry. Cooperative inquiry is the first type, and values the full participation of individuals where both researchers and participants cooperate to derive new knowledge (Speziale and Carpenter, 2002:14). Participatory action research is the second type and was chosen to guide the intervention process of this study. The community-based action research is the third type, and values researchers' engagement with participants as equal partners (Speziale and Carpenter, 2002:14). Action science or enquiry is the fourth type of action research and is a form of inquiry into practice which focuses on identification of theories of action leading to the development of systematic change within an organisation (Speziale and Carpenter, 2002:14).

Action research with a qualitative approach was adopted as the most appropriate research methodology for the intervention phase of this study. It involved interaction between young people and researchers since action research involves participants in the process of investigation and researchers who are actively involved with the phenomenon or situation being studied (Iosifides, 2003:443). Action research has two aims. Firstly, an action dimension implies intervention to sensitise and bring about change in participants. Secondly, a research dimension is intended to increase understanding of the phenomenon which is being studied and has a theoretical and scientific value for those involved, as learners or researchers. (Dick, 2006:4; Iosifides, 2003:443). Action research helps to solve practical problems of the participants, and emancipates and empowers them through the active involvement of the researcher (Iosifides, 2003:443).

There are a number of advantages that made me choose action research, and also disadvantages, rendering it a challenging method. I prefer to start by highlighting the advantages, to justify my decision to use a qualitative action research methodology. Other research methods may be appropriate for other types of research, but for this particular intervention programme, conducted in high school settings, an action research

methodology was found to be more suitable and possessed of adequate rigour. It focuses on learning through interaction between researchers and participants and giving a voice to the exploited and vulnerable. (Speziale and Carpenter, 2002:14). For example, learners who participated in the gender-based HIV prevention intervention in this study were sensitized to gender-power inequalities, assertiveness, decision-making and negotiation skills in sexual relations. This aimed at empowering them to avoid risky sexual practices and promote HIV prevention.

The intervention phase exposed learners, at an individual level, to a gender-based skills building programme using a combination of innovative strategies such as focus group discussions, role-plays and games. Action research assisted in re-enforcing existing HIV and AIDS knowledge and attitudes of learners, enabled them to develop new knowledge, for example that STIs increases the risk of HIV. It further enabled learners to develop gender-based skills and increased their confidence. This was demonstrated by their ability to assert themselves when demonstrating their negotiation and sexual decision-making skills through role-plays in sessions eight and nine of the intervention phase of this study.

The aim was to give young people an opportunity to benefit by learning something of value. It should not be seen as a one-way process of young people's acquiring information without benefiting from the study. The research conducted in the intervention phase of the study was participative. It offered me, as a midwife and lecturer, a chance to make more use of my facilitation practice. It enabled me to conduct a process which has a direct relevance to my practice. I entered into an interaction with learners which I found ethically satisfying. I concur with Dick, (2006:7) who states that one of the advantages of action research is that there need be no gap between theory, practice and research.

Action research has some dangers. For example, it is more challenging than other types of research. I found it more demanding in terms of energy, financial costs and time, as I was doing it on part-time basis. In most forms of action research, the data you collect, your interpretation of it and your findings determine what critical literature is relevant. On the other hand even the difficulties are part of being responsive to the situation, and can result in better informed actions and secure conclusions. Action research requires

more work and time to set it up, takes longer to carry out and report on. It is likely to take longer than other research methods (Dick, 2006:8).

Action research values responsiveness over replicability because in intervention programmes, responsiveness is needed as part of the research (Dick, 2006: 2). A common criticism of action research is that its results tend to be difficult to generalise; this is sometimes called a lack of external validity. To some extent this is true. The harder researchers try to find explanations appropriate for specific situations, the more likely they are to differ from what would be suitable for a different situation. Kirk and Miller, (1986:3), argue that qualitative research has an ecological validity and can explore natural, inborn feelings and opinions of people, which quantitative research cannot. Experimental research achieves generalisability by limiting its focus (Dick, 2006:3).

We did not experience any practical problems, such as difference of language, cultural unfamiliarity, inability to interact—any of which might lead to the learners being reluctant to talk (Iosifides, 2003:442). This was largely because I and my assistants belonged to the same Zulu culture as participants and spoke the / isiZulu language. The intervention programme that I conducted in the second phase of this study met the culturally specific expectations of the learners as participants. I explained our role as researchers and the purpose of the study and we created a relaxed atmosphere from the first day of the intervention. The assistants and I were seen as researchers who facilitate the study and this helped us to remain more objective. Both girls and boys, were free to express themselves openly; my presence and my talking to them about sex explicitly did not intimidate them, despite taboos in Zulu culture attached to talking about sexual issues.

Much action research has already been done, such as the peer education programme reported by Campbell (2003:101), conducted among sex workers in Summertown. It shows both the positive and negative limitations of action research. For example, on the one hand, that project succeeded in raising the levels of community awareness of the risk of HIV, exposed the high levels of perceived vulnerability to HIV and the importance of condom use in a community that previously had little or no awareness of HIV. On the other hand, after the first six months, it was reported that only two out of ten women were using condoms and only some of their sexual encounters,

whereas consistent condom use is essential to prevent sexual transmission of HIV infection (Campbell, 2003:101). The findings of this peer education programme indicated that information alone does little to help people change their behaviour. It is crucial to work with people rather than talk to them and to build what they already know.

Campbell (2003:184), like other researchers, claims that there is a need for efforts to change behavior in order to address the wider community and the social determinants of sexuality, as opposed to targeting individuals. This approach will make HIV prevention approaches more effective in many southern African contexts. She further stresses that the extent to which approaches can persuade participants to adopt new patterns of sexual behaviour to safeguard their health, is constrained by the degree to which social circumstances support them in these challenges (Campbell, 2003:184). The broader picture of causes or factors that contribute to HIV epidemic and the political economy of South Africa were far beyond my scope. I could not hope to intervene at the level of future job creation for these young people or better education or more food for them. I focused on HIV prevention in the context of gender. This reinforced the importance of considering cultural factors, such as socially constructed notions of gender, which play a major role in influencing sexual behaviour.

PURPOSE OF INTERVENTION PHASE

The purpose of this intervention phase was to develop, conduct and integrate a gender-based skills building intervention programme. It was designed to expose young men and women to a gender-sensitive ideas intervention and to address young women and men on the issue of preventing HIV infection, in the context of gender. The objectives of this second or intervention phase were outlined in Chapter 1.

The aim of this intervention was to provide young women and men with an opportunity to stimulate transformation in their minds through the development of their critical thinking, analysis, insight, and understanding into the ways in which cultural factors, particularly those related to socially constructed notions of gender inequalities, could influence their sexual relationships, and sexual decision-making and efforts to prevent the transmission of HIV infection.

In addition, intervention was done to create an opportunity for young women and men to critically look inward, introspect, assess their cultural upbringing or socialisation and become conscious or aware of the gender-based stereotypes and barriers that sometimes prevented them from making informed decisions that would promote the likelihood of better sexual health.

Furthermore, it was done to stimulate the development of the youths' belief that existing gender norms could be changed through informed and shared gender-based mutual equal respect and responsibility in decision-making with an aim of reducing risky sexual behaviour and preventing HIV infection. In other words it aimed to do a lot such as bringing some possibilities that other research projects similar to mine have aimed to achieve.

Preparation for workshops that were conducted during the intervention phase as a method of collecting data included development of the material for conducting sessions of the intervention programme. The introductory session was conducted on the first day of the workshop, as outlined below.

DEVELOPMENT OF GENDER-BASED SKILLS BUILDING INTERVENTION PROGRAMME

The materials for conducting sessions of workshops as instruments for collecting qualitative data were prepared before the intervention phase of this study.

The materials used in other action research programmes influenced the development of the material used to conduct sessions of my intervention programme. An example of such action research programmes was the skills-building workshop that I attended at the World AIDS conference in Durban in July 2000. Maria de Bruyn and Nadine France developed the material as part of the project carried out by an international non governmental organisation (NGO) and the World Health Organisation (WHO). These skills-building materials were called "*Ipas*" and were presented by representatives from organisations in the United State of America, Mexico, Brazil, Bolivia and East Africa and in Nairobi. Copies of the *Ipas* material were given to all the delegates at the end of the workshop. We were encouraged to make use of the material to conduct similar

workshops in our areas with a special emphasis on the prevention of HIV, other reproductive health issues and violence (de Bruyn and France, 2000: 39).

The presenters encouraged the delegates present to make use of the *Ipas* material, modifying where necessary and combining it with other materials. I found the *Ipas* material very useful in some of the sessions of the intervention phase of this study because it had skills-building material that dealt with gender, adolescents, sexual and reproductive health issues as well as negotiation skills. I therefore used it in modified form in sessions one, two, four, five, eight and nine, as outlined in Tables 3.2 and 3.3.

Other materials from existing programmes, suitably modified, were used to conduct some sessions. These programmes included *Planned Parenthood in South Africa* (PPSA), *Family and Marriage Society of South Africa* (FAMSA). Others included those programmes already conducted in both primary and secondary schools such as *Drama in AIDS Education* (DramAide) whose purpose was to create HIV and AIDS awareness among learners in schools of KwaZulu-Natal using Drama (Dalrymlpe, 2000, DramAide, 2000). In addition, *LoveLife* programmes that come out as newspaper supplements, such as *S'camto*, *thethajunction*, *ReadRight* and *NAFCI Adolescent Sexual and Reproductive Health Rights*, were used. *LoveLife* has similar programmes of employing young people, called 'Ground Breakers' to conduct peer education programmes pertaining to the prevention of HIV infection. They use methods such as story telling and train tour campaigns. Further materials from existing programmes that were used in developing material used in these sessions included resources such as *Soul City: Living Positively with HIV and AIDS* (2001) and *Soul Buddyz: Tomorrow is Ours*, based on a television series.

Of all these programmes used to develop material for sessions of the intervention phase, *LoveLife*, *Scamto* and *thethajunction* were the most useful because they were aimed at allowing the youth to ask questions and get advice about issues that are of concern to them such as puberty changes, relationships and HIV prevention. Furthermore, *ReadRight*, a supplement to the *Sunday Times*, was also found useful because it covers challenging issues, such as sexual rights, and makes young people aware of their rights and assists them to make informed choices. *ReadRight* (*Sunday Times* 2001:5) also had board games dealing with the basic facts about HIV/AIDS and instructions on how to

play them (*Sunday Times*, 2001:6). These were used in the third part of session six, as outlined in Tables 3.2 and 3.3.

In addition the material from DramAide and *Planned Parenthood Association in South Africa* (PPASA) were useful because it contained patriarchy awareness and life skills material that were modified and used for focus group discussions in session 3 and for role plays in session 7, as outlined in Table 3.3, *Soul City: Living Positively with HIV and AIDS* had basic information on HIV and AIDS in English and isiZulu and a copy of it was given to each learner, together with a *Certificate of Attendance*, as a token of thanks, at the end of the last phase of this study.

Focus group discussions were conducted to explore perceptions, attitudes, sexual decision- making, reported sexual practices and HIV prevention in the context of gender. Games and role-play strategies were used to sensitise learners to the values of gender equality and mutual respect in relationships and sexual decision-making. Role-plays were further aimed at enabling learners to acquire assertiveness and negotiation skills that created a transformation from the harmful gender norms and roles that they had already internalised, as outlined in Chapter six, where the results of the evaluation phase are presented. It was in the introduction of these role-plays that learners got the idea that they were going to be “in a play”.

This intervention phase lasted from the last two weeks of August to end of November 2001. It occurred after school hours, like other two phases of this study, and consisted of nine sessions, excluding the introductory and thanksgiving sessions. These sessions were conducted for two (2) hours, once a week in each high school, in the form of workshops, as outlined in Table 3.2. The school principals, teachers and learners who were participating in the study jointly determined the workshop times. The sections of each two-hour session and their duration will be outlined later, together with the workshop sessions. These sessions were conducted on Tuesdays after lunch at Khono High School, Wednesdays from 12:00 to 14:00 at Drama High School and from 15:00 to 17:00 at Zintombi High School. At Thela High School, these weekly sessions were conducted on Thursdays from 13:00 to 15:00. The classrooms where sessions were taking place were well prepared, closed rooms, to ensure privacy and quiet since these sessions

were conducted after school hours, immediately after the last period and in the same classrooms as those used during the first phase.

FIRST DAY: INTRODUCTORY SESSION

The first day of the workshop was an introductory session, lasting for about 45 minutes, and aimed at preparing for the next nine sessions of the intervention programme. It began with an introduction of about 10 minutes and included a short speech by the researcher, thanking the learners for their participation in this three-phased study, as they had already participated in the first phase. The purpose and objectives of the intervention phase of the research study were again explained to remind participants. I further explained to participants that it was essential to share perceptions and ideas that individual participants attach to complex issues, such as those covered in the completed questionnaire in the first phase, relating to gender, sexuality, rights and HIV and AIDS. I explained to learners that this sharing was aimed at producing beneficial outcomes for them and would provide them with the skills necessary to build their self-esteem. This in turn contributed to equipping them with life skills in the context of gender that might safeguard them from situations that put them at risk of contracting HIV infection.

Basic techniques included an icebreaking exercise and the opportunity to formulate ground rules that prepared them for the sessions. Participants enjoyed the exercise and development of the ground rules for about 15 minutes. They expressed a feeling of ownership of these rules (see Appendix 2) and applied them throughout the sessions. Other rules included the maintenance of confidentiality, to ensure that all ideas raised during these sessions were kept secret; a ban on teasing or ridiculing each other's comments outside these sessions. Ground rules also made participants aware of how to proceed in a constructive manner and how to treat individual viewpoints with respect even if they do not agree with those viewpoints.

The role of the researcher and the research assistants and the professional counselling skills of the researcher were explained to participants for about five minutes. It was made clear that the researchers were going to make every effort to be non-judgmental, open, flexible, active listeners and observers.

We (the researchers) also promised to be honest and trustworthy and to put aside our preconceptions about issues discussed, to ensure that the data obtained became a true reflection of the views of participants.

Holliday (2002: 22) asserts that it is essential to Schutz's phenomenology, (see page 84), that the qualitative researcher should act like a stranger when learning about a culture, and as a writer, should see every part of what she has done in the field as a fresh phenomenon. Schutz (1970:316) defines 'bracketing' as setting aside prejudgements about the 'nature' of things, and this bracketing should occur during the research experience itself. Together with my assistants, I adhered fully to the principle of bracketing and remained objective and non-judgemental of the views of learners throughout the study. I warned learners that some aspects of these sessions would focus on sensitive issues and obtained permission from them to address these sensitive issues, such as asking them to express their views on gender, culture, sex and HIV prevention. Precautionary measures were taken to spare the feelings of those learners who might be HIV positive or had relatives who were already afflicted.

A ten-minute opportunity was provided for learners to ask questions that were discussed openly, and to clarify critical issues that were unclear. The introductory session clarified the roles and questions of learners as well as the roles of researchers. The importance of maintaining ethical principles in the intervention phase and hopefully, throughout their daily lives, was clarified and emphasised.

This introductory session helped to reduce anxiety amongst the participants and created a relaxed atmosphere as learners expressed their ideas freely and a relationship of trust was established and maintained throughout this phase of the study. The total number of learners who participated in this three-phase study was 175.

Formation of groups of participants

In preparation for the intervention, four groups of participants were formed at each high school. These groups were formed by dividing participants into two main groups, one for girls and the other for boys, in the three schools attended by boys and girls. I further requested the groups of girls and boys to divide into two groups of girls and two groups of boys, with not more than 13 members in each group. The groups were formed by each

participant counting off a number from 1 to 2 until all participants had a number. Then all those numbered 1 formed a group, and all those numbered 2 another group (de Bruyn and France, 2000:18). The two groups of girls and two groups of boys were formed in the three schools that were attended by girls and boys. The fourth school was a single-sex school, in which girls formed four groups of not more than 12 members in each group, by counting off a number from 1 to 4 until all participants had a number. Then all those with number 1 formed a group, all those with number 2 another group, those with number 3 another group and those with number 4 another group. These were separate male and female groups that consisted of between 6 and 13 members, either boys or girls. In Thela, Drama and Khono, which were attended by both female and male learners, the groups were gender specific: male and female learners were not mixed in the same group. There were two groups consisting of 6 to 13 boys, separate from the two groups that consisted of almost the same numbers of girls. In Zintombi High School, a girls-only high school, offering both day and boarding facilities, all four groups consisted of 6 to 12 girls.

The reason for separating boys and girls into different groups was to create an environment that encouraged open dialogue, where participants felt comfortable to say what they thought or felt in a free and non-discriminatory manner. Some boys or girls could be uncomfortable about freely expressing their ideas on the issues of gender, sexuality and prevention of HIV infection in the presence of the opposite sex. They would be reluctant to talk.

It is not unusual to divide respondents into single-sex groupings when discussing sensitive issues. Kreuger and Casey (2000: 27) argue that it is better to avoid mixing people who may feel that they have different levels of power or expertise related to the issue. They write, "At times it is unwise to mix genders in the focus group; men may have a tendency to speak more frequently and with more authority when in groups with women sometimes, this is called the "Peacock Effect" and can irritate women" (Kreuger and Casey, 2000: 27).

As already explained in the methodology chapter, the aim of this study was to explore learners' perceptions, attitudes, sexual decision-making approaches and sexual practices and to raise learners' awareness on the issues of gender, sexuality and prevention of HIV infection. If male and female learners were mixed in the same focus

groups, it would be more difficult to analyse, on a basis of gender, across groups, and compare and contrast findings of mixed groups (Kreuger and Casey, 2000: 27).

The results of the intervention phase of this study will be examined in Chapter five and compared, to determine similarities between the views of girls and boys as they draw from the same Zulu culture and or differences in relation to gender roles and identities.

INTERVENTION PROGRAMME AND COLLECTION OF QUALITATIVE DATA

Sessions of the workshops of the intervention programme were conducted using material, methods and strategies of gathering data. The intervention phase consisted of nine workshops, excluding the first introductory session and the final session, where participants were thanked and received certificates of attendance. Each session of the intervention phase lasted about two hours. The time was divided into various sections that were explained prior to the commencement of each session¹¹.

Table 3.2 Format for sections of each session of the intervention programme

SECTIONS	Duration
Introduction	10 minutes
Group exercise	30 minutes
Reporting or role-playing section (10 min per group)	40 minutes
Refreshment break	10 minutes
Researcher's summary: clarification and identifying of shared meanings, as well as feedback for validating group themes	30 minutes
Total hours for each session	2 Hours

The introduction, about ten minutes, included giving instructions to participants. I explained the key topic area to be discussed, or done as an exercise in the session by learners in the groups. Each group was given a copy of the topic of the session, with instructions, objectives and methods of conducting each session, to guide the group

¹¹ Each session followed the format outlined in Table 3.2.

discussions and to prevent unfocussed discussions¹². The group was provided with a flip chart and a marking pen used to write their views. Due to financial constraints tape recording was not done, as had been planned earlier.

Each group chose one scribe and a volunteer to lead the discussion and later to present their views. Sometimes group members were asked to role-play to the combined-groups for about 10 minutes at the end of an exercise. The total duration of reporting or role-playing was forty minutes for four groups. The length of time spent during an exercise was also announced prior to the commencement of the session. It was explained that each group was expected to discuss, play the game or role-play the key topic area for about thirty minutes. It was also stated that a short break of about ten minutes would be taken, during which refreshments would be served to participants.

After the group presentations and the refreshment break, I summarized the key focusses in relation to what had emerged from the presentations of the four groups. This gave a further opportunity for questions and discussion to clarify issues raised by learners. In addition, it assisted in identifying particular interests which I grouped into categories as learners emphasised on their views. Shared meanings were identified and reference to relevant literature was made to confirm meanings and key focus areas.

Various methods and strategies were used in the group exercises to address the topic areas and ensure that the collected data corresponded with the research objectives and questions of the study.

The use of a variety of data collection methods is known as triangulation of methods (Henning, van Rensburg and Smit, 2004: 103). It is used in qualitative methodology, since it allows data to be collected from various angles and it could assist in finding the true position and testing the trustworthiness of data. According to Henning, van Rensburg and Smit's, (2004:148) argument, qualitative researchers need to ask the question whether, by using certain methods, they are collecting data that will correspond with the reality of what they are investigating. The topics of sessions, purpose and various methods that were used to collect data during the sessions of this intervention phase are outlined in Table 3.3 below.

¹² Refer to Table 3.3 of the Methodology of Chapter, Appendices 2.3, 2.4, 2.5, 2.6, 2.7, 2.8 and 2.9 for Session one to nine topics, instructions, objectives and facilitator's summary for end of sessions.

Table 3.3: Sessions, topics, purpose, methods and strategies used to gather data during intervention session

Session	Topics of Sessions	Purpose of exercise: to clarify these terms towards the end of each session and arrive at an agreed meaning of these terms and other gender, sexuality, rights and HIV prevention issues:	Method and Strategy
First Day	Introductory session	Preparation for the nine sessions of the intervention phase. Explained purpose of intervention phase and format for sections of each session, as outlined in Table 3.2.	<ul style="list-style-type: none"> • Group Discussion
One	Perceived meaning of terminology	<ul style="list-style-type: none"> • To provide female and male learners with an opportunity to explore the meaning of terms used in issues of sex and gender. To determine and describe the perceptions of female and male learners concerning these terms and to clarify these terms towards the end of each session to arrive at an agreed meaning of terms used in issues of sex and gender. 	<ul style="list-style-type: none"> • Flip charts and pens Focus / small group discussion [FGD] of 6 to 13 members in each group. Separate groups of female or male learners, except in Zintombi school)

Two	Rights	<ul style="list-style-type: none"> To determine how being female or male can affect one's understanding of rights in the area of sexual and reproductive rights. To clarify these rights towards the end of the second session and to arrive at a shared meaning of rights used in relation to sexual and reproductive rights issues in the context of gender. 	<ul style="list-style-type: none"> Flip charts and pens FGD
Three	Patriarchy	<ul style="list-style-type: none"> To allow female and male learners to explore, discuss and share their perceptions of patriarchy, in relation to perceived meanings and examples of patriarchy. To state other examples of patriarchy and to make recommendations of what they regard as their role in relation to patriarchy. Towards the end of the third session to arrive at a shared meaning of patriarchy. 	<ul style="list-style-type: none"> Flip charts and Pens FGD
Four	Gender-based stereotypes	<ul style="list-style-type: none"> To give female and male learners an opportunity to identify gender based stereotypes. 	<ul style="list-style-type: none"> Gender game
Five	Issues of sex	<ul style="list-style-type: none"> To allow female and male learners to identify, outline and share common synonyms of terms used in relation to sex and sex-related issues. To outline and share information learnt about sex from different sources. 	<ul style="list-style-type: none"> Flip charts and pens FGD
Six	STIs, HIV and AIDS	<ul style="list-style-type: none"> To allow female and male learners to express their perceptions about factors that they think make them vulnerable to STIs including HIV infection. To provide female and male learners with an opportunity to re-inforce and demonstrate their understanding of STIs, HIV, AIDS and HIV prevention. 	<ul style="list-style-type: none"> Flip charts and pens FGD Role-play Peer education/ counselling STIs, HIV/AIDS Cards game and HIV/AIDS board Games
Seven	Life skills: Assertiveness and Decision-Making skills	<ul style="list-style-type: none"> To provide learners with an opportunity to learn and demonstrate their understanding of life skills such as assertiveness and sexual decision-making, with the aim of applying those skills in sexual decision-making and HIV prevention. 	<ul style="list-style-type: none"> Role-play
Eight & Nine	Life skills: Negotiations for abstinence and condom use	<ul style="list-style-type: none"> To provide female and male learners with an opportunity to learn and demonstrate their understanding of negotiation skills with the aim of applying such skills in their real life situations in relation to HIV prevention. 	<ul style="list-style-type: none"> Role-play

Ten	Last / final Day: Thanksgiving ceremony	<ul style="list-style-type: none"> To thank learners for their participation in these workshops and encourage them to attend the evaluation phase, the third and last phase of this study. They were also told about what will happen to their views, as findings for all these three phases of the study. It explained to participants that on completion of the study, the research report will be written, research findings will be presented at conferences and will be published in accredited journals. They were further assured that adherence to the principles of research ethics, such as confidentiality and anonymity will be maintained to ensure the protection of their rights throughout documentation and presentation of the findings of this study. To encourage them to share with their peers and apply what they have learned in these sessions positively in their lives, especially in the area of their sexual health and their efforts to prevent HIV infection. 	<ul style="list-style-type: none"> Discussion
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Combinations of innovative learning strategies were used during the sessions of these workshops, including focus group discussions, games and role-plays, as outlined in the summary. These were used to address identified topics of sessions and were aimed at sensitising learners, changing their attitudes and making them aware of mutual or shared-gender equality respect in sexual decision-making in order to prevent HIV infection. The same learners as those involved in the established four groups discussed these issues in these sessions, using focus groups in the sessions 1, 2, 3, 5 and the first section of session 6. These focus group discussions lasted 30 minutes. Each group was provided with flip chart sheets and a marking pen to record their responses as a means of gathering data. Tape recording of data was not done, due to financial constraints, as already explained. A group representative would present the views of their group to the combined groups for 10 minutes at the end of each session.

The researcher and research assistants monitored group exercises to stimulate discussion amongst the participants. The research assistants, being young, were not branded with an image of adult authority and that prompted the sharing of sensitive topics: the participants were able to identify with them and they had the ability to make learners feel comfortable with the topic. My presence as the researcher who was facilitating sessions of the workshop did not inhibit learners to say what they felt like

saying. Their relaxed attitude could be associated with the informal manner in which sessions were conducted.

The intention of facilitated group discussions was to clarify certain key aspects as required by participants. Consequently, the group kept focused on their discussion of the key topic areas and themes that emerged from those areas. Participants sat in a semi-circle during the discussion to encourage face-to-face interaction by group members. This seating arrangement enabled facilitators to concentrate on each participant, measuring the non-verbal communication that added meaning to what was being said. Some difficulty was experienced in managing the debate in the focus group discussions. Some participants tended to dominate the discussion and had to be reminded to give others a chance to add their views, while other participants were merely compliant.

Each group of learners was provided with the topic and objective/s of the session and instructions for each exercise that guided them in the focus group discussions, and helped them to act their responses in the form of games or role-plays (see Appendix 2). The groups of learners practiced their games and role-plays for 30 minutes in preparation for the combined group feedback at the end of each session. Participants used games in sessions 4 and the second section of session 6 as well as role-plays in sessions 7, 8 and 9, as outlined in the summary. The games and role-plays used for these sessions were suitable for the intervention phase, because young people enjoy communicating through art, drama and music (Kreuger and Casey, 2000: 188). They reinforced and increased learners' knowledge of HIV and AIDS and sensitised them to gender and sexuality issues and provided them with gender-based skills of HIV prevention¹³.

The following topics for the nine sessions of the workshop were addressed once a week, after school hours in each high school. Session One was concerned with determining the participants' perceptions of terminology, such as the meaning of the terms 'sex' and 'gender.' Session Two addressed sexual and reproductive health rights. It was crucial to approach gender and sexual issues as well as rights through questions that provoked reflection among participants on their own experiences and perceptions. This further assisted in making these issues come alive. Session Three was conducted using the same focus group discussions to discuss patriarchy and address issues relating to it,

¹³ As outlined in Table 3.3, Appendices 2.6, 2.9, 2.10 and 2.11.

such as meaning, examples and recommendations in relation to patriarchy and prevention of HIV infection.

Session Five was also conducted using focus group discussions and had two parts concerned with issues of sex. In the first part of this session participants were required to state the synonyms of the terms used for sex and its related issues. In addition, in the second part of this session they were required to discuss the sources from which they learnt about sex. The first section of Session Six was concerned with HIV and AIDS and factors which increased youths' vulnerability to STIs including HIV. The second and third sections of this session also gave participants an opportunity to play games and play the roles of peer educators to address the issues of HIV and AIDS. This exercise reinforced and increased their knowledge of HIV and AIDS and gave them an opportunity to demonstrate their understanding of the following four basics of HIV and AIDS: meaning of and difference between HIV and AIDS, HIV transmission and ways of preventing it, risky behaviour and STIs, including HIV.

Session Four was conducted using a game focusing on gender-based stereotypes. The second and third sections of Session Six were conducted using cards and board games focusing on STIs, HIV and AIDS and HIV prevention. In Sessions Seven, Eight and Nine role-play was used and focused on life skills such as assertiveness, negotiations and sexual decision-making skills for HIV prevention in the context of gender (see Appendix 2). These games and role-plays were practiced as exercises by the established four groups of participants for 30 minutes each and then demonstrated by each group to the combined groups for 10 minutes at the end of each session. One or two participants were absent during some sessions.

At the end of the group sessions the group leader was given a chance to present the views and perceptions of the group, on the topic of a session as the group members had discussed them. Role-plays were also used as one of the feedback methods, as already explained above. There was often laughter and fun during group work as well as during the presentation or demonstration feedback sessions. The four group leaders' reports took about forty minutes in total.

Refreshments were served to participants during a short break of about ten minutes, immediately after the group reports as in the other two phases of this study. Each session ended with the researcher taking about thirty minutes to summarise the similarities, differences and shared meanings of the topic of the session which had been highlighted during the group reports. An opportunity was also available for learners to ask questions, and clarify any issues that had emerged from the group sessions. This summary strengthened awareness amongst the learners of their views and the categories of meaning into which the opinions of female and male learners could be fitted. This summary further assisted me to reflect on the female and male learners' impressions and to clarify their views while collecting data.

I gave my summary orally, and on a flip chart to participants to give them a chance to check whether it made sense to them and to allow them to comment on whether it reflected their views. This ensured the credibility of findings as qualitative principles that represent validity. However, the action research utilised during the intervention phase had more to do with promoting change and making a difference than with recording data.

Towards the end of each session, I explained to the learners the relationship between their views and those of scholars who had worked in the same area. This was done to support the meaning of terms and key focus topics. In addition, the summary was given to all participants to ensure that they left each session with an understanding of the agreed meanings of terms such as gender, sex, sexual and reproductive rights, HIV and AIDS, assertiveness and decision-making, negotiation skills and how to apply these in the prevention of HIV infections¹⁴.

Participants also gave feedback to the researcher at the end of each session, where all four groups wrote their comments on the evaluation form for each session. They indicated what they found most interesting and useful, what they liked least, what would they like to be explored further and suggested ways of improving each activity or session (see Appendix 2).

¹⁴ This is shown in Tables 3.3 and 5.3

Action research with a qualitative approach, such as this one is supported by Paulo Freire's conceptual framework, explained by Campbell (2003:51). It shows that it is important to provide a context for the development of people's critical consciousness about sexual health. It is on the basis of such critical thinking that a group of people is most likely to challenge social relations that place their health at risk and become agents of change around issues relating to HIV prevention (Campbell, 2003:51). This intervention phase was completed at the end of November 2001.

The following section will outline how the data analysis was carried out. The analysis of data collected during sessions of the intervention phase of this study was done using content data analysis method, which will be briefly explained below.

THE PROCESS OF QUALITATIVE DATA ANALYSIS

The purpose of data analysis is to examine the data in an appropriate manner to reveal meaning of the phenomenon studied. This indicates the importance of selecting rich fragments of data containing as many features of the key elements as possible within a short space of time (Holliday, 2002:119). This means reducing an enormous amount of information into categories of units of meaning and identifying broader themes by the process of data analysis and interpretation. These help to create and build the picture because according to Holliday's (2002:78) assertion, thick descriptions of rich data show the different and complex facets of particular phenomena. However, the purpose and methodology of the study guided the data analysis as well as the theoretical framework that followed the approaches of feminist and masculinity theories.

The analysis of data that emerged from group exercises was faithful to the words used by the learners themselves. This was done to ensure that the analysis of this data truly reflected female and male learners' perceptions of the topics of sessions. Henning, van Rensburg and Smit, (2004: 148)), as qualitative interpretative researchers, concur with this view: they argue that it is important to discuss the truth values of data to ensure that they support the credibility, dependability and conformability of research findings.

The analysis of data collected during sessions of the intervention phase of this study was done using content data analysis method. It provided for the narration of the

perceptions and views of learners on various aspects of the topics of sessions of the intervention phase, as will be shown in Table 5.1.

The data that was obtained during the sessions was analysed manually, using the qualitative content data analysis method. All the views of the different groups of female and male learners, written on the flip chart sheets during each session, were transcribed, reviewed, dated and labelled into female and male groups, with pseudonyms for the high schools from which they were taken. This was done to ensure that transcriptions accurately represented what was said and how it was said by different groups of learners. Data was then coded into units of meaning, categories and themes, as it will be shown in Table 5.1 in Chapter 5 where the results of the intervention phase will be presented.

CONSTRAINTS AND LIMITATIONS OF THE STUDY

Burns and Grove (2001:374) assert that non-probability sampling is limited in terms of representativeness of the sample: not every element of the population has the opportunity to be included in the sample. The probability of each element of the population that is included in the sample is unknown, since a non-probability sample is selected without random sampling. This limiting factor of non-probability sampling has been catered for in this study by choosing purposive sampling and the selection criteria to overrule the limiting factor of other types of non-probability sampling. I also counteracted this limiting factor of non-probability by using triangulation of methods (Henning, van Rensburg and Smit, 2004:103). The use of focus group discussions, role-plays and games in the intervention phase of this study allowed data to be collected from various points. It assisted in building the strength of an enquiry and rigour of this study.

The sample chosen in this study is appropriate for the population of the group studied and this was done to ensure transferability of the qualitative findings of the intervention phase of this study to other similar population groups. Transferability of the findings of the study will occur if the context in which this research was done is similar to the context in which similar research is done and the same method will become applicable. Qualitative data obtained in action research is contextualised within a specific community or cultural group in order to provide solutions that are relevant to that community or group (Naude, Meyer and van Niekerk, 2000: 10).

The following were the major limitations of this study: the length of the questionnaire used to collect quantitative data during the pre-test and evaluation phases was one of the limitations. It was very long, and the questions on gender issues contained several leading questions; and not all questions were analysed. The questionnaire is limited in its effectiveness in assessing negotiation skills and sexual decision-making. Hence I resorted to triangulation, using other methods: qualitative methods, using types of data collection such as focus group discussions¹⁵ gender games¹⁶ and role plays¹⁷ to counteract the limitations of the questionnaire.

An unavoidable but real limitation of the study, which must occur in almost every piece of research into sexual behaviour of individuals, was that the questionnaire used asked each individual to report on his or her own behaviour. Shame and fear may well have been constraints, and these constraints were unlikely to apply equally to boys and girls. Zulu culture condones, to a great extent, promiscuity in a young man, whilst disapproving strongly of it in young women. It may have been the case that girls were more apprehensive at the beginning of the study but in fact, only two more girls reported that they had become sexually active in the third phase. I was obliged, in fact, to accept the possibility of individuals misrepresenting their practice as a necessary limitation of my work.

Financial constraints that prevented me from tape recording qualitative data during the intervention phase posed a serious problem. The inability to record qualitative data prevented me from including analyses of data obtained through gender game and role plays. However, I managed in 2005, with the help of my supervisors, to secure funding from the University of KwaZulu-Natal Research Office and from National Research Foundation (NRF), which was used for the employment of substitute lecturers and editing of chapters. Lack of computer access was a problem until February 2003, when I was given a personal computer at UKZN. My computer skills, such as data analysis skills for analysing the collected data, were at first inadequate. However, I

¹⁵ Refer Table 3.3 of the Methodology Chapter of this study, Appendices 2.3, 2.4, , 2.5, and 2.7 for sessions one, two, three and five, instructions and Facilitator's summary for end of sessions

¹⁶ Refer Table 3.3 of the Methodology Chapter of this study, Appendices 2.6, for session four, instructions and the Facilitator's summary at end of sessions.

¹⁷ Refer Table 3.3 of the Methodology Chapter of this study, Appendices 2.9, 2.10, and 2.11, 2.4, , 2.5 and 2.7 for sessions seven, eight and nine, instructions and the Facilitator's summary for end of sessions.

managed to get the assistance of a statistician during the analysis of quantitative data. Constraints on the time I could allocate to the process of analysis and writing, because I was in full time employment, led to delays in completing this study.

CONCLUSION

The sessions of the intervention phase exposed girls and boys as participants, to gender-based life skills that sensitised them to sexuality, gender issues and mutual gender-based respect and responsibility in sexual decision-making. At the end of each session, I summarised issues that had been discussed or demonstrated by various groups and clarified where necessary. These sessions assisted in achieving the purpose of the intervention programme that aimed at contributing to the reduction of risky behaviour and HIV infection among the school-going youth of Northern KZN.

The research methodology that was chosen for this study has been described. The quantitative approach was used to collect data during the first/orientation phase and the last or evaluation phase as well as the qualitative approach. This was used to collect data during the second or intervention phase of this study. Research ethics followed in this study have also been explained. In addition, the methods used to analyse quantitative and qualitative data for the different phases of this study have been described.

The results for the first/ orientation and the last/ evaluation phases will be presented in Chapters 4 and 6.

CHAPTER FOUR: ORIENTATION PHASE RESULTS

INTRODUCTION

My study consisted of three phases, as already explained in the Methodology Chapter. The first phase determined the baseline data, phase two was the intervention phase where gender-based, skills building workshops were conducted. In phase three, the last phase, evaluation was done with participants. In this chapter, I shall describe the orientation phase and analyse the data that were generated during this phase. The findings of the orientation phase will assist in meeting the second and third objectives and in giving answers to the first, second and third research questions of this study.

Among the major findings that emerged from the baseline study undertaken in the pre-test or orientation phase were the following. One hundred and seventy five (175) learners participated in the three phases of this study. High levels of abstinence from sexual activity were reported especially by girls but also by boys. Half – 88 (50.3%) – of the learners reported that they were abstaining from sexual activity, compared to those, 87 (49.7%) that reported they were sexually active.

Eighty seven (87) learners reported that they were sexually active during the pre-test phase of the study. Boys appear to have sex marginally earlier than girls but not to a significant extent. The majority of male and female learners, 56 (64.4%), reported their age of sexual debut to be between 13-16 years of age, as outlined in this Chapter and shown in Table 4.2 below. High levels of knowledge of HIV and AIDS existed, even though these were not translated into safer sexual practices. Early sexual debut was reported by boys and girls who said that they were sexually active. They had multiple sexual partners and low levels of condom use. Despite their knowledge, there were low levels of awareness of the risk of HIV infection amongst the majority of learners.

One hundred and seventy-five (175) learners who participated in this study were asked the following question: “What do think you can do to protect yourself from becoming HIV positive?¹⁸” Over a half, 61, (56.5%) of all girls and nearly a third 22 (32.8%) of boys reported that abstention was an effective measure against HIV and

¹⁸ Refer Appendix 1: Questionnaire for first and third phases of the study, question number 52

thought that this would protect them from HIV infection. Despite this, most boys indicated that they were sexually active at the time of data collection in the first phase. In addition most male learners indicated that it is acceptable for males to be sexually experienced, while they did not believe this should be the case with females.

High levels of trust of parents were reported by female and male learners; all were eager to be taught by parents about sexuality, gender and HIV prevention; this was one of the major findings of the first phase.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

In this section the characteristics of the sample are presented to describe the condition of learners who participated in this study. I am interested in a number of variables, including gender, schooling, location of schools and homes, religion and social class, as some of these could shape learners' sexual behaviour. Furthermore, the three variables of parents' social class, type of house and number of occupants in the learner's home, are compared in order to search for similarities or differences in relation to each factor. Social class, as part of the socio-economic profile of learners who participated in this study, has relevance to some of the outcomes of this study.

These three indicators were relevant because there were no other easily available indicators, such as household income, to determine class of participants. With the help of the statistician, I therefore had to find other indicators. I selected type of house, crowding in relation to the number of occupants per learner's homestead and occupational class, for reasons that I will explain in Appendix 11. This data helped us to understand the lives learners have and to determine if there is any association with their sexual practices. For example, an association was found between the family backgrounds of learners with early or late sexual debut. The findings of baseline data obtained in the first phase suggested similarities and differences in the profile of girls in relation to those of boys.

In addition, the three indicators of social class (see Appendix 11) of parents were examined as part of the socio-demographics of learners.

COMPOSITION OF THE SAMPLE

A total of 175 learners participated during the first, second and third phases of this study. The majority of participants, 108 (61.7%) were females and 67 (38.3%) were males. All learners who participated in this study were isiZulu-speakers.

AGE

The ages of learners who participated in this study were from 13 to 19 years. The mean age for boys and girls was 16.3 years and 15.8 years respectively. The ages ranged, for boys from 14 to 19 and for girls from 13 to 19 years. The numbers show that the sample contained no major gender or age bias.

GRADE OF LEARNERS AT THE TIME OF DATA COLLECTION

In this study 'grade' refers to the educational level of the learner at the time of data collection. Participants occupied grades 8 to 11. Boys constituted a higher number 40 (59.7%) in Grade 8 compared to 32 (29.6%) girls. There were 12 (17, 9%) boys in Grade 9 compared to only 5 (4.6%) girls. However, girls constituted a higher number 31 (28.7%) in Grade 10 compared to 10 (14.9%) boys. There were 40 (37.1%) girls in Grade 11 compared to 5 (7.5%) boys.

RELIGION

All learners (100%, $n = 175$) reported that they belong to one of the following four branches of Christianity. However there was a borderline difference in relation to religious affiliations of female and male learners ($p = 0.050$). A higher percentage of females, 70%, ($n = 75$) compared to 50.7% ($n = 34$) male learners indicated that they belong to Protestant Christian churches. On the other hand, a higher percentage of male learners, 14, (20.9%) than females, 20 (18 %) indicated that they belong to Roman Catholic Church. Similarly, a greater proportion, 28.4% ($n = 19$) of males than 12 % ($n = 13$) of females indicated that they belong to the Shembe religion (see P 6), also known as Nazareth Church.

LOCATION OF SCHOOL AND HOME

The majority of learners, 113 (65%), were attending peri-urban high schools, while 62 (35%) learners were attending rural high schools. Most learners, 75 (69.4%) girls and 38 (56.7%) boys, indicated that they were attending peri-urban high schools. However, a higher percentage 43.3% (n= 29) of boys, than 30.6% (33) of girls, indicated that they were attending rural high schools. Learners indicated that they were from homes in rural, peri-urban (township) and urban areas. Most learners, 87 (49.7%), reported that they came from peri-urban homes, while 78 (44.6%) reported that they came from rural homes and 10 (5.7%) reported they came from urban homes.

A higher percentage, 50.7% (n=34), of boys as opposed to girls, 40.7% (n= 44) reported that they came from rural homes. By contrast, 59 (54.6%) girls compared to only 28 (41.8%) boys indicated that they came from peri-urban (township) homes. Few learners, 5 (7.5%) boys and 5 (4.6%) girls, indicated that their homes were located in urban areas.

PARENTS AND HEADS OF HOUSEHOLDS

Overall, 136 (77.7%) learners had both parents, 36 (20.6%) had one parent and only 3 (1.7%) had no parents alive. The majority of participants, 136 (77.7%) who had both parents were from male-headed families, compared with 36 (20.6%) who had single parents, of whom the majority, 31 (96.9%) of them were from female-headed families and only 5 (3.5%) were from male-headed families.

The head of household was defined economically as the main breadwinner in the household, refer Appendix 1, question 11.1.6. Of the three (1.7%) learners who reported that they did not have parents alive, 1 (3.1%) was from a female-headed household as opposed to 2 (1.4%) who were from male-headed households. The three learners who reported not having parents said that they had other financial supporters who were not their biological parents. These were reported by learners as people who were self-employed or grandparents who were pensioners. The total number and percentage of learners from male-headed households was 143 (82%) as opposed to 32 (18%) who were from female-headed households.

Learners who had both parents 136 (100%) were all from male-headed families, as commonly observed in Zulu families. It can be assumed that in the female-headed households, the male parent was dead. I did not investigate the causes of these deaths, which might have been the result of AIDS, which has been so prevalent and fatal in the recent past (UNAIDS and WHO, 2005:2).

In the past, female-headed families were uncommon among Zulu families because women were regarded as minors. If a woman had a child before marriage, she would never be regarded as the head of the house, even if she had her own home. She and her child would remain under the control of her father while he was still alive or her elder brother, if their father was no longer alive. Females are now granted the status of heads of households by the post-apartheid, South African democratic government.

The change in KwaZulu-Natal has followed the new Constitution of 1996 and the famous constitutional court case of Shibi versus Sithole and others, where Mrs Shibi was not allowed to inherit the property of her brother who has died. Langa, DCJ, the former Judge of the South African Constitutional Court, suggested that the African customary law rule of male as heirs of inheritance of property is unconstitutional and unfair as it deprives women and illegitimate children from receiving property. He ruled that it was therefore invalid and recommended that it be amended in order to implement the constitutional principle of equality between the gender groups (Constitutional Court of South Africa Case 69/03).

The change that led to legal recognition for women household heads was derived from such reforms to customary law. In 1998 recognition of Customary Marriages Act 12 of 1998, which came into effect in 2000, declared that customary unions in South Africa could be considered as legal marriages provided that the criteria such as consent and community of property are met (Budlender, Chobokoane and Simelane, 2005: 16). This law was passed in order to protect the rights of married women, particularly with regards to children and property (Chambers, 2000: 102; Posel, 1995: 1468).

It was essential to understand the family background of a participant in terms of whether s/he has parents or not and also to know whether the head of the household was a female or male. The type of family the learner grew up in is related to his or her socialisation. If the individual grew up without parents or in a female-headed family, for

example, in Zulu culture s/he is assumed to be an individual who grew up from a family without authority and without discipline and expected to indulge in early sexual activity.

It is assumed that mothers are easily persuaded by their children and are more likely than fathers to give them permission to go to visit their friends and more easily forgive them if they have done wrong. This however is not always the case. Some individuals who do not have parents or male headed families become independent early and might either avoid engaging in sex because no parent will assist her/him.

The following section discusses the results, focusing on specific areas of sexual practices and HIV prevention in relation to gender. Measures relevant to HIV prevention, such as sexual practices, including age of sexual debut, number of partners, decision-making, negotiations, and condom use are examined in this section. The outcomes of these measures are also considered. Furthermore, the roles played by youth and other stakeholders, such as parents, in HIV prevention will also be discussed.

HIV AND AIDS KNOWLEDGE, GENDER, ATTITUDES AND SEXUAL BEHAVIOUR

Some findings were surprising, such as the lack of awareness in some learners of the risk of HIV infection. This section also examines young people's methods of HIV prevention in the context of gender and the role of parents in teaching their children about sex, gender issues and HIV prevention.

COMPARISON OF SOCIO-DEMOGRAPHIC VARIABLES TO SELECTED OUTCOMES

SOCIO-DEMOGRAPHIC VARIABLES AND SEXUAL ACTIVITY

This section deals with the comparison of socio-demographic variables to sexual activity. The main findings showed that about half of the learners, both boys and girls, reported themselves to be abstaining from sexual activity, compared to less than half the learners who reported themselves as sexually active. The majority of boys reported they were

sexually active; their numbers exceeded those of girls who reported they were sexually active. Boys indicated that they had sex earlier than girls.

ABSTINENCE FROM SEXUAL ACTIVITY IN RELATION TO GENDER

Half the learners, 88 (50.3%), reported that they had never had sex, compared to 87 (49.7%) who reported they were sexually active. There was a significant correlation between sexual activity and gender ($p = 0.001$). More girls, 68, (63%) than boys 20 (29.1%) reported that they had never had sex, compared to 47 (70.1%) boys and 40 (37%) girls who reported that they were sexually active. This pattern is fairly normal and reflects other studies which find that teenage boys tend to have sex at a younger age than teenage girls, as outlined later.

Table 4.1 Sexual activity by gender (n = 175)

	Have you ever had sex?		
	Yes	No	
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	40 37 %	68 63%	108 100%
Male	47 70.1%	20 29.9%	67 100%
Total	87	88	175
Percentage	49.7%	50.3%	100%

An important finding in Table 4.1 is the gender difference, which highlights a higher level of abstention amongst girls than boys. In Zulu culture, as part of social constructions of femininity, more emphasis is placed on encouraging girls to be chaste and celibate than boys. Girls, especially in rural areas of KZN, are socialised by elder sisters, known as “*amaghikiza*” about sexual relationships. A high value is placed on the

preservation of their virginity until marriage. Consequently, virginity testing may be done to monitor girls' sexual conduct, as discussed in chapters 1 and 2 of this study. In contrast, as part of the social construction of masculinity, boys are socialised by other young men to initiate sexual relations and to acquire more sexual experience than girls. Such factors put young people at risk of contracting HIV. Hunter (2002:112) claims that in poorer locations, girls are more likely to be 'trading' their sexuality for gifts such as cash, cell phones, cars (known as 3Cs), from different sexual partners. Hunter (2002:112) quoted a 23 year-old woman, born in the informal settlement adjacent to townships in KwaZulu-Natal, when she was asked "Why do you have three boyfriends?" She responded "One gives money...another Checkers groceries... another buys me clothes" (Hunter, 2002:112).

When comparing the reasons given for abstaining from sex, the most common response by learners (33 (48.5%) females compared to 12 (60%) males) was 'waiting to prove their love to the right future partner'. This reason was followed by the fear of pregnancy, reported by more, 19 (27.9%) females than 5 (25%) males. Thereafter, more (8 (11.8%)) females compared to 1 (5%) male) reported that they were waiting for marriage, which they believed was the right time when they would be ready for love. On the other hand, five (7.4%) females reported other miscellaneous reasons for abstinence such as "Never trust a man when it comes to sex"; "I am too young and concentrating on my school work"; "I do not have a boyfriend because I do not want sex".

There was no significant difference between the number of females (3 (4.4%)) and males 2 (10.0%) who reported fear of HIV infection as their reason for abstaining from sex. This finding shows that HIV infection is not a significant worry or fear in the minds of young people compared to other reasons. This finding highlights the need for further research to understand why young people think this way. However, my findings are consistent with those of Harrison (2005:4), who found that HIV risk is seen as a secondary problem amongst school-going girls and boys in rural KZN compared to pregnancy, which is their biggest concern in relation to school completion. These findings correlate with learners' knowledge score on HIV and AIDS, obtained during the

first phase of this study: learners who were worried about pregnancy scored¹⁹ 16.9, below the average level of learners that reported having heard about HIV and AIDS.

Learners who reported they were abstaining from sexual activity were assumed not to be at risk of contracting sexually transmitted HIV infection at the time of data collection in the first phase of this study. However, these findings need to be interpreted with caution due to the difficulties associated with analysing data about self-reported sexual activity. Some studies have shown that self-reports on sexual activity are not reliable and may be sources of error and bias (James, Bignell and Gillies, 1991: 333). By contrast Jennin, Konings, Dubois-Arber, Landert and Van Melle (1998: 1) report that the reliability of reports on sexual behaviour and condom use in a Swiss evaluation survey was good. However they cautioned that more research is required on the validity of data.

Validity and reliability is further complicated as there is no way to test self-reported responses about sexual activity. Some learners who reported no sexual experience may have had sex before but wanted to conceal this fact as a way of conforming to Zulu cultural norms; girls are more likely to hide that they are sexually active due to social disapproval of sex for young women.

The findings of my study are consistent with findings of research studies conducted in Kenya and Namibia among school-going youth (Kiragu and Zabin, 1993:92; Santon, Fitzgerald and Li, 1999: 132): large differences between boys and girls were noted in younger samples with the mean age of 15 and below. A higher percentage of boys, 56% in Namibia and 48% in Kenya, were more likely to report having had sex than girls (17%) in both countries. Such findings demonstrate that in some contexts boys boast about their sexual experience, whereas girls do not.

It is possible that girls might under-report the extent of their sexual activity while boys might over-report their experience (see Chapter 6 for further discussion of this matter). This view was also supported by the findings of articles from Tanzania, Namibia and Kenya, on the sexual behaviour of school-going young people in sub-Saharan Africa. These studies indicate that the under-reporting bias of sexual activity by girls was stronger than by boys. The reviewers argued that it would be applicable to most studies of

¹⁹ The term knowledge 'score' is derived from the statistician's practice in assessing the questionnaire.

sexual behaviour of young people in southern Africa (Kaaya, Fisher, Mbwambo, Sehaalma, Aaro and Klepp, 2002:156).

In this study 87 (49.7%), learners reported being sexually active (see Table 4.1). This group of sexually active school-going youth will be discussed in relation to the age of sexual debut. It is of great concern to me, as a midwife, mother, and isiZulu-speaking woman because almost half of the learners who participated in this study reported that they had already had sex. Associated with this finding are additional details of sexual activity, including multiple sexual partners, inconsistent and low levels of condom use that seemed to indicate that they were engaging in dangerous sexual practices.

The data collected on the age of sexual debut was divided into three categories during data analysis. These three categories were used to determine sexual debut in relation to the individuals' developmental stages. Furthermore, this categorization was used to allow for Chi-square test of significances. Learners who reported having had their first sexual experience at the age of 12 and younger were put into the 'Children' category. Those who had had their first sexual experience between the ages of 13 to 16 were put into the 'Early Teenage' stage category. The last category was called 'Late Teenage', for learners who reported have had their first sexual experience at the age of 17 to 19 (see Table 4.2 below).

SEXUALLY ACTIVE LEARNERS

AGE OF SEXUAL DEBUT

Eighty-seven (49.7%) learners reported having had sexual activity. There was a significant difference between sexual activity and gender ($p = 0.001$). More boys 47 (70.1%) than girls 40 (37%) reported having had sex. On the other hand, no association was found between age of debut and gender. This means that gender does not predict the age of first sexual activity, since similar or equal proportions were found between female and male learners in the Children, Early Teenage and Late Teenage stage categories of age of sexual debut.

Table 4.2: Age of sexual debut and gender (n = 87)

	Age of sexual debut			Total
	Children ≤ 12 years	Young teenage 13-16 years	Late teenage 17 to 19 years	
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female	5 12.5%	26 65.0%	9 22.5%	40 100.0%
Male	6 12,8%	30 63.8%	11 23.4%	47 100.0%
Total/ Percentage	11 12.6%	56 64.4%	20 23.0%	87 100%

Boys appear to have sex marginally earlier than girls but not to a significant extent. This pattern may be caused by shifts from traditional social cultural constructions that promoted male engagement in sexual activity to more assertive female sexual behaviour, as girls now use their sexuality to get rewards from multiple sexual partners. This shift in gender roles is shown by the findings in Table 4.2 where females also reported having had early sexual activity.

The findings of my study, as shown in Table 4.2 show a picture that is inconsistent with reports in the literature and previous research findings that revealed that sexually active boys consistently reported a wider earlier age gap of their sexual activity than their female counterparts. In contrast to my findings, Kaaya, et al., (2002:156) report that at least a year's difference appeared between genders in the mean age of the onset of sexual activity in the findings of the majority of studies conducted in school-going adolescents in sub-Saharan Africa, (Fisher et al., 1993: 495; Buga, Amoko and Ncayiyane, 1996:523; Kiragu and Zabin, 1993: 92). When the findings of the studies were disaggregated by gender, the reported mean age of the onset of sexual activity among boys varied from 12 to 15.5 years, while the corresponding range among girls was 13.6 to 15.9 years (Kaaya et al., 2002:156).

However, I argue that such findings must be interpreted with caution due to the possibility of inaccuracy in self-reported data on sexual activity,. It may be that some learners who reported their age of sexual debut may have had other sexual experiences that they did not recognise as sexual activities. They may have reported only the age at which they first had heterosexual intercourse than other sexual practices. In support of my argument, Kaaya et al. show that in establishing the extent of sexual activity and the age at which it commences:

Few studies address other sexual practices, whether they are high risk (such as anal intercourse) or low risk (such as “outer course”). The few studies that included sexual activities besides heterosexual vaginal intercourse confirm that many students have engaged in a wider repertoire of activities. (2002:156)

Van Aswegen’s (1995: 310) study, conducted on a sample of 200 black South African high school boys of 15 to 19 reported that same-sex anal intercourse occurred amongst 30 % of the respondents and same-sex oral-penal-rectal intercourse amongst 18%.

AGE OF SEXUAL DEBUT AND AGES OF SEXUALLY ACTIVE LEARNERS

When comparing learners by age of sexual debut, Table 4.3 shows that actually only a few (11 - 12.6%) learners reported having lost their virginity at the age of 12 or below. However, this is obviously doubtful because even that very small number of learners will be at risk of contracting sexually transmitted infections including HIV at that young age. The data indicated that there was an association between the age of participants at the time of data collection during the first phase of this study and age of first sexual activity as shown in Table 4.3.

Respondents who were younger than 17 could obviously not report a sexual debut in the 17-19 year range and therefore these respondents only reported their sexual debut in the ‘children’ and ‘early teenage’ phases. Taking the sample as a whole, the majority of learners (56 -64.4%) became sexually active between the ages of 13 and 16 years, with a few (20 - 23%) learners reporting that they delayed their sexual debut to 17-19 years.

There was a statistically significant variation between the age of the sexually active group of learners at the time of data collection during the first phase and the age of their sexual debut ($p = 0.035$). The majority (88 - 50.3%) of learners reported that they were still virgins. Sixty-three (56.3%) learners in the age group 13 to 16 years and 25 (39.7%) learners between the ages of 17 and 19 years reported that they had never had sex. In contrast, 49 (43, 8%) learners between 13 and 16 years and 38 (60.3%) learners at the age of 17 to 19 years reported being sexually active. I will return to this later in chapter 6 to see how many of these learners had lost their virginity by the end of the intervention since this is one of the key areas of my study.

Table 4.3: Age of sexual debut and age of participants at the time of data collection (n = 87)

	Age of first sexual debut			Total
	Children ≤ 12 years	Young teenage 13-16 years	Late teenage 17-19 years	
Age of participants at the time of data collection.	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
13-16 years	6 12.8%	41 87.2 %		47 100.0%
17-19 years	5 12.5%	15 37.5%	20 50.0%	40 100.0%
Total/ Percentage	11 12.6 %	56 64.4%	20 23.0%	87 100%

The above findings refer specifically to the sexually active group, i.e., those learners who reported that they were already sexually active at the time of data collection during the first phase. Learners who were already sexually active were more at risk of sexually transmitted infections including HIV due to the fact that their relationships were secret, their lack of emotional maturity and probable inability to negotiate or use safer sexual practices. These participants were also at risk of pregnancy, early, unplanned parenthood

and dropping out of school. Previous studies have shown that pregnancy is the biggest danger for young women and men in relation to school completion (Harrison, 2005:4).

AGE OF SEXUAL DEBUT AND AGE OF SEXUAL PARTNERS

There was a statistically significant variation in terms of gender in the ages of sexual partners and age of sexual debut amongst sexually active learners ($p = 0.001$). The majority of sexually active boys (19 - 40.4%), compared to girls (3 - 7.5%) reported that they experienced sexual debut with girls of 15 to 16 years of age who were the same age as they were. Most of the sexually active girls, (14 -35%), reported that they first had sex with young men of more than 19 years of age.

These findings of the first phase are consistent with reports in the literature and previous research findings that have shown that female youth tend to have sexual partners that are older than themselves. As Whitehead (2001: 440) asserts, the traditional age difference within couples is for the male to be slightly older than the female. Another reason could be associated with the economics of sexual activity. The so called 'Sugar Daddy' culture has already been mentioned, in which school-going girls are attracted to older, financially stable men and have sexual relations with them for material gain. Studies such as those done in KwaZulu-Natal by Leclerc-Madlala (2002:31) in the community of St Wendolin's and Hunter (2002b: 104) in Mandeni both reflect this trend. The findings of Gorgen, Mohamed, Marx and Millimounou's (1998:65) study, conducted among urban youths in Guinea revealed that boys and younger girls are more likely to have partners who are the same age as them while older girls are likely to report income-earning partners who are much older than them.

In this era of HIV and AIDS this trend could increase young girls' vulnerability to HIV infection, as it could also be associated with increasing rates of rape. Men may attempt to seek relations with younger girls to avoid HIV infection or to cleanse their blood of HIV, in a belief that sex with a virgin can cure AIDS (Leclerc-Madlala, 1997: 369).

A substantial age difference between sexual partners may bring with it the patriarchal notion of domination by the older male, accompanied by social pressure on

the younger female to maintain a relationship with the male partner. This contributes to gender-power inequalities that inhibit a girl's ability to negotiate with the partner, due to her respect for an older partner coupled with the traditional gender-power inequality. Men, and to an even greater extent women, become more vulnerable to HIV infection.

Where there was a considerable difference between the ages of sexual partners at the time of data collection during the third phase of this study, the girl's ability to negotiate seemed to be less.

AGE OF SEXUAL DEBUT AND HOME LOCATION

An association was also found between the age of first sexual encounters of learners and the location of their homes. The learners in urban areas were, on the basis of this data, more likely to engage in sexual activity below 13 years, than learners in other contexts. All learners from urban areas (4 - 50%) reported having made their sexual debut at less than 13 years of age. This is significantly higher than the 5(10.6%) out of a total of 47 (100%) rural dwellers and the two (6.3%) learners out of the 32 (100%) township dwellers. These findings could be influenced by the fact that in the city, young people have easy access to media influences.

However, the limitation of this data is that it is difficult to generalise from such small numbers. It nevertheless seems to be the case that learners coming from homes located in urban areas reported sexual debut earlier, followed by those from homes in rural areas and then those from homes in peri-urban areas. It is possible that young people engage in early sexual activity as a result of the influence of the home environment. The difference in locations could be associated with the type of families of learners.

For example in urban and peri-urban areas, nuclear families are common and may favour early sexual debut because most of the parents are busy working and do not have time to talk with their children at home. To compensate for that they might allow them to watch television or use the internet or stay out late. The delayed sexual debut in learners from rural areas could be shaped by the presence of their parents or family members, who are usually available at home to keep a watchful eye over their children. An association

was found between the age of participants in data collected during the third phase of this study and age of first sexual activity, as I shall explain later in Chapter 6.

No significant association was found between age of sexual debut and other socio-demographic characteristics of learners. This means that similar responses were obtained from learners concerning their sexual debut. There appeared to be no difference between females or males, members of religious groups, or grades at school. No difference seemed to exist between learners at rural or peri-urban schools, and nor did the fact that learners were staying with parents, were or were not orphans, lived in female- or male- headed households, came from a high or low social class. Data about social class of the sample, houses in which the participants lived and high and low social class, including parents' categories of occupation, are presented in Appendix 11.

The findings of previous studies, such as those reported in the 1st South African National Youth Risk Behaviour Survey, "Umthente uhlaba usamila" conducted in 2002 by the South African Medical Research Council, (MRC, 2003: 52), show that other factors in addition to gender and place of dwelling were associated with the age of sexual debut. The MRC (2003:52) report revealed that 41% of learners in grade 8 to 11 reported having had sex, with significantly more male learners (50.1%) than female learners (34.1%). More 'black' learners (43.6%) compared to 'white' learners (25.9%) reported having had sex: 14.4% reported having had sex before the age of 14 years, with significantly more males (25.4%) than females (5.6%) (MRC, 2003:52). Racial differences in adolescent sexual behaviour may be attributable to cultural factors such as the social construction of gender roles, stereotypes, expectations conveyed to girls and boys in relation to sexual matters (Bingham, Miller and Adams, 1990:30).

The findings of my study, though they differ from the MRC findings, which are based on nationwide research amongst learners of different groups, are consistent with the findings of other KwaZulu-Natal regional studies. Harrison's (2003:199) study, conducted in rural KwaZulu-Natal, reported that a high proportion of adolescent girls became sexually active between the ages of 17 to 19 years. Males reported their first sexual relationship at age of 14 or less, with a range of sexual debut from 9 to 14 years (Harrison, 2003:2000). Richter's (1996:1) study of age of sexual debut showed that South African youth became sexually active, on average, between the ages of 13 and 15 years.

In 1999, the MRC reported on adolescents in Durban, which revealed that over 50% of the youth between the ages of 14 and 22 years were sexually active (MRC, 1999: 26). However, more than half of the learners who participated in my study (see Table 4.1) reported that they were abstaining from sexual activity, which is significant given the ABC approach to HIV prevention in South Africa.

ROLES OF PARTNERS IN SEXUAL ACTIVITY

In my study gender was found to be a predictor of initiating sexual activity, as shown by significant variations between introduction of sexual activity and gender ($p = 0.001$). The majority of sexual interactions were initiated by boys. Eighty three percent ($n=39$) of boys compared to 17.0% ($n=7$) of girls reported that they initiated sexual activity. This confirms findings of previous studies conducted in KZN schools (Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries, 2002:70; Thorpe, 2002:62).

Most of the findings of this study are consistent with the findings of various studies that have been conducted in South Africa. Leclerc-Madlala's (2002:33) study in St Wendolins found that young people believed that a man was expected by society to be the initiator of sexual activities. This finding was confirmed by male students at the University of Botswana, who were interviewed in Pattman's (2002: 41) study. They justified their initiative in sexual matters by stating, among other things, that their identities as men implied the expectation that they would take the initiative in heterosexual relations.

In support of the findings of this study and of the other studies, Kaaya, et al, (2002:156) argues:

Mores and norms regulate sexual relations and reproductive life, such that women are generally expected to be chaste and show deference to men, while men are viewed as virile and initiators of sexual encounters.

Similar sexual roles apply to boys and girls in the Zulu culture. These norms suggest that there are various factors, such as the socio-cultural construction of gender and power

inequalities demonstrated by the expectations of males to be initiators of sexual activities that increase young men's and in turn young women's risk of being infected with HIV.

These findings indicate the need to examine whether there was consensus between partners concerning their sexual encounter and the decision-making patterns of partners prior to sexual activity, as will be examined in the following section of this chapter.

SEXUAL DECISION-MAKING, CONSENSUS AND CHOICE IN SEXUAL ACTIVITY

The majority (57 - 65.5%) of sexually active learners of both sexes indicated that it was their choice to have sex, compared to 30 (34.5%) learners who reported that they were forced to have sex. There was a significant variation between the decision to engage in sexual activity and gender ($p = 0.001$). As the findings in Table 4.4 reveal, out of the 87 (100%) learners who reported having had sex, the majority 38 (80.9%) of boys, compared to 19 (47.5%) girls, reported that they had an agreement with their partners and it was their choice to have sex. Over half of all sexually active girls 21 (52.5%), did not agree to have sex and a significant number (one fifth) of boys 9 (19.1%) were in the same predicament.

Table 4.4 Decision or choice to have sex in relation to gender (n = 87)

	Was it your choice or decision to have sex?		
	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	19 47.5%	21 52.5%	40 100%
Male	38 80.9%	9 19.1%	47 100%
Total/ Percentage	57 65.5 %	30 34.5%	87 100%

These findings suggest that there is too little negotiation and communication on issues of sex and this is particularly to the detriment of girls, as shown by the larger number of boys (38 - 80.9%) than girls (19 - 47.5%) who reported that it was their decision to have sex. These findings, shown in Table 4.4, correspond with those about the initiation of sexual activity, where males were more likely than females to report that they initiated sexual activity.

When they were asked about their reasons for becoming sexually active, significantly more (26 - 68.4%) boys than 11 (57.9%) girls reported a wish to prove their love for their partners as the main reason for becoming sexually active. On the other hand, almost similar proportions of learners, (8 - 21.1%) boys and (4 - 21.1%) girls cited pressure from friends. Three (15.8%) girls and two (5.3%) boys cited pressure from their partner; two (5.3%) boys, compared to one (5.3%) girl reported other miscellaneous reasons such as “I was ready and craving” (reported by one boy) “I do not know why but it just happened” reported by one girl. My study shows that a relatively small minority of learners (12 - 21.1%) were influenced by peer pressure, since most of them reported that they had sex voluntarily.

COERCED SEX IN RELATION TO GENDER

In contrast, the findings in Table 4.4 indicate that there was significant variation by gender because out of the 87 (100%) learners who reported having had sex, in response to the question ‘was it your choice or decision to have sex?’ (see Appendix 1), the majority of girls 21 (52.5%) compared to boys 9 (19.1%) reported that they did not choose to initiate sexual activity. However, just because it was not their decision it does not always necessarily mean that they were coerced. It might not have been their decision to initiate sexual activity but they might have agreed for a variety of reasons; this did not necessarily indicate that they were coerced or raped. Negotiating sex is subtle and often non-verbal and it is often difficult to ‘read’ the language of enthusiasm, agreement, disagreement or refusal. Nevertheless, weight should be placed on responses that indicate a lack of agreement.

Table 4.4, shows the number of girls far exceeded that of boys who reported that it was not their choice to start engaging in sexual activity. In response to the question 'if the answer is 'no' to question 20, were you forced?' (See Appendix 1), boys were more likely (7 - 78%) than girls (3 - 14%), to report that they were not forced. Of 30 learners who reported that it was not their choice to initiate sexual activity, the majority of girls (18 - 86%) compared to boys (2 - 22%) reported that they were forced. This shows that the majority of , but not all girls, and few boys suffered coerced sex associated with gender power inequalities. This indicates that there are a range of complex gender patterns in which not only girls, though they are generally a majority, but also the minority of boys at various points, are made to engage in sexual activity against their will. This situation exposes the vulnerability of both girls and boys to HIV infection. Later in Chapter 5, other factors reported by boys and girls as increasing their vulnerability to HIV will be discussed.

Other findings of the questionnaire (see Appendix 1) on the section of gender issues also revealed that the majority 24 (35.8%) boys compared to 11 (10.2%) girls indicated that it is right for a boy / man to demonstrate his manhood by hitting his girlfriend. These findings correlate with the findings of other studies such as Mark Thorpe's (2002: 64) study which reported that some boys were quoted saying " Some friends say she is making you a fool, they will say you have to beat her until she has sex with you". In addition, the MRC (2003:55) report revealed that nationally, 8.3 % of learners reported having forced someone to have sex and 9.8% reported having been forced to have sex. Out of these data, 10% of females and 2.4% male learners reported having been forced to have sex.

Issues of masculinity and male power in contexts of sexual intimacy are critical in understanding sexual coercion and violence. Existing studies (Wood and Jewkes, 2001:29; Susser and Stein, 2000:41) have already demonstrated how constructions of masculinity are implicated in HIV risk. This study, later in Chapter 5, will return to the question of masculinity and examine how current understandings of masculinity among the boys remain influenced by Zulu cultural and patriarchal values.

The following section examines sexual activity in relation to the number of sexual partners on the basis of the number of partners reported by participants and attitudes towards the number of sexual partners.

THE NUMBER OF SEXUAL PARTNERS AND GENDER

As has already been shown, boys tend to begin sex at an earlier age than do girls. In this section, I discuss the number of sexual partners that boys and girls have in an effort to establish whether boys are having more sex than girls. There was a statistically significant variation between the number of sexual partners reported by sexually active learners (87 - 49.7) related to their gender ($p = 0.001$) during the first phase, with boys being more likely to report having numerous sexual partners than girls. Significantly more boys (25 - 53.2%) than girls (14 - 35%) reported having had more than one sexual partner.

There was further statistically significant variation ($p = 0.001$) with more boys (24 - 51%) than girls (7 - 18%) reporting having more than one sexual partner at the time of data collection. In response to one of the questions asked during data collection, "how many sexual partners do you have at present?" Among those who said that they had more than one partner, more boys, (13 - 19.4%) than girls, (4 - 3.7%) reported two partners, five boys (7.5%) compared to 3 females (2.8%) indicated three partners, four boys (6.0%) and only one girl (0.9%) reported four partners, two boys (3.0%) and one girl (0.9%) indicated five partners and only one girl (2.3%) reported six partners. There were two extreme cases where one (1.5%) boy reported having 14 sexual partners and one girl reported having 10 sexual partners. This data could result in a boy being referred to as "*Isoka lamanyala*" meaning that he is a womaniser, with a lot of girlfriends without any intention of marrying them (Hunter, 2002: 2). By contrast, according to Zulu culture, the girl would be referred to as a woman who is without morals and is promiscuous, as explained earlier.

The findings of this study were similar to the reports in the findings of other studies looking at HIV and AIDS and youth culture. Larger proportions of sexually active males than females reported two or more sexual partners in most studies conducted among school adolescents of rural, mixed urban and rural backgrounds, as well as urban

samples (Buga, Amoko and Ncayiyana, 1996: 523; Kiragu and Zabin, 1993: 92; Jinadu and Odesanmi, 1993: 111). As one of the boys in Selikow, Zulu and Cedras's (2002:24) study stated:

“If I have many girlfriends, then I see myself as *ingagara*. Wherever I go no one can claim he is better than me...If you have six ladies you are in control...”

In Thorpe's study (2002:63), girls stated that it was against Zulu custom for them to have more than one boyfriend. Girls further suggested that even if they wanted sex it was not for them to request it from boys because their request would carry the stigma of promiscuity (Thorpe, 2002:63). Such gender-power inequalities that manifest as cultural and social constructions of masculinity and femininity increase young men's and most particularly young women's vulnerability to HIV infection.

NUMBER OF SEXUAL PARTNERS IN THE PAST FOUR MONTHS AND GENDER

Significantly, more boys (25 - 53.2%) than girls (7 - 17.5%) among those who have ever had sex reported having had sex with more than one sexual partner in the past four months. This is not an unexpected finding. Three times more boys than girls were having sex with more than one partner.

This study shows that although many learners are abstaining from sex amongst those who were sexually active, some reported multiple sexual partners. It is evident that sexual behaviour in this group is not uniform and it may be suggested that young people are responding differently to the HIV and AIDS epidemic. Yet adolescence is a time of sexual experimentation and it is not surprising that some of these respondents are doing precisely this. School-going youth are in a stage of development in which the formation of sexuality and the development of trust frequently involves a high turnover of sexual partners (Lear, 1995: 1311).

The findings of the first phase of this study were consistent with the findings of the national youth health risk behaviour survey aimed at the whole adolescent population of South Africa, conducted by the Department of Health in partnership with the

Department of Education and South African and Medical Research Council (MRC), (2003:12). The study population comprised grades 8,9,10 and 11 public school learners in the nine provinces (MRC, 2003:18). The findings of the survey, according to the MRC (2003:53), were that there was 70.2% national prevalence of having had one or more sexual partners in the past three months among white, coloured, and African learners in South Africa. Out of these, the highest percentage (77.8%) was among KwaZulu-Natal learners. A critical difference is present between the findings of MRC and my study. My findings suggest that abstinence, shown in Table 4.1 and monogamy, as reported by the majority of girls earlier, were commoner among learners who participated in this study than in the earlier, national average.

ATTITUDES TOWARDS THE NUMBER OF SEXUAL PARTNERS

Both boys and girls seemed to have the same attitude towards the number of sexual partners, with most girls (74 - 68.5%) and boys (45 - 67.2%) reporting that it was wrong for a girl or woman to have more than one sexual partner. There was however a difference in attitudes in relation to the gender groups, with more boys (33 - 49.3%) than girls (21 - 19.4%) indicating that it is 'right' for a boy or man to have more than one sexual partner.

Attitudes may not necessarily translate into sexual behaviour; nevertheless these findings indicate different gendered expectations of boys and girls. It is possible for someone to believe in monogamy and to practice polygamy. Views reported by participants need not be taken as reflections of what actually happens between them and their sexual partners.

There was a statistical significance between attitudes towards the number of sexual partners and gender ($p = 0.009$) with 53 (79.1%) males out of the total of 67 compared to 59 (54.6%) females out of 108 reporting that it is acceptable for men to have more than one sexual partner. However, whereas three quarters of boys believe that boys have this 'right' only about half of girls have the same view, indicating that there is an emerging criticism among girls of gender double standards.

This study shows that more than half of the girls believe in the male's sexual prerogative to have many girlfriends but almost half do not believe this. From the various reasons offered by learners, the main reasons reported by boys (20 - 29.9%) out of the 67 boys in the sample and only 21 (19.4%) girls out of the 108 were, "African culture supports polygamy for real men" and the concept of *amasoka*, ie men with multiple female sexual partners, who were generally admired, was another reason reported by an equal number of boys (20 - 29.9%) out of 67 boys and girls (20 - 18.5%) out of 108 girls.

The other reasons that were presented were that a man should have more than one sexual partner to avoid disappointment from a girlfriend who might decide to dump him as a response to pressure from friends, and so that he would be known as a 'playboy'. "Men exploit women" was reported by 11 (10.2%) girls and 6 (9.0%) boys as an explanation why men have more than one sexual partner. 'Freedom of choice and rights' were reported by 8 (7.4%) girls and 2 (3.0%) boys, when it came to reasons for having sex, and this was advanced as a reason for men to have more than one sexual partner by almost equal proportions of boys (4 - 3.7%) and four (3.7%) girls. Lastly, the need for satisfaction was reported as a reason by four (3.7%) girls and only 1 (1.5%) boy.

These findings show that 'traditional' and 'natural' reasons are offered by the minority to explain their views: for instance boys need to have sex more than girls and are unable to control their sexuality.

There was no statistically significant difference in relation to learners from different school and home locations in the attitudes towards the number of sexual partners.

Similarly, of those who used the concept *amasoka* as a reason, the majority, 20 (32.3%) were from rural high schools, compared to 19 (16.8%) from peri-urban high schools. 20% (2) learners from urban homes also used the *amasoka* concept. These perceptions of learners should be noted with concern as they might impact on the number of sexual partners that boys and girls have. They may grow up thinking that it is the norm to have more than one sexual partner if the practice of having multiple sexual partners, polygamy and *amasoka* are common and acceptable in their communities.

Although there were differences in responses between rural and urban, there is still widespread support for Zulu cultural understandings and the legitimisation of types of sexual activity from between 20% (one fifth) to 33% (one third) of the young Zulu men in my sample. This finding is probably associated with socialisation to the notions of polygamous patriarchy, as reported in other studies such as Hunter's (2002:104) in the community of Mandeni. He reported that a man who had more than one girlfriend was celebrated as "isoka" and that formed part of a discourse that celebrated some aspects of virility as part of masculinity. Hunter's most important suggestion is that AIDS deaths are altering discourses of masculinity and that there is evidence of young men turning away from displays of hyper-heterosexuality, as such behaviour is increasingly associated with HIV infection, ill health and death. The first phase of my study shows, however, that both the 'isoka' approach, which celebrates promiscuity amongst young men, as well as more circumspect behaviours are present among participants.

The following section focuses on examining boys' and girls' awareness, perceptions and attitudes towards condoms. It includes negotiation for and condom use in relation to the risk of sexually transmitted infections, including HIV in the context of gender. Few learners considered themselves to be at risk of HIV infection.

CONDOM AVAILABILITY AND GENDER

Virtually all learners (67 - 100%) males and 106 (98.1%) females reported having seen a condom. This represents an achievement: near-saturation in terms of HIV education in South Africa. However there was a minority of 2 (1.9%) female learners who reported having never seen a condom. Confirmation was made when they completed the questionnaires during the data collection process of the first phase of this study.

Table: 4.5 Learners who have seen a condom in relation to gender (n = 175)

	Have you ever seen a condom?		Total
	Yes	No	
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	106 98.1%	2 1.9%	108 100.0%
Male	67 100.0%		67 100.0%
Total/ Percentage	173 98.9%	2 1.1%	175 100.0%

Participants who had not seen a condom were from the lower social class category and their homes and schools were located in rural areas. This finding suggests that some communities have not been reached with regard to HIV and AIDS awareness and HIV prevention. This means more work remains to be done and policy makers and all other stakeholders involved in HIV and AIDS prevention programmes should be informed about the need to correct such situations.

Out of those who reported having seen a condom, more (38 - 56.7%) males than females (37 - 34.3%) females reported that it was via the health services in the area that a condom had been seen for the first time. More (17 - 15.7%) females, than four (6.0%) males had seen one at school; 13 (12%) females compared to 8 (11.9%) males had seen one at home, for example in a wardrobe. Eleven (10.2%) females compared to 2 (3.0%) males had seen one in the street and 7 (10.4%) males compared to 10 (9.3%) females had seen one on television for the first time. These findings seem to suggest that while health services remains the major source of disseminating information and preventive measures of HIV such as condoms, there are also other valuable sources of information such as schools, homes, streets and media such as television that play a major role in the fight against HIV and AIDS.

Fifty-nine (88.1%) males out of the total of 67, compared to 87 (80.6 %) females out of a total of 108 female learners reported that condoms were easily available to them. This is an achievement and supports the view that a lack of availability and knowledge of condoms cannot be cited as reasons for the high rates of HIV infection.

These findings show that knowledge and availability of condoms are high, however in the following section will first examine condom accessibility and later examine condom use with an aim of determining the sexual active learner's risk to HIV infection.

More females 21 (19.4%) than males 8 (11.9%) reported having difficulties in obtaining condoms and provided reasons such as "I am embarrassed and shy of what others might think of me when I take condoms," reported by some female learners. Others reported age reasons: "I am too young to obtain condoms". "I do not know where to get condoms" was reported by females. "I do not trust condoms from the clinic; they are not strong" was mostly stated by male learners, "I do not have time to go to the clinic to fetch condoms because the clinic is too far from my home," is mostly claimed by female learners.

Those who stated this last reason were from the lower social class category while the other reasons were reported by learners from both high and low social class categories. Of those learners who reported difficulties in obtaining condoms, the majority 17 (21.8%) were from homes located in rural areas compared, to 10 (11.5%) learners who were from homes located in peri-urban / township areas and 2 (20%) learners who were from homes located in urban areas. These findings suggests that there was no significant association between difficulties in obtaining condoms and location of homes of learners except that the majority of learners who reported this problem were from homes located in rural areas.

Studies conducted by S and Q Abdool-Karim, et al (1992 a, b, c) pointed out ongoing difficulties faced by adolescents in obtaining condoms. Their study was conducted more than ten years before my study, but these difficulties continue to act as a barrier to safer sex practices. In contrast to their findings, it appears from the data I obtained that condoms are now more readily available. The availability of condoms however cannot be simply associated with condom use because of certain attitudes

towards their use. Many men do not like using them and women are sometimes accused of being unfaithful if they ask their partners to use them. This is one of the reasons why female-controlled methods of HIV prevention such as female condoms and microbicides (the latter still being tested) are advocated to give women more sexual autonomy since they face barriers to condom use.

The issues relating to condom use will be examined in the following section of this chapter.

CONDOM USE IN RELATION TO SEXUAL ACTIVITY AND GENDER

The findings of this study suggest that relatively few of the 87 learners who reported being sexually active used condoms. This is worrying given the self-reported number of sexually active learners. As shown in Table 4.6 above, there was a difference between male and female learners ($p=0.001$), with 9 (19.1%) males compared to 5 (12.5%) female learners who reported having used condoms when having sex. Of those who reported using condoms more males (10 - 71.4%) than females (4 - 28.6%) reported knowing how to use condoms properly. Six (67.0%) males out of the 9 male learners and 4 (80%) females out of five female learners reported that they used condoms consistently.

In addition, similar proportions of males (3 - 33.0%) and only one (20.0%) female learner reported that she was using condoms, though inconsistently when having sex. The higher percentage (83.9%) ($n = 73$) of sexually active learners reported never having used condoms. Amongst those learners who reported having had sex, similar proportions, 35 (87.5%) girls out of 40 girls and 38 (80.9%) boys out of 47 boys reported never having used condoms (see Table 4.6).

Table: 4.6 Condom use in relation to sexual activity and gender (n = 87)

	Do you use a condom during sexual activity?		
	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	5 12.5%	35 87.5%	40 100.0%
Male	9 19.1%	38 80.9%	47 100.0%
Total/ Percentage	14 16.1%	73 83.9%	87 100.0%

Those who were sexually active but reported having never having used condoms gave various reasons for not using condoms such as not trusting condoms because they burst, forgetting to buy them and wanting "... flesh to flesh because I cannot eat a sweet in a paper. Condoms take away feelings and I am not afraid of anything such as disease or death". More male than female learners expressed the latter three reasons for not using condoms.

There was no significant association found between condom use and the age of learners. The reason for this is not clear because boys and girls of 17 to 19 years of age would be expected to have more knowledge the boys at least had condoms readily available. Another reason could be that older girls are having sex with older men. As indicated earlier, 14 (35%) females as compared with four (8.5%) males who participated in the first phase of this study reported having had sex with sexual partners of more than 19 years of age.

Based on my findings presented above, this study suggest that the majority of learners who were sexually active were not using condoms during sexual encounters and even some of those who reported using them they were doing so inconsistently. These

findings suggest that the majority of learners who reported having had sex were engaging in unsafe sexual practices and were at risk of contracting HIV.

Previous research studies support these findings: the MRC study (2003:53), reported that only 14.5% learners in KwaZulu-Natal consistently used condoms – significantly lower than the national average. This compares with the findings of the South African National Youth Sexual Activity Survey conducted in 2000, which revealed that 90% of respondents reported having heard of AIDS; such awareness failed to translate into behaviour change: one in five young people has had sex with more than two people and one of the boys in rural KwaZulu-Natal stated that even if he has two girlfriends, he uses a condom only if one of them is not trustworthy (“Love Life”, cited in *Sunday Times*, 2001:1) Knowledge does not translate into condom use and the majority of young people are prepared to take risks.

These findings show that substantial numbers of school-going learners of most age groups, especially males rather than females, are sexually active and some are engaging in unprotected sexual activity. I will return to this later in Chapter 6 to see if there has been any change between the first phase of my study and the end of my intervention.

NEGOTIATION FOR CONDOM USE IN SEXUAL RELATIONSHIPS

The findings of this section are based on the 87 learners who reported being sexually active at the time of data collection during the first phase of this study. There was a significant variation in gender among those learners who reported using condoms, with more boys (32.8 %) than girls (18.5%) reporting that they suggested the use of condoms to their sexual partners. More boys (25.4%) compared to girls (15.7 %) reported that their partners agreed. One of the boys expressed his partner’s response, “It is the right thing to do and it is safe”.

Some partners refused to use condoms, as reported by 10.4% males and 3.7% female learners. Some of the reasons reported were that their partners were angry with them. One girl reported, “My boyfriend said that he wants “flesh to flesh”, we must trust each other, the condoms could burst”.

The majority of boys, 23.9% compared to 13.9 % girls reported that their partners suggested the use of condoms to them and they agreed, while 10.4% of the males compared to 8.3% of the female learners reported that they refused their partner's request. As one male partner said, "I hate using condoms, I do not trust them and they burst easily" However, one of the female learners reported her reason for not agreeing to her boyfriend's suggestion to use condoms: "I was afraid to agree to use condoms because he always accuses me of having other sexual partners and I wanted to prove that I am faithful to him".

The findings of this study show in a gender-skewed way, the willingness of some young people to use condoms, although that willingness is not always translated into consistent condom use.

These findings are consistent with findings of other studies which seldom find consistent use of condoms among young people (Kaaya et al., 2002:157). However in the two studies conducted by Rodier, Morand, Olson, Watts and Saidi-Salah (1993:414) and Maswanya, Moji and Horiguchi (1999:185) examining the use of condoms amongst sexually active school adolescents in relation to gender showed that the rates of consistent use of condoms were lower amongst females, with a range of 24 to 36% compared to males who had a range of 48 to 53%. Studies conducted by other researchers such as Adler and Qulo (2000: 27); Ndiaye (2000:31) reported that despite adequate knowledge of the benefits of condoms, many men still resist using them.

In addition, the studies of Selikow, Zulu and Cedras (2002:27) and Abdool-Karim et al. (1992 a: 108) reported that negotiating the use of a condom is not a simple issue for most women. They pointed out the difficulties encountered by women in negotiating for condom use such as the strong association between condom use and notions of unfaithfulness, lack of love and incompatibility with manliness.

RISK OF HIV INFECTION IN RELATION TO PREVENTION OF THE SPREAD OF HIV IN THE CONTEXT OF GENDER

The majority of learners, 59.3% out of 108 girls and 55.2% out of 67 boys, reported that they thought that their partners had other sexual partners. However, there was a

significant variation by gender where more (34.3%) boys than (17.6%) girls reported that they would continue having sex with their partners without protection even though they had already heard that their partners had other partners. This is dangerous in the era of HIV and AIDS because such responses indicate that these young people are at risk of contracting HIV infection and yet seem not to heed the danger.

Various reasons were reported by learners to explain why they did not use condoms. "I love my partner" was reported by more (19.4%) males than (7.4%) females, "It would be too late because my partner would have already given me the disease" was reported by 4.6% of the female and 4.5 % of the male learners. 6.5% of the females and 6.0% of the males reported that "I am not sure how risky it is" as the reason for choosing to have unprotected sex with their partners whom they knew had other sexual partners.

In view of the continuing prevalence of HIV, it was important to determine learners knowledge of HIV in relation to their sexual behaviour and the increased risk of contracting HIV, if having unprotected sex with a partner who has other types of STIs that could possible enhance the risk of HIV transmission.

There was a marked difference by gender: more boys (56.7%) than girls (35.2%) reported that they were not aware of the increased risk of contracting HIV if a partner had unprotected sex with someone who had an STI. Furthermore, the significant finding of this study was that almost equally high percentages of both (52.8% girls and 46.3 % boys) reported that they did not regard themselves as at risk of contracting HIV. For example, one of the female learners gave the following statement as her reason for believing she was not at risk of becoming HIV positive, "My man is truthful to me and he is my only one" This means that this female learner felt that she was not at risk of becoming HIV positive because she had one male partner whom she trusted. She believed that he belonged to her alone.

However the findings of this study, particularly the fact that more boys than girls reported that they were unaware of the increased risk of contracting HIV associated with having unprotected sex with a partner who had an STI is of concern as it could increase boys' and girls' vulnerability to HIV . Learners who report that they do not regard themselves as being at risk of becoming HIV positive are of great concern, since

perception of vulnerability to HIV infection is essential to understanding and practicing precautionary measures.

The South African National Sexual Activity Youth Survey (LoveLife, 2001:1) reported that more than half of sexually active teens thought that they would not get the HIV infection from their partners and one in five has had sex with more than two people.

In contrast to the LoveLife report, which was national, my KZN study shows an almost equally high percentage of boys and girls (59.3% boys and 58.2 % girls) reported the age group 14 to 20 years as that in which people were most likely to be infected with HIV. These findings identify major contradictions in the way young people think about HIV and personal risk. Learners indicated their own age group to be most vulnerable to HIV, but did not relate it to their understanding and practice of safer sex and the precautionary measures to prevent STIs as well as HIV infection.

Current research studies worldwide are trying to find out the reasons why HIV and AIDS knowledge fails to translate into safer sex practices. Examples of those research studies include UNAIDS (2002:1); Di-Clemente (1990: 7), Slovin-Nevo, Ozawa and Auslander (1991:20); South African National Sexual Activity Youth Survey (LoveLife, 2001:1) which all reported high levels of awareness and knowledge of HIV and AIDS which have failed to translate into behaviour change.

These findings indicate that learners remain vulnerable to HIV infection: MRC (2003:55), reports that 7.4% of learners in South Africa have had a sexually transmitted infection (STI). Significantly fewer (1.2%) white and (3.2%) 'Coloured' learners who reported having had sex reported having had an STI, compared to 7.7% of the black learners who have had STIs. The reported prevalence of STIs among KwaZulu-Natal learners was significantly higher at 14.6% (11.0-18.2, well above the national average. The findings of my study, as well as an MRC (2003:55) study are supported by those of previous research studies such as those presented by Population Services International (2002:1) which reported that little to no impact has been made on the youth's perception of risk nor has there been behavioural change.

The following section focuses on examining young people's reported methods of HIV prevention in the context of gender.

LEARNERS' ROLES IN HIV PREVENTION AND GENDER

Boys and girls who participated in this study during the first phase were asked to respond to this question “What do you think you can do to protect yourself from becoming HIV positive?” This was done to determine their knowledge and personal practices related to HIV prevention and to strengthen their awareness of HIV and AIDS. Learners reported different ways of protecting themselves and their partners from contracting the HIV infection. These included abstaining from sex, which was reported by more females (61 - 56.5%) but only 22 males (32.8%). Being faithful to one partner was advocated by 30 females (27.8%) and 18 males (26.9%).

Using a condom when having sex was reported by more males (19 - 28.4%) than females (20 - 18.5%) as one of the ways of preventing HIV. Sleeping with the girl who is a virgin as a way of preventing HIV infection, was mentioned by few learners, mainly males 3 (4.5%) and one female (1.9%), while going for virginity testing was mentioned mainly by female learners (11 - 11.3%). Making responsible sexual decisions, meaning knowing that you are responsible for your sexual decisions was mentioned by slightly more females (14 - 13%) than male learners (8 - 11.9%), while ‘eating well’ was stated by a few males (4 - 6%) s and two females (1.9%) as means of preventing HIV infection.

It was observed in this study, that there were variations by gender, where girls reported abstaining from sex, being faithful to one partner and making responsible sexual decisions more than boys as their responses to what they would do to prevent HIV infection. In contrast, more boys than girls reported using a condom when having sex, as what they would do to prevent HIV infection. Only females reported going for virginity testing, while only males reported sleeping with a girl who was a virgin, as what they would do to prevent HIV infection. These findings reveal that children are socialised into traditional socially constructed gender role patterns and internalise them at a young age. Furthermore the responses indicate that the “Abstain, Be Faithful and Condomise” (ABC) model has informed young people about the prevention of HIV. However, the question remains as to whether they practice what the ABC model advocates. It is significant, for example, that one third of the boys, who participated in this study, believe that abstention is a good protection against AIDS; this is striking in the context where sexually activity used to be considered a marker of masculinity.

The findings of this study relate to Obidigbo's study (2002: 24) where it is stated that gender-role socialisation has been revealed as a strong factor in the construction of gender identities, such as those related to sexual behaviour of children. Few of the learners in his study perceived condom use positively although more boys (28.4%) than girls (18.5%) were in favour of condoms. The low levels of condom advocacy by girls, in Obidigbo's study and others, such as Taylor, Dlamini, Kagoro, Champaklal, Jinabhai, Sathiparsad and De Vries study (2002:71) is of major concern.

Although Kuzwayo (2002) claims that virginity testing for boys does exist, there are significant differences in terms of gender when it comes to the practice of virginity testing which is mainly done on young women and girls only. Virginity testing in young women is done by older women to check for '*iso*' meaning an eye-like shining structure representing the intact 'hymen' whose presence would indicate that young women are not yet sexually active. In my study, only 11 females (11.3%) reported going for virginity testing as one of the way of preventing HIV infection. I did not ask learners who participated in this study whether they had attended virginity testing or not. This response therefore does not mean that these girls had actually gone to virginity testing. They stated this as a method they could opt for to protect themselves against HIV.

Virginity testing for boys is rarely documented. As indicated earlier, Khuzwayo (2002:68) reports that historically, according to Zulu custom, an elder used to observe the way a boy passes urine as well as the skin of his genitals; the back of his knees was also observed for tightness, to check if the boy had started to be sexually active. Khuzwayo also emphasised the importance of reviving the practice of virginity testing for boys in this era of HIV and AIDS. Virginity testing for girls is the only one practiced nowadays (Khuzwayo, 2002:65). Virginity testing for boys seems to have been non-penetrative, not invading their private parts, as compared to virginity testing for girls. The human and sexual rights of boys would be less violated than those of girls, where a stranger touches the girl's private parts when their virginity is tested.²⁰

²⁰ For more details of the current practice and the ABC rating scale of girl's virginity testing "*Ukuhlolwa kwezintombi*" and the awarding of certificates for those found to be virgins, refer to the study that was conducted in 2000 in KwaZulu-Natal (Khuzwayo, 2000: 13; Leclerc-Madlala, 2001:537).

The emphasis on virginity testing to check if girls are still virgins may in fact promote gender inequalities and the spread of HIV infection if the same emphasis and practice of virginity testing is not applied to boys. In support of this view Leclerc-Madlala (2003:16) and the Commission on Gender Equality (2001:2), advocate that virginity testing for girls, while boys are not tested, is an infringement of their human rights. Only a few male learners (3 - 4.5%) who participated in this study, whose virginity status is not known, reported sleeping with a virgin as one of the means of preventing HIV. This shows that virginity testing for girls, while boys are not tested also contributes to power inequalities that increase young African women's vulnerability to HIV. If they are known to be virgins, they are prone to sexual abuse, such as rape by men who are sexually experienced and those who believe in the myth that sleeping with a virgin will help to cure AIDS.

The folk belief in virgin cleansing, meaning the belief that a person with AIDS or another sexual disease can cure themselves of it by having a sexual encounter with a virgin has been documented as increasing the vulnerability of individuals with disabilities to rape and HIV infection (Groce and Trasi, 2004:1663).

However, despite the negative results and critiques of virginity testing for girls, I acknowledge that there are other approaches to girls' virginity testing that are non-penetrative, such as looking at the breasts and the back of the legs of young girls. Such rituals might be structured into processes of gender identity construction rather than approaching it from the angle of equality between boys and girls.

The following section examines the role of parents, as examples of the influence that various 'stakeholders' might have in making boys and girls aware of complex issues such as sexual and gender issues and HIV prevention.

PARENTS' ROLE IN TEACHING THEIR CHILDREN ABOUT SEX, HIV PREVENTION AND GENDER EQUALITY

The vast majority of boys and girls in the sample (85.2 % of girls, and 80.6% of boys) believe that parents should play an active role in making their children aware of gender and sexuality issues and of HIV and AIDS. This was indicated by learners in response to

one of the questions asked at the time of data collection during the first phase of this study: "Should parents play an active role in making their children aware about gender issues, sex as well as HIV prevention?". There was a slight difference by gender in responses given by learners. In contrast to the young people's preference for a parental intervention in teaching them about these issues, parents still seem to face difficulties in playing this role. Top talk show host Felicia Mabuza-Suttle reported that as a parent, she is still unable to speak to her two daughters about sex (Jacobson and Levin, 2000:8). Former Miss South Africa, Kerishnie Naicker reported that she had to wait until University to discover the full facts about sex (Jacobson and Levin, 2000:8).

There were statistical differences between boys and girls, with more boys (20.9%) compared to fewer girls (9.3%) reporting 9 as the most appropriate age for sex education. By contrast 19.4% of the female and 10.4% of the male learners reported 12 years as the most appropriate age when parents should start making their children aware of sex and gender issues as well as HIV and AIDS and the prevention of HIV infection. These gender differences in the age when parents should start making their children aware of sex related issues and HIV prevention correspond to those noted in sexual practices, where 9% males and 4.6% females reported having had their first sexual encounter at less than 13 years of age. Three percent (3%) of males compared to 0.9% of female learners reported having had their first sexual experience at less than 9 years of age.

Nearly all learners trust their parents enough to talk to them about sex and HIV and AIDS, although more females (100 - 92.6%) than males (51 - 76.1%) are prepared to take this step, as they indicated that they would like parents to talk to them about these issues. Eight males (11.9%) compared to three females (2.8%) reported that parents do not have time to talk to them at home. This implies that parents should set aside a special time to talk with their children at home about sex, gender issues, HIV and AIDS and prevention of HIV infection.

CONCLUSION

The findings of this study show that substantial numbers of school-going learners are engaging in unprotected sexual activity, meaning that the younger generation in KwaZulu-Natal is vulnerable to HIV. According to the MRC (2003:55) report, KZN had a significantly higher prevalence of HIV than other provinces. High knowledge of HIV and AIDS and self-reported high levels of abstinence were evident, especially amongst girls. This was also evident amongst boys though it did not correlate to safer sexual practices. An early age of sexual debut, multiple sexual partners, low levels of condom use combine with relatively high levels of sexually active learners. Low levels of awareness were reported by the majority of learners to the risk of HIV infection.

Over half of the girls and one third of boys who participated in this study, believe that abstention is a good protection against AIDS. However boys also consider that being sexually active is a marker of masculinity. Another main finding included high level of trust in parents by learners and their eagerness to be taught by parents about sexuality, gender and HIV prevention issues.

The results of data collected during second or intervention phase are discussed in Chapter 5 while results collected after the intervention phase in the third or evaluation phase are discussed in Chapter 6.

CHAPTER FIVE: INTERVENTION PHASE RESULTS

INTRODUCTION

The second phase of the study consisted of the intervention which I introduced to a cohort of school-going youth in the Northern KwaZulu-Natal area. The intervention was designed to empower learners about gender-based life skills that will impact on the knowledge, attitudes and behaviours of the cohort. The expectation was that the intervention would improve the knowledge of the participants, enhance their gender sensitivity and lead to less sexual risk-taking as they explored their sexual identities and molded their gender identities as heterosexual young men and women. Zulu boys and girls are likely to draw their identities and their own subject discourses from the gendered Zulu culture in which they live. A consequence of this is that they receive, but do not necessarily accept, the messages of Zulu culture in their own gendered ways.

I developed materials for the gender-based intervention that made it possible to use combined methods such as focus group discussions, games and role-plays in this intervention, as will be outlined below.

THE DESIGN AND PROCESS OF THE INTERVENTION PHASE

An action research method was used during the intervention phase. This approach allowed me to engage actively with girls and boys of school-going age. It also helped to determine their perceptions and the meanings they attached to notions of gender such as femininity, masculinity and patriarchy. It further assisted in exploring and discussing the ways in which these notions of gender influenced their sexuality and sexual decision-making processes. The participatory action research method was also as a vehicle to explore and challenge their notions of patriarchy and to create a mindset that might raise learners' awareness of the measures needed to prevent HIV infection.

The intervention encouraged boys and girls to adopt notions of gender equality, respect and healthier sexual behaviour that might protect them against HIV infection. It is appropriate to talk about the construction of gender identities because the goal of the intervention was to sensitise young people to gender-based life building skills with the

aim of changing attitudes relating to issues of sex and relationships and to promote HIV prevention in the context of equal respect for both genders.

After establishing the level of knowledge of learners in the first phase, nine workshop sessions were held with learners who had participated in the initial phase. These nine workshops constituted the second phase of this study, as shown in Table 5.1.

Table 5.1 provides a guide to the intervention. Each session was devoted to a single topic. The table indicates what methods and learning strategies were used to ‘teach’ the topic. The final column indicates what themes emerged in the session itself. Only the most significant themes are identified. There were other themes that emerged less frequently, but these have not been included in the table because they were not relevant to the purposes of the intervention.

Table 5.1: Topics of sessions of intervention, methods and themes

Session Number	Topics of sessions	Methods and Strategies	Themes
01	Perceived meaning of terminology	. Flip charts and pens . Focus group Discussions (FGD)	
	Sex		*Genital organs # Sexual intercourse
	Gender		*Being female or male # Women and men issues
	Gender equality		* Women and men are equal #Men and women are equally human
	Sexuality		*Knowing your body # Study of sex
02	Perceived meaning of ‘reproductive and sexual rights’	. Flip charts and pens . FGD and Role-play	
	Reproductive rights		* Decision-making prior to doing ‘things’ .# Planning for a baby
	Sexual rights		* Sexual decision-making rights # Natural rights for boys to have sex

03	Patriarchy	. Flip charts and pens . FGD	
	Perceived meaning and examples of patriarchy		* Discrimination against women # Are men rulers and decision-makers?
	Other examples of patriarchy		*Male domination and violence against women. # Are men initiators and sexual decision-makers?
	Recommendations / suggestions		Young peoples' role in HIV prevention in relation to patriarchy
04	Gender-based stereotypes	Gender games (see Appendix 2.6)	
	Gender role stereotypes Gender identity Sexual identity		
05	Issues of sex	. Flip charts and pens . FGD	
	Terms used for the language of sex and related issues:		
	What were the sources of information on sex?		Parents Other family members Friends Other
06	STIs, HIV and AIDS		
	Factors promoting youth vulnerability to STIs including HIV	Flip charts, pens and FGD	* Fear of dominant males # Experimentation
	Peer education about STIs, HIV and AIDS basics	Role-play (see Appendix 2.8)	
	STIs / HIV risk, transmission and prevention	STIs, HIV and AIDS Cards and HIV and AIDS board games	
07	Life skills		
	# Assertiveness	Role-play (see Appendix 2.9.a)	
	# Sexual decision-making	Role-play (see Appendix 2.9.b)	
08	Life skills		
	# Negotiations for abstinence	Role-play (see Appendix 2.10)	

09	Life skill		
	#Negotiations for safer sex	Role-play (see Appendix 2.11)	

The topics of sessions indicated in the table above were planned after obtaining the baseline data during the first phase, in preparation for the sessions of the intervention phase. These session topics constituted a structure that governed how the topics of the various sessions were planned and presented during the intervention phase. The topics were selected because they served as indicators of the participants' basic knowledge. They were also selected to serve as convenient arenas of change. These arenas and evidence of the impact of the intervention are discussed in Chapter 6.

The change in learners' views was expected to be revealed in the third or evaluation phase, when comparing the data that was obtained in the first phase with the data obtained in the last phase. These results, relating to changed views, will be outlined in Chapter 6.

THE RESULTS OF THE INTERVENTION PHASE

The results presented in this chapter were the product of focus group discussions which occurred in each session. Themes that emerged were recorded on flipchart sheets. In addition, the presentation of female and male learners' views during first, second, third and fifth sessions also provided material for the results discussed below as did the first part of the sixth session.

The aim of this chapter is to give the reader insight into the views of learners who participated in the sessions of the intervention phase. The most frequently occurring views will be incorporated as quotations or narrative descriptive statements.

Session 1: Perceived meaning of terminology

Session one was concerned with determining the participants' understanding of the English terms²¹ used when discussing gender and sexuality terms such as 'sex', 'gender', 'gender equality' and 'sexuality'. The group was asked to brainstorm and explain any other words they thought of when they heard one of the terms displayed in Table 5.1. Any change or shift that occurred will be noted and discussed further in Chapter 6.

Groups were either all-male or all-female, since I believed that girls especially would speak more frankly in single-sex groups. Learners, both girls and boys, were free to express themselves. My presence and my talking to them about sex explicitly did not seem to intimidate them despite taboos attached to talking about sexual issues in Zulu culture. Learners accepted my explanation of the role of a researcher and the purpose of my study, which together contributed to a relaxed atmosphere from the first introduction day of the intervention.

Gender issues were approached through questions that activated reflections among learners on their own experiences in order for gender issues to come alive and to stimulate their minds (see Appendixes 2.3, 2.3.1). The findings obtained after the brainstorming exercise were then categorised into the following themes.

'Sex'

Two themes were formulated from the units of meaning given by learners after brainstorming as they were asked to say what came to mind when they heard the term 'sex'. These were "genital organs" and "sexual intercourse", (see Table 5.1).

Most responses from the female learners indicated that they perceived the meaning of the term 'sex' in relation to biological parts or genital organs. They perceived genital organs as the private parts that a person is born with and which differ in males and females. This was illustrated by the following reported by one female group:

²¹ Although focus groups discussions were mainly in English, I allowed the use of isiZulu in the groups where participants wished or needed to refer to isiZulu terminology or meanings.

Sex means “*isitho sangasese umuntu azalwa naso, owesilisa noma owesifazane*”
[private organs that a person is born with, a male or female].

Boys understood the term differently. Most responses from groups of boys seem to associate the term ‘sex’ with sexual activity. One boy made the following statement:

“Sex is about man and woman sleeping together having sexual intercourse. Sex serves as a way of showing that you love some one and a proof of being loved.”

In this study, the gender of the participants was found to be a predictor of young peoples’ understanding of the term ‘sex’. Significantly, most male learners’ views seemed to relate the term ‘sex’ to ‘sexual encounter’. This finding suggests that boys and girls in Zulu culture are brought up differently and develop different understandings of sexuality.

In Zulu culture, as part of the development of traditional masculinity, young men are encouraged to be aggressive, sexually knowledgeable and to initiate and dominate sexual relationships to prove their manhood. Society expects young women to be passive, ignorant and innocent about sexual matters, as part of the development of their femininity. In traditional Zulu culture there were formal structures that guided and monitored sexual matters of young men and women and enforced discipline. Some examples of these structures were the roles played by elder women, commonly known as ‘*amaqhikiza*’, who advised young women to practice non- penetrative sex by using activities such as ‘*ukusoma*’ meaning a non-penetrative, thigh sexual encounter. The fact that the young men and women who participated in this study had fundamentally different understandings of the meaning of ‘sex’ suggests that both are influenced by cultural and social pressures.

‘Gender’

“Being female or male” and “women and men issues” were the two themes that emerged from discussions of the term ‘gender’. This was illustrated by the following views of female and male learners:

“Gender refers to who you are. You are either being a female or male.” (Reported by one female group)

“Gender is about differences between males and females. Gender refers to women and men issues.” (Reported by one male group)

The findings of this intervention phase show that both female and male learners perceived the meaning of the term ‘gender’ similarly. They associated the term ‘gender’ with roles or characteristic features socially constructed by society as being associated with females or males. I would have expected a group like this to have some misunderstanding about the complex term ‘gender’, but participants in this study appear to have understood it as referring to socially constructed differences. They may have been influenced by the statements about gender in section B of the self-administered questionnaire (see Appendix 1) completed in the first phase of this study.

The participants’ understandings of ‘gender’ did not change between phase 1 and the early parts of phase 2 of the intervention. The findings of this phase 2 intervention are similar to the findings of phase 1, where no association was found between the sex of the participants and their understanding of the meaning of the term ‘gender’. In phase one, equal proportions were found between males and female learners who reported agreement with the statement: “gender refers to the socially defined roles and responsibilities of females and males”.

The change in learners’ perceptions regarding issues of gender was expected to occur gradually throughout the nine sessions of the intervention phase. The change in learners’ views was expected to be reported by learners after the intervention phase as a result of cumulative input from group interactions, reported views and summaries of shared meanings of gender issues. These were stressed and the skills demonstrated by learners as well as the researcher towards the end of every session. Their final understandings were assessed in the last phase, conducted nine months after the intervention phase, to allow the process of change to take place gradually. This change will be examined in the next chapter.

Towards the end of the first session of the intervention phase I confirmed the views that were presented by female and male learners. I reminded learners that the purpose of the first session was to provide learners with an opportunity to arrive at a shared meaning of terms commonly used in sexual and gender issues. The need to clarify the meaning of these terms to young people and to eliminate any confusion became clear from the above findings. The essential difference between these terms was explained during the summary section of the session, after the participants had shared their understanding of the terms. This was done by referring to various previous studies and literature, as discussed in Chapters 2 and 7.

‘Gender equality’

Two themes emerged from the units of meaning reported by different groups responding to the question of how they understood the term ‘gender equality’: “Women and men are equal” and “Men and women are the same” as shown in Table 5.3. This was illustrated by the following views: “*Ukulingana kobulili*”, [women and men are equal]. It does not matter who they are, whether women or men. “*Abesilisa ababedluli abesifazane ngokuhlakanipha*” [males are not cleverer than females].” (Reported by a female group); “Men and women “*bangabantu ngokufanayo*” [are the same human beings].” (Reported by one group of male learners). These views show that both girls and boys perceived the meaning of the term ‘gender equality’ in almost the same manner, even though they stated it differently. Boys seemed to understand the term even though they seemed not to agree with the idea of gender equality because they were unable to expand on it, even after being probed. They could not relate gender equality to a real life situation.

The term ‘gender equality’ was perceived differently from other terms, such as ‘sex’, where male and female learners openly reported different views related to their Zulu-cultural upbringing with its characteristic unequal power balance between men and women. The views of boys and girls differ, because for girls, gender equality seems to represent the promise of an improvement in their lives whereas boys may understand it as a diminution of their status.

The other possible reason why some learners, particularly males, had difficulty in explaining the meaning of ‘gender equality’ could be because learners during the first

phase indicated that they had not been taught about gender and related issues. Female learners in this intervention phase explained that males and females are the same even in terms of intelligence; they reported: “Males are not cleverer or better than females” Female learners’ views here are similar to the findings of the first phase, where significantly more female than male learners disagreed with the statement that men are superior to women. Girls may resent the fact that they are usually deprived of certain rights as female children at home. Parents, in patriarchal societies, tend to favour male children at the expense of females

The difference that was made by this intervention to the minds of girls and boys and their behaviour will be outlined later in Chapter 6 where the results of phase 3 will be presented.

These findings suggest that female and male learners, even in rural areas, have picked up discourses of gender equality that permeate the media. Boys, however, while acknowledging them, do not act them out in their lives. People who accept gender equality discourse do not necessarily subscribe to it in their own lives.

Gender equality’ was explained during the summary section of this session, after the participants had shared their understandings of this term. I explained that I concurred with the meaning given by the learners and in addition stressed that ‘gender equality’ means that people are equal, irrespective of their gender: males and females need to be treated with equal respect. I further clarified the meaning of the term ‘gender equality’ by referring to examples of Zulu culture and literature as outlined in Chapters 2 and 7.

‘Sexuality’

Two themes emerged from the perceived meaning of the term ‘sexuality’ that was reported by learners after brainstorming the meaning of this term. The two themes were “knowing your body” and the “study of sex”. The majority of girls perceived the meaning of the term ‘sexuality’ in relation to getting to know your body and yourself throughout the different stages of the life-cycle. This was illustrated by the following units of meaning of the term ‘sexuality’ that were expressed by one group of female learners:

“Sexuality *“ingokwazi umzimba wakho njengezitho zakho zangasese ikakhulukazi ngesigaba sokukhula kwakho nezinye izigaba ezahlukeneyo zempilo yakho”*. [is about knowing your body like knowing your private organs, more especially during the stage of puberty and other different stages of your life].

Sexuality is about who you are and what you believe in.”

In contrast to this meaning of the term ‘sexuality’, boys perceived the same term differently. Most groups of male learners seemed to associate the term ‘sexuality’ with the study of sex and homosexuality. The following views illustrate the units of meaning of the term ‘sexuality’ that were expressed by groups of male learners:

“Sexuality *“ukufunda ngezocansi njengokufundisa intsha gezocansi oluphephile”* (is the study of sex, such as teaching young people about safer sex).” (Reported by one group of boys)

“Sexuality is about the study of sex” *“Njengokufunda ngokuthi yini isitabane noma ungqingili lokho okusho umuntu wesilisa othanda abanye abantu besilisa noma owesifazane othanda abanye abantu besifazane”* [For example the study of homosexuality, that is referring to a male person who is attracted to other males or a female person who is attracted to the other females].” (Reported by one group of males)

Many other male groups had similar constructions to those above. The above findings show that the term ‘sexuality’ has different meanings. The themes that emerged from the units of meaning of the term ‘sexuality’ are similar to the different meanings that female and male learners attached to the term ‘sex’.

I explained the shared meaning of the term ‘sexuality’ as perceived by most groups of female and male learners to the combined group of female and male learners, during the summing up section of this session. I explained that ‘sexuality’ refers to the aspect of being human throughout life and covers sexual orientation and gender identity. ‘Sexuality’ is expressed in various ways such as thoughts, behaviour, practices, beliefs, attitudes, values, roles, desires, the way we talk, walk or dress, our relationships and the way we think of ourselves and others. It is about who one has sex with, whether one is attracted to the members of the same sex or members of the opposite sex, why, in what

way, under what circumstances and outcomes. I further clarified the meaning of this term by referring to the literature as outlined in Chapters 2 and 7.²²

The findings of this first session of the intervention phase of the study showed that boys and girls have different understandings of the meaning of ‘sex’ and ‘sexuality’ but a similar understanding of ‘gender’ and ‘gender equality’. These differences may influence their sexual behaviour but this can only be established by looking at other gender and sexuality issues examined during other sessions of the intervention phase.

Session 2: Perceived meaning of ‘reproductive and sexual rights’

In session 2, as in other sessions, the terms ‘reproductive rights’ and ‘sexual rights’, were given to groups of female and male learners who familiarised themselves with them and then discussed them in groups. The findings presented in this section represent what transpired during focus group discussions.

‘Reproductive rights’

Two themes were formulated by learners reporting what came to their minds when they heard the term ‘reproductive rights’. The two themes were “decision-making prior to doing things” and “planned-baby” (see Table 5.3). Most responses from female learners indicated that they perceived the meaning of the term ‘reproductive rights’ in relation to decisions that partners should make prior to “doing everything” meaning having sex or being intimate. This was illustrated by the following comments that were reported by female groups:

“Reproductive rights are about “*amalungelo*” (rights) of both partners “*ukwenza izinqumo*” [to make decisions] before they do ‘things’ that will make them to have children.” (Reported by one group of female learners).

Another group of female learners reported their points of view as follows:

²² See Appendix 2.3.1 for the facilitator’s summary at end of session one in Appendix 2.3., for further clarification of these terms.

“Reproductive rights mean that partners have *“amalungelo”* (rights) but females have to remember first to get education, look at their age, *“isimo somnotho”* (economic status) and the responsibility of having a baby and *“benze isinqumo”* (to make decision) before doing ‘things’. Reproductive rights help us as girls to think about our rights; they are not for boys because males do not feel the pain but females are the ones who feel the pain *“uma beteta noma bezala ingane”* [when in labour and or giving birth to a child]”.

The views of girls seemed to focus on the responsibilities of partners in knowing and applying their understanding of reproductive rights when making sexual decisions prior to engaging in sex. The views of some girls also reminded other girls and boys present about the importance of doing certain other things first, such as getting an education, considering their age, economic status and the responsibility of having a baby, before engaging in sexual activity. They were aware that reproductive rights are best implemented by mature people who know their rights, who are well-educated, have adequate income and are responsible enough to take care of their baby. Another female group emphasised that reproductive rights are there to protect both partners, more especially females, from pain and suffering. The female views further reminded females to think about the responsibility of having a baby before they decided to do what they call “things”. The most interesting feature is the saying that reproductive rights “are not for boys”. This suggests gender antagonism between boys and girls, possibly a knowledge on the part of girls that boys frequently ‘take advantage’

When I probed the female groups to explain what they meant when they said “doing things”, most reported that ‘doing things’ referred to what adults do to get children. I think the reason that made most female groups say “doing things” when referring to sexual activity, might be their upbringing: in Zulu culture, young females are socialised not to talk about sexual matters because they are ‘taboo’.

In contrast to the girls’ understanding of ‘reproductive rights’, boys seemed to have understood the term in a different manner. They seemed to understand ‘reproductive rights’ as equivalent to readiness or planning to have a baby. This view was illustrated by the following, reported by one of the boys on behalf of his group: “Reproductive rights

“asho ukuthi uma ngeshela ithekeni ngisuke ngifuna libe ithekeni lami” [mean when I propose to a girl, the aim is to have her as my girlfriend, not to be a flower but to sleep with me, enjoy *“ucansi”* [(sexual intercourse)] and be ready to have a baby.]”

Most other male groups had similar constructions of the term. Male learners seemed to associate the meaning of ‘reproductive rights’ with the outcome of heterosexual activity. However, they seem to forget that reproductive rights, such as that of having a baby, go with the responsibility of becoming a parent and all its responsibilities including, for example, being a father to that child. The fact that men are unable to fall pregnant and bear children may have shaped male learners’ views; another factor is that girls are often left with the responsibility for the baby while the fathers, are generally allowed by society to evade this responsibility. I concur with the view reported by some female groups, who indicated that reproductive rights are mainly the concern of females, who have to face the consequences of their actions which might be pregnancy and the responsibility of taking care of a baby.

The views reported by male groups associated ‘reproductive rights’ with a male’s right to have sex with his girlfriend with the aim of sexual pleasure and planning to have a baby as a way of proving his manhood. Such views render both girls and boys vulnerable to HIV infection.

‘Sexual rights’

Two themes were formulated by different groups of female and male learners after they discussed ‘sexual rights’. These were “Sexual decision-making rights” and “Natural rights for boys to have sex”.

The majority of girls perceived the meaning of the term ‘sexual rights’ in relation to the rights of an individual to make sexual decisions and choose whether to agree or refuse to have sex, and on what conditions. This was illustrated by the following understandings of the term ‘sexual rights’ expressed by different groups of girls:

“Sexual rights mean “*amalungelo omuntu okuxoxisana no phatina wakhe ngezocansi, nokunquma ukukhetha ukuthi 'cha' noma 'yebo' ukuya ocansini ngaphandle kwempoqo*” [The rights of an individual to negotiate sexual matters with the partner and to decide or choose to say ‘no’ or ‘yes’ to sex without being coerced].” (Reported by a group leader)

“Sexual rights refer to “*amalungelo omuntu okuya ocansini oluphephile futhi avikeleke ekuhlukunyezweni ngokocansi*” [the rights of an individual to have safer sex and be protected from sexual abuse]. Girls should avoid going in dark places and must protect themselves from situations that could lead to sexual abuse like rape” (Reported by another group leader).

Sexual rights mean “*umuntu unelungelo lokunquma ukuthi ufuna ukuya nini futhi nobani ocansini*” [an individual has a right to decide when and with whom to have sex]. Some say that they have decided to have sex with their boyfriends or fiancés, when they reach the age of 23 or more. One female leader emphasised this loud and clear, full of confidence, “*Kodwa mina ngiyoya ocansini uma sengishadile nobambo lwami, umnyeni wami wakusasa*” [I will have sex when I am married to my Mr Right, my future husband] (Reported by a female group leader).

The statement was applauded and supported by most female learners who stood up and clapped their hands after this female leader had pointed this out.

Most girls who participated in this study seemed to display a good understanding of sexual rights, as they related its meaning to the rights of individuals to negotiate sexual matters with the partner and to make sexual decisions such as choosing to say ‘no’ or ‘yes’ to sex without being coerced. They related the meaning of sexual rights to the right to choose to have safer sex.

The first two statements by female learners are similar to the findings of the first phase of this study where more female than male learners agreed with the statement that girls or women have a right to say ‘no’ to sex and decide when, with whom and how to have sex. However, negotiating sexual matters and being able to say no to unsafe sex might be the ideal rather than the reality for female learners. The reality is that fewer

females than male learners reported that they negotiated the use of condoms with their partners in the first phase of this study. In addition, a minority of females as well as a few male learners reported coerced sex. The second view of female learners was the individual right to decide when and with whom to have sex. This was reported by the leader of one group of female learners; her report was applauded by most of the learners who stood up and cheered. These findings seem to indicate that there is a debate about sexual rights: while girls and women may be subordinate, there are spaces where girls and women have power although they seem to have difficulty in exercising it.

Some female learners reported that some females decide to have sex only at the age of 23 years. They are encouraged to remain virgins ideally until they get married. Youth in the rural areas still express support for delaying sexual debut though this is less common among those in urban or township areas. In practice, however it seems that their behaviour is different, as is shown by the very high HIV rates amongst women in urban as well as in rural areas.

In Zulu culture '*Umemulo*' is the ceremony commonly performed for a girl who has remained a virgin until the age of 21 years. This is her parents' way of saying well done to their daughter for maintaining good morals by not becoming sexually active and to give her their permission to have a partner who plans to marry her and will allow her to remain a virgin until marriage. This latter view was reported by one group of female learners: "I will have sex when I am married to Mr Right, my future husband", is similar to the findings of the first phase of this study. Significantly, the majority of learners who participated in this study (more females than males) agreed with the statement that 'women should be virgins until they get married'²³.

By contrast, boys seemed to relate the meaning of 'sexual rights' to their presumed right to initiate, or dominate decisions about sexual matters. Male learners saw themselves as having a natural right to decide to engage in sexual activity whenever they wanted to with their girlfriends. This was illustrated by the following comments by boys:

²³ These are learners responses to Question number 12.16, variable number Q 44 of Section B of the first phase

“Sexual rights mean *“kuyimvelo ukuthi abafana baqale ezothando namathekeni abo futhi bathathe izinqumo ngezocansi”* [it is natural for boys to initiate love matters to their girlfriends and to make sexual decisions].” (Reported by one boy’s group)

“Sexual rights mean that *“Abafana banamalungelo abazalwa nawo abawaphiwa ngumvelingqangi* [Boys have inborn rights given them by the Creator, God] to make decisions about sexual matters and to decide how often to have sex. Some boys may decide to have sex once or three times a week, once in two weeks or whenever a boy feels like he ‘wanna’ have sex he may have it anywhere, any time and anyhow with *“ithekeni lakhe”* [with his girlfriend]”. (Reported by another boy’s group).

“Sexual rights *asho amalungelo abesilisa, ngokosiko lwase Africa okweshela abesifazane baqale ezothando futhi bagqugquzele ezocansi kumathekeni abo.*” [Males, according to African culture, have the right to propose love to and initiate sexual activity with their girlfriends].” (One male group reported this).

The majority of boys, who participated in this study, seemed to display a different understanding of ‘sexual rights’ from female learners. Most boys seem to relate the meaning of ‘sexual rights’ to the biological rights that boys were born with, given to them by God. Hence male learners seemed to believe they had a right to initiate relations and make sexual decisions such as choosing how often to have sex with their girlfriends.

The purpose of the second session was to provide female and male learners with an opportunity to arrive at a shared meaning of rights in relation to sexual and reproductive rights. The aim was to determine and describe how being female or male could affect learners’ understanding of rights with reference to the area of sexual and reproductive rights.

The need to clarify the meaning of ‘sexual and reproductive rights’ to young people and to eliminate misinterpretation of these rights became clear. I explained the meanings of the terms ‘sexual and reproductive rights’ during the summary section of this second session, by referring to authors such as Mkhize (2001: 2) after the participants

had shared their perceptions of these rights. The approach I used was to emphasise the importance of being well-informed and knowing their rights, especially sexual and reproductive rights. I highlighted that it is essential for young people to base choices based on reliable information, and that they should remember that they are responsible for the choices they make. I also reminded learners that young people have the right to choose to make informed decisions based on the ABCDE principles of preventing STIs, including HIV infection. I clarified these principles by referring to Zweli Mkhize, the KwaZulu-Natal Provincial Minister of Health from 1994 to 2004. According to Mkhize (2001: 2), the ABC principle is based on the following actions:

- A stands for “Abstain from unhealthy lifestyle”, such as unsafe sex;
- B stands for “Be faithful” namely, to yourself, your partner, your family, your decisions and your goals in life;
- C stands for the right to “Choose”, such as to choose to abstain from sex or to engage in protected sex by using a condom properly.

I also added the D and E principles to encourage girls and boys to make informed decisions and protect themselves from STIs including HIV infection.

- D stands for “Do a blood test in order to know your HIV status”
- E stands for “Enquire – get information, look for help”, for example, by going for counselling in order to be well informed about STIs including HIV, gender and sexuality issues. Inform others about what you know through ‘peer education’ to promote sexual and reproductive health.

I further clarified the meaning of the term ‘sexual rights’ by referring to Mkhize, (2001:2): “your sexual rights are your responsibility”. Learners had a short role-play, demonstrating the scenarios that were written by Mkhize (2001:1). This empowered learners who participated in the intervention phase with knowledge about STIs and encouraged learners to apply what they learnt about these issues in order safeguard themselves from STIs, including HIV.

At the end of the discussion, learners were given copies of the summary of Mkhize’s article (2001) for referral purposes and they were encouraged to use this information to educate their peers.

In addition, I also referred to the “SEXUAL RIGHTS CAMPAIGN” that advocates “Sexual rights means your right to choose when, with whom, and how to have sex, to have a respectful sexual relationship and to enjoy pleasurable and safe sex” (Women’s Health Project, 2000: 1). I further explained that sexual rights include the rights of all to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health, freedom from discrimination, coercion or violence in their sexual lives and in all sexual decisions and equality, mutual respect, full consent and shared responsibility in sexual relationships (De Bruyn, 2000: 1 (*Ipas: Sexual & Reproductive Health Briefing Cards, 2000:1*)).

In addition I emphasised that sexual rights are part of the human rights of all people, particularly women, including their rights to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free from coercion, discrimination and violence. (For further clarification of these terms, refer to Appendix 2.4.1 facilitator’s summary for end of session two, in appendix 2.4.)

The references to Mkhize, De Bruyn and the Women’s Health Project were used to correct any misinterpretation of the sexual rights evident in the views of learners, such as those expressed by the three male groups.

Session 3: Patriarchy

Session three was concerned with providing all learners with an opportunity to discuss their understanding of ‘patriarchy’ as one of the major terms forming the basis of the socio-cultural construction of gender issues in which young people are socialised as part of the development of their gender identities. Learners were asked to brainstorm and discuss what they thought of when they heard the term ‘patriarchy’. to give examples of patriarchy and to make suggestions about the role of young people in relation to patriarchy, as outlined in Tables 5.1.

Perceived meaning and examples of patriarchy

The units of perceived meaning of patriarchy that were reported by different groups of female and male learners after brainstorming lead to the formulation of two themes:

“Discrimination against women” and “Men are rulers and decision-makers”.

These were illustrated by the following views expressed by female learners:

“We think patriarchy is about *“ubulili nokubandlululwa kwabesifazane”* [gender and discrimination against women]. Patriarchy is about giving male *“imvume yokwenza izinqumo”* [permission or authority to make decisions] for women. The decisions made by men will never change, as if men are living alone on earth, they do not want to listen to women’s ideas. *“Uma abesifazane bezama ukushintsha izinqumo ezenziwe ngabesilisa bayashaywa kuthiwe abahloniphi abesilisa”* [When women try to change men-made decisions, women are beaten and are told that they are disrespecting men]. For example when a man hits a woman, people always say it is the woman’s fault.” (Reported by a female group.)

“Patriarchy is all about gender specification. It is about the rules and decisions made by men for women. It seems as if males are stronger, superior, more intelligent and more brave than women. For example, here in South Africa, men usually have top positions at work: most ‘bosses’ are men and in *kwezombusazwe* (politics), our President is a man. It is as if men were made to be leaders and women should obey everything that is said by man.” (Reported by another female group).

“Patriarchy is about men who believe that they have that natural power to accomplish whatever they want at any time. Males believe that females are useless and they cannot do anything. For example men expect women to do the housework, wash their clothes and cook food for them and be in the kitchen all the time, while men sit, eat food and leave the room without tidying-up. Men think that females do not have any rights to do something better than staying in the kitchen. When it comes to sports, men are regarded as more powerful than women. For example out of the two South African football teams,

“Bafana Bafana”, the national male soccer team, is regarded as superior to the national female team, *“Banyana Banyana”*.” (Reported by a female group.)

The male groups made the following points to illustrate their perceived meaning of the term ‘patriarchy’: “Patriarchy is about the ruling of men within and among the society. Men are the rulers of the country.” (One group of males).

“Patriarchy means women are controlled by men in every way and women should accept and obey because it is natural. For example, our fathers at home are always heads of the families. *“Abesilisa baphiwa amalungelo ngokwemvelo nguMvelingqangi okuphatha nokwenza izinqumo emhlabeni”* [Men were given natural rights by the creator- God to rule and make decisions in the world]. For example a King is always a man.” (This was reported by another male group).

The findings of this intervention phase tell us that although female and male learners perceived the meaning of the term ‘patriarchy’ similarly, there is an important difference in their attitudes. Girls are aware of, but disapprove of male dominance; boys approve of and claim it is ‘natural.’ All were aware that in the traditional Zulu patriarchal system, men dominated and controlled women at all levels. However, the last female group expressed anger about the notion of ‘natural power’ that men believe they possess.

The same female group also expressed dissatisfaction about what men think of women. They appeared not to like being seen as inferior to men: “Males believe that females are useless and they cannot do anything ... Men think that females do not have any rights to do anything better than staying in the kitchen.” The statement, “When women try to change men-made decisions, women are beaten and are told that they are disrespecting men” tells us that female learners were aware and reject the use of violence as one form of male domination that occurs in a patriarchal system where men rule the society. The views of one female group were, “It seems as if males are stronger, superior, more intelligent and braver than women...” displaying the young women’s interpretation of the attitudes they observed in their society. Their views indicated the patriarchal society they live in, marked by males who are dominating and making decisions, which they expect to be accepted and obeyed by women.

The male participants believed that patriarchy is 'natural', legitimate and just. They invoked various authorities to justify the dominance of men: "Men were given natural rights by the creator-God to rule and make decisions in the world". During the session I challenged his view with the male participants. For example, I disagreed with the view that males make decisions, by pointing out that in other countries, women are the rulers and decision-makers, such as Queen Elizabeth 11 in England. I could only agree with them, when they referred to African countries where the rulers and decision-makers are generally males although there are female heads of state such as Liberia's President, Ellen Johnson Sirleaf.

Other examples of patriarchy

Learners gave examples of relationships and sexual decision-making as examples of patriarchy. Some of the examples that they gave led to the formulation of the following two themes: "Male domination and violence against women" and "Men are initiators and sexual decision-makers".

The views reported by groups of female learners highlighted that females are frightened of the manner in which males behave, as if they own and rule women. This was illustrated by the following views that were reported by female learners:

"Girls like to hide their feelings even though they do like the boy, therefore making themselves inferior to boys. Girls are afraid to express their feelings about love and what they want to say because they are afraid that their boyfriends will beat them, since males do not want to face the truth as it is. Males believe that they must always rule the females. Boys do not want to hear and to accept our feelings and opinions, for example, boys think that if a girl says "No" she means "Yes" " (One group of female learners reported this).

"Males always start to fight with girls because they believe they are stronger and have more power than girls. Most of the time, the boys want to rule the relationship, for example boys like to beat or threaten to leave their girlfriends if the girls refuse to have sex with them. Boys believe that they have the right to beat up a girl, if she does

something wrong and yet in most cases, boys are the ones who cheat on girls” (Reported by a female group)

“When a boy wants a girl to be in love with him, he forces her. Males do not want to abstain from sex because they believe that sex is the proof of love. For example, the boy may ask a girl to go out with him and pay for everything like meals, transport and movies. Thereafter he will say the girl owes him and he can also force that girl to kiss him and to have unprotected sex with him. Even if a man sleeps with other women and you do not even know them, he usually forces you to have sex without a condom. Males do not want to use condoms, they demand flesh-to-flesh. They usually say, “they do not want to eat a sweet that is wrapped with a paper”, others say, “How can you eat banana without peeling it off” (This was reported by a group of girls).

“Some men say that they believe in that if you sleep with a virgin the HIV infection will disappear. You will never find a woman raping a man. Men always do. Men are women abusers, for example men always beat up their girlfriends and their wives” (Reported by a female group).

“Men think that they deserve to have more money than women. In most cases, girls go out with boys because of their wealth. Thus women tend to depend on men for everything” (Reported by a female group).

“When a man goes out, in Zulu culture it is said “*Indoda ayibuzwa ukuthi iyaphi noma ivelaphi*” (never question a man about where he is going or where he comes from), even if “*eyisoka*” (he has many girlfriends). But when a woman goes out, it is always like “Where are you going?” Men always make decisions at home. For example, men are the ones who decide for women, where to go, what to do, when, how and when to come back home. The woman leaves her house to stay with a man. A man is believed to be the one who owns and rules everything in the house. Men decide how to run the family as the head of the family” (Reported by a female group).

Some of the groups of boys used the following statements as their perceived meaning of other examples of patriarchy: “A male is the one who is always expected to approach a

female. For example, a boy is supposed to tell “ithekeni” (a girl) that he wants to go out with her or ask her for a date in order to propose love to her, but a female is not supposed to do that. If she does, it will be a shame on her” (Reported by a male group).

“*Umuntu wesilisa wadalwa kuqala nguMvelinqangi waphiwa amandla okuphatha awesifazane*” [Man was the person that was created first by God and he was given power to rule or control a woman]. Therefore, we believe that males were born as leaders. It is our duty as males to initiate relationships and to make sexual decisions. We cannot let females tell us what to do about sex because females do not know anything “*Bafundiswa ngabesilisa ngocansi*” [Males teach them about sex].” (This was reported by another male group)

“It is a man who should decide to introduce their relationship to their parents and to ask a woman to marry him. *Indoda njengenhloko yomuzi, kumele inqume nangezingane*” [A man as head of the family should make a decision about children]. For example, a man is always the one who should decide when to have babies and how many babies they should have”. Men can decide to have “*isithembu*” [(Many wives or polygamy)].” (Reported by another other group of males).

The findings of this intervention phase tell us that female and male learners who participated in this study demonstrated a similar understanding of patriarchy even though it was stated in a different manner. This is probably linked to elements of the patriarchal system that favour male dominance and female subordination that still exists in Zulu society.

The emphasis is always placed on men as decision-makers in all aspects including sexual matters. In this way male children are socialised to dominate females and are encouraged to make important decisions at home even if they are younger than their sisters. They are told from infancy that they are the decision-makers, potential heads of families and they will take over if their father dies. The socio-cultural norms that create power imbalances in favour of men are accepted as normal by both men and women and yet they have grave implications for young people’s relations, sexual decision-making abilities and their vulnerability to HIV infection.

Recommendations and or suggestions

Learners expressed their views in the last part of session three about how they should fit in with patriarchy or how the system should change. Their views lead to the formulation of one theme: “Young people’s role in HIV prevention in relation to patriarchy”. Girls emphasised the importance of knowing that both females and males have rights that require equal respect. By contrast boys emphasised their inborn right to take control of females and to be in control of sexual decision-making and behaviour.

Examples of girls’ views:

“In our days we live in times of democracy. It is known that boys usually make decisions about relationships and sexual matters, but boys should remember that girls have rights too. Girls have the right to make decisions about their bodies, their relationship and their sexual lives. Boys should understand, accept and respect that boys and girls are equal. Girls should know that they have a right to say “no” to unwanted or unprotected sex. Boys must also agree and have respect when girls disapprove of having sex. Boys must know that “no” is “no” and “yes” is “yes”.” (This was suggested by one group of girls).

“Men and women must discuss all about what they want in their love lives. They must not argue but they must pay attention and listen to one another’s opinions. They should have equal respect for each other’s ideas. Males should not undermine women but they should understand that ideas, even if they come from females, could mean something. Young men should move away from the idea that men are superior to women and should stop controlling women as men’s property. Girls and boys should be well- educated about HIV and AIDS and avoid exposing themselves to risky behaviours. A boy or a girl must decide to say “no” to sex or decide to have one partner, be faithful, negotiate the use of condoms and must always use condoms “Dark or Blue” [meaning always, no matter what happens, come rain or come shine] and use condoms properly as a means of protection against HIV.” a second group of girls stated this suggestion).

“Girls must say “no” to sex and must wear “lockable panties”. Boys must be proud of their virginity as girls are, they must not force girls to have sex with them as that is rape,

sexual abuse. As a girl, you should have a female condom and or male condoms ready and “unexpired”, in your bag, to protect yourself from HIV, in case you get raped. You need to have a blood test for HIV regularly ‘just in case you get HIV.’” (Recommended by another group of females).

Example of boys’ views:

“Naturally as males we were made to take control over females also when it comes to sexual decision-making and behaviour. Girls must avoid associating themselves with boys if they feel they are not ready for sexual activity. Girls should be honest enough to express their feelings from the start and not to pretend to be in love with boys. For example, a girl can decide and say whether she wants to have a date with a boy or not, or whether she agrees to go through sexual activities, unless she is raped.” (Suggested by a group of males)

Most other groups made similar suggestions to those stated above.²⁴

Session 4 is about a gender game. The findings of games and role-plays, as outlined in Table 5.1, will not be included in this report. The following section will report about the findings of session 5 that were obtained during focus group discussions.

Session 5: Issues of sex

Session five was aimed at providing learners with an opportunity to identify, outline and share common synonyms for terms used in relation to the language of sex and sex-related issues. Learners were also required to outline the sources of their information on sex, as shown in Table 5.3, and to discuss what they learnt about sex from different sources.

²⁴ For clarifications of the meaning of patriarchy, refer to Appendix 2.5.1 facilitator’s summary for end of session three, in appendix 2.5.

Terms used for the language of sex and related issues

The first part of session five was an exercise aimed at encouraging female and male learners to talk freely among themselves about their language of sex and sex-related issues. The purpose was to allow girls and boys to share their views pertaining to synonyms used in the language of sex and other issues related to sex. This exercise aimed at revealing and understanding youth's language in relation to sex and to be able to understand their language when discussing issues of sexuality and HIV prevention. It was also intended to determine if terms used by both girls and boys differ. In addition the aim was to identify if there are any communication barriers between boys and girls, youth and adults, pertaining to sex and related issues.

In this first part of session 5, like in other sessions, instructions²⁵ were given to groups of female and male learners who familiarised themselves with them and then discussed them in the established groups. The terms that were given to learners included male and female genital organs, breasts, sexual activity, condoms, sexually transmitted infections (STIs) and HIV. The findings that are presented in this section represent recordings on flip charts of what transpired during focus group discussions.

This was a learning exercise for me, as well as for the research assistants and most of the female learners, even though we were all isiZulu speakers. The males seemed to enjoy this exercise more than females. Males mentioned most of the synonyms for the terms. The exception was words for female genitalia whose synonyms female learners stated with ease.

I found it challenging even to record these synonyms of young male learners but I had to write them to share young people's language of sex. While I was writing this section, I even asked my fourteen-year-old son to tell me about the synonyms that he and his friends used to name the private parts of a male. He exclaimed "Oh no ma!", paused and continued later, while still hiding his eyes, "Why do you ask me to tell you about such a 'thing' because I feel like it is not right for me to talk with you about this 'thing'?" I told him that it was part of the study to know the language of such 'things'. To my surprise, he then told me the synonyms, exactly the same as those that were mostly understood and used by boys, when referring to the male genitalia in English. This

²⁵ As outlined in Appendix 2.7

comparison between the sexual vocabularies of male participants in my study and that of my (urban) son made me reflect on the differences between male and female vocabularies in sex-related matters, as well as on generational differences.

However, most of the isiZulu terms that were mentioned by young people as meaning of the terms used when referring to sex and its related issues were similar to those terms I heard in my childhood, as I grew up in KwaZulu-Natal. Hence I kept on adding examples or detailed knowledge about them from memory.

‘Male genital organ’

All male and female learners reported that it is most common and acceptable when speaking in isiZulu to use *‘Ugwayi kagogo’ noma* (or) *‘Ipipi likamkhulu’ noma ‘isitho sowesilisa sangasese’* [grandmother’s cigarette, or grandfather’s pipe used for smoking or private part of a male]. The learners displayed understanding of the terms used in isiZulu when referring to the male genital organ. These terms are used by grandparents playing with a young boy when they see his private part and call it *‘Ugwayi kagogo’* if the boy is playing with the grandmother or and call it *‘Ipipi likamkhulu’* if the grandfather is playing.

Both male and female learners reported that ‘penis’ is the most commonly used term that is acceptable in English. Learners might have learnt this word in their Life Orientation (LO) class when learning about the body parts of a male. Young males reported, “We have other terms that are mostly understood by young people, particularly us as boys, such as, ‘dick’ or ‘cock’ or ‘snake’ that we use when referring to the same male organ”.

‘Female genital organ’

It was easy for female as well as male learners to report that it is regarded as normal when talking isiZulu language to use *‘Inkomo kamama’* (mother’s cow), or *‘vagina’* in English. The term *inkomo kamama* originated from Zulu culture, referring to *‘ilobolo’*, the payment made by a man for the woman that he wants to marry. Among other things that he pays are eleven cows, the eleventh cow being for the girlfriend’s mother. This cow is also called *inhlawulo* [payment for the girl’s mother made by the man who had

first sex with a girl]. Elder women could detect this event during virginity testing when the girl's hymen was found to be torn and no longer intact, even if the girl was not pregnant. However, young males reported, "We have another term that is mostly understood by young people, especially us as boys, such as 'pussy' that we use to call the same female organ".

The use of these terms by young people is significant since it shows that they have already been socialised to know isiZulu terms used for female and male genital organs, the same as those that I heard during my childhood. Hence the patriarchal notion of linking vagina with marriage or being a bride and likely to bear children still exists in the minds of young people, as they still used isiZulu term "*inkomo kamama*" to refer to the female private part. The new terms that were added by boys in relation to the same organs were unfamiliar to me and have been adopted from English. They may have learned these terms from films or in the street from other males. They may prefer to use these terms to create a language gap between adults and youth.

'Breasts'

Female and male learners reported that it is just as common when talking isiZulu to use '*amabele*' [breasts] just as it is when speaking in English to use the term 'breasts'. The learners displayed a good understanding of the term 'breasts' or '*amabele*'. The 'breasts' are amongst most important organs of the female reproductive system. At puberty these small raised structures develop into two round structures known as breasts. The appearance of breasts usually precedes menarche, that is, the first menstrual period that occurs in females at puberty. The appearance of rounded breasts symbolises a female's transition to adulthood which causes parents, particularly mothers and grandmothers, to be concerned about the safety of their daughters from males who are going to start proposing love or may even convince them to engage in sexual activity with them.

In Zulu culture, the grandmother used to take '*isifociya*' [belt used by grandmothers to fasten *isidwaba*' - Zulu skirt made of cow hide] and beat the breasts that appeared for the first time in her granddaughter. That practice used to make the first breasts disappear for about two years, delaying the onset of puberty and discouraging the

female adolescent from thinking that she is ready for love relationships. When the breasts re-appeared for the second time, grandmothers used to tell their granddaughters that they have reached adulthood and they need to be very proud of their bodies. They usually advised them to preserve themselves as '*Izintombi Nto*' [virgins] until they get married and to proudly expose their breasts always when they are wearing their Zulu attire, because if they are still virgins their breasts will remain firm with the '*izingono*' [nipples] pointing straight forward.

Female adolescents were also advised by grandparents and or '*amaqhikiza*' [elder females who are not yet married], never to allow males to touch their breasts or to have sexual activity with males. If they did allow that, they were told, their breasts would become soft, with '*izingono*' [nipples]. As with the two previous terms used in the language of sex and its related issues, I was not surprised when male learners reported "We have other terms that are mostly understood to young people, particularly us as boys, such as, 'Boobs', 'Clover' or 'Dairies' that we use when referring to female breasts".

'Sexual activity'

Female, as well as male learners all reported that it is most common and acceptable when speaking in English language to use the words '*sexual intercourse*' when referring to sexual activity. They also reported that the word '*ucansi*' is used to refer to sexual activity when talking isiZulu. Learners displayed a good understanding of 'sexual activity' as one of the terms used in the language of sex in both English and isiZulu languages. I agree with learners that '*ucansi*' is also used in relation to the act of sleeping because it relates to the grassmat used in early Zulu culture for sleep on.

'*Ucansi*' [a grass mat] is still used for various purposes, such as to sleep or even sit on as a way of respecting our Zulu custom. For example '*Ucansi*' is used, together with a blanket, to wrap a person prior to putting him or her in the grave because in Zulu culture, when a person is dead, that person is believed to be sleeping and joining the ancestors. Other examples of Zulu custom, where '*ucansi*' is still being used, include among others, when people are attending a Zulu ceremony such as '*umgonqo*', meaning the hidden

place where a girl stays, sitting on “*ucansi*” (grass mat) for a few weeks during her first menstrual period. The purpose of ‘*umgongo*’ is to allow a girl to have an opportunity of getting advice from the ‘*amaqhikiza*’ (senior females not yet married), pertaining to the way she is expected to behave as a woman regarding sexual matters. She will be informed about ‘*ukusoma*’ [thigh sex] one of the examples of a non-penetrative sex that used to be practiced by girls with their partners to preserve themselves as virgins until marriage.

‘*Umgongo*’ is the special place that is also used to hide a girl away from males. She is not to be seen or talked to by males during this period of puberty, to ensure that her mind is not distracted from the moral advice, to equip her so that when she comes out of this place she is empowered to deal with men and love and sexual matters. Male learners reported that they have other terms, understood by young people, particularly boys, to refer to ‘sexual activity’ such as, ‘Bang bang’, or : ‘Beating / Playing/ hitting the drums’.

‘Condoms’

Learners displayed a good understanding of ‘condoms’ as one of the terms used in both English and isiZulu. All learners reported that it is common and acceptable when speaking English to use ‘condoms’ and in isiZulu to use *ijazi lomkhwenyana* [husband’s coat] when referring to male condoms used when practicing protected or safer sex.

A possible reason why learners described condoms as ‘male condoms’ is because most people are familiar with ‘male condoms’ since they were well advertised, easily accessible, and free of charge. Female condoms have only recently become available and, are expensive, not easy to obtain, and are therefore not as popular as male condoms. Male learners reported that they have other terms that are understood by young people, particularly boys, who refer to ‘condoms’ as, ‘CDs’ or ‘Raincoats’ or ‘Plastics’.

‘Sexually transmitted infections (STIs)’

Female and male learners reported that it is commonest when talking isiZulu to use *izifo zocansi’ noma* (or) *ugcusula’ noma* (or) *‘izifo zamasoka’*, just as it is common when speaking in English to use the term STIs. Learners displayed a good understanding of the terms *izifo zocansi’ noma*, *ugcusula’ noma* or *izifo zamasoka*, used in isiZulu when referring to ‘sexually transmitted infections’. Hence the terms *umtholampilo wamasoka noma* or *emasokeni* are used when referring to the clinic attended by those suffering from STIs because they are known as ‘*amasoka*’. In addition, male learners reported that they have other terms understood by young people, particularly boys, to refer to ‘*STIs*’. One such word is ‘Drop’ because many times when young males have a burning sensation when passing urine, they usually report that they have a ‘Drop’, hence ‘Drop’ is sometimes known in isiZulu as *isifo sabesilisa* [males’ disease].

‘Human immunodeficiency virus (HIV)’

Female as well as male learners reported that it is commonest when speaking English language to use ‘HIV’ when referring to ‘Human Immunodeficiency Virus’. Learners displayed understanding of HIV as one of the terms used to identify a fatal consequence of unprotected sexual activity in both English and isiZulu. They further reported three terms in isiZulu referring to HIV. *Isandulela ngculazi* (something that occurs before AIDS which is known as *Ingculazi noma* (or) *amagama amathathu* [three names *noma*] or *Hlengiwe Ivy Vilakazi*’ (where H for Hlengiwe was reported to stand for H for Human, I for Ivy, for immunodeficiency, V for Vilakazi stands for virus). This was reported by the learners to be the reason why “HIV” is also known as “*Amagama amathathu*” (three names).

Towards the end of the first part of session five, I asked learners whether they freely use the language of sex that is most acceptable to them when talking with adults, including parents and teachers in the community. The aim was to identify communication barriers²⁶ between young and old people, and to understand youth language in relation to issues of sexuality and HIV prevention. Learners reported the following to explain the barriers that prevent them, as young people, from using the language of sex and issues

²⁶ Refer Appendix 2.7.B in Appendix 2.7

related to sex. They said, “We live in a community where people do not understand our language and as young people we are not even allowed to talk about sex and issues related to it”. “Fear” was reported as another barrier that prevented young people from using language of sex that is most acceptable to them. They further said “We are scared to be labelled as *“izichwensi”* (meaning rude) when using terms that are not acceptable to the community”. This suggests that the participants would like the communication gap between themselves and their parents to close, but are afraid of what adults may think of them.

What were the sources of the youth’s information on sex?

The second part of session five was devoted to establishing the different sources of information on sex. Learners mentioned the commonest sources that taught them about sex: parents, family members, friends/peers, teachers, religion, radio, television, adverts and music. The purpose of this exercise was to allow female and male learners to share the information that they learnt about sex from different sources.

Parents

Most female learners reported that parents, especially their mothers, always say *Niziphathe kahle* [behave well] and say ‘no’ *ocansini* [sexual activity], until you get married.” One 15year old girl reported, “I first heard about sex when I was about 10 years old; it was from my mother. She told me that I was about to reach the puberty stage and I would soon have a lot of changes in my body. You must never kiss and or sleep with a boy because you will get pregnant and have a baby. I listened to what she told me and I was scared to ask her more questions that came to my mind at that time”. Male learners reported, “Parents do not say much to us about the subject”.

Generally the above findings of the intervention tell us that mothers play an important role in talking to their daughters and sons about sex more so than fathers.

Most parents find it uncomfortable to talk to their children about sex, although they want children to approach sexuality with healthy attitudes, a thorough understanding of sex and how to avoid irresponsible sexual behaviour and its consequences. It is a challenge for most parents, as they feel uncertain about how to start, what to say, how, where and

when to start talking to their children about sex. Yet it is desirable for young boys and girls to get accurate information about sex from their parents as this will encourage girls and boys to make informed and responsible choices and decisions.

Other family members

Other family members included sisters, brothers, cousins, aunts, uncles and grandmothers. Female learners reported that family members, especially grandmothers say *Nibe zintombi Nto* [be virgins – never have sex]; *Indlela ibuzwa kwabaphambili ngokuthi 'cha' ocansini* [young people should ask adults about how to say 'no' to sexual activity]. Boys reported, “Other family members do not talk to us about... sex”.

The findings of the intervention phases of this study that suggest family members play a role in talking to young people, about sex. There appears to be some gender bias in relation to these sources, as young girls appeared to get more information from family members than do boys. It seemed as if young boys are not urged to be respectful or restrained by family members, who thus support by default attempts by young boys to have sex when and where they can.

Friends

Most female learners reported “Our friends always ask us whether we are grown up and ready for it or not.” Most male learners reported, “Our friends usually convince us to have sex to prove that “*sesingamadoda*” [we are mature males]. They say sex gives you power as a male. They also say for guys, that if they do not have sex they are called ‘cowards’ and that your sperm will go to your mind and make you to go crazy.

The views of female learners here show that their friends asked questions that gave them an opportunity to make their own decisions about whether they were ready to be sexually active. In contrast, male learners seemed to have been pressurised by their peers to engage in sexual activity, irrespective of whether they were ready for it or not.

Generally, the findings of the intervention phase of this study seemed to suggest that peer pressure plays a major role in the social development of manhood. Male learners are encouraged by their peers to become sexually active to prove their

masculinity. Similarly the views of female learners seemed to be making us aware about the social development of their femininity. Female learners felt it was left to them to make choices as to whether they wanted to be sexually active or not.

Other sources of information

All females and male learners reported that they had learnt about sex from other sources of information such as religious figures and schoolteachers. Both female and male learners reported that they were told not to have sexual activity before marriage by the religious teachers.

Female learners reported that teachers told them: “Think well and be ready before you take the decision to have sex, and you should know how to use a condom”. Similarly, male learners reported that teachers said, “Abstain and if you decide to have sex make use of condoms”. The messages given to learners seemed to be similar. However, teachers seemed to be more concerned about females and warned them to be careful, and to think prior to making decisions to become sexually active and also to know how to use condoms. The same message was given to male learners, but with no emphasis on prior thinking and without emphasis on knowing how to use condoms properly. Regarding what learners learnt from the media about sex, they reported similar messages with regards to safer sex, as male learners reported “Music gets you in the mood for having sex while television and radio tells you to be faithful to your partner and have safer sex”.

On the other hand, female learners reported that music, television and radio taught them “You must have an agreement with your partner, do not agree if your partner forces you into sex.” Female learners reported that advertising taught them to “Be faithful to your partner, stick to one partner and make sure that your partner has been tested for HIV”. Male learners reported that advertising taught them to “Use a condom”. Learners reported slightly different messages: females are encouraged to be faithful to one partner; to male learners, no mention is made about the number of partners that they should have, though they are advised to use a condom.

I found it encouraging to hear that female learners hear messages of empowerment in the media. The media spread messages about sexual rights and encourage female learners to know, be assertive and stand up for their sexual rights, such as deciding to abstain or to be sexually active. More females than male learners agreed with the statement provided for them in the first phase: "A girl or woman has a right to say "No" to sex and to decide when, with whom and how to have sex"

The following were the views of learners pertaining to the rating they gave to the different sources of information about sex. Female learners reported that parents, religion, schoolteachers and magazines are the best sources of information to learn about sexuality because they tell the truth about sex. This was in contrast to music, television and radio that offer what they regarded as the most negative information about sex. In contrast to female learners' views, male learners reported television, radio, *LoveLife* and the *AIDS Help-line* as the best sources of information for young males to learn about sexuality. The latter sources "tell it as it is, unlike our parents who tend to hide things from us and friends who give us the wrong information about sex."

Towards the end of this session learners were asked to answer the question: Where would you like condoms to be placed at home? More males than female learners reported, "We would like condoms to be placed anywhere at home but in safe and different places. Not in one place because whenever you are going to that one place parents will know that you are going to take a condom." In contrast to males, females said that they would like condoms to be made available at clinics and school toilets.

More females than males seemed to be uncomfortable with condoms being kept at home. Male learners verbalised their fear of being found by parents to be taking condoms if they are kept in one place at home. I believe they feel comfortable if condoms are kept in a neutral place, where they will not be seen taking them. The following section focuses on findings of the first part of session 6.

Session 6: STIs, HIV and AIDS

Factors promoting youth's vulnerability to STIs including HIV

The first part of session 6 was the last session where data was obtained from focus group discussions involving female and male learners; their views are outlined in Table 5.1. The purpose of the first part of session six was to provide learners with an opportunity to express their perceptions about factors that make them vulnerable to STIs, including HIV.

The groups of learners were given instructions²⁷ and were asked to discuss what they believed to be the factors that put them at risk of STIs, including HIV. Two themes were formulated from the units of meaning given by learners, namely 'fear of male domination' and 'experimentation'. Most responses from female learners indicated that they were not experienced and needed more time to gain confidence to negotiate sexual matters with their male counterparts. They also named fear of male domination as another factor that puts female learners at risk. This was illustrated by the following views of female learners:

We young females "*sinamahloni futhi siyabesaba abantu besilisa*" [we are shy and afraid of males]. We need more experience to discuss sexual matters with our partners. We usually find it difficult to discuss the use of condoms with our partners. (One group of girls).

We feel as if our male partners "*basiphethe*" [are controlling us]. "*Siyazithoba kubo ukuze basithande*" [We humble ourselves to them for them to love us] and end up relying on them for everything. We usually try to do whatever they want from us to please them so that they do not beat or 'drop' us. (Another group of girls).

Boys seemed to emphasise factors that encourage them to engage in sex to demonstrate their masculinity. They demonstrate this by becoming more sexually experienced than

²⁷ As outlined in Appendix 2.8

their female partners, thus making them vulnerable to STIs, including HIV. The following views were reported by male learners: *“Kuyindalo ukuthi umuntu wesilisa abelisoka ukuze azihlole ukuthi uyindoda ngempela”* [It is natural for a male to have more than one sexual partner to experiment and or prove that he is a real man].

Towards the end of the session, I began my summary by discussing with participants what they reported as factors that increase the risk of STIs including HIV and AIDS. Learners seemed to enjoy this: it encouraged them to talk openly about their fears and experiments. The aim of this discussion was to verify what had been reported by learners in the first section of session six. I encouraged them to ask questions, answered their questions and clarified their queries and fears by referring to existing literature. In addition, I gave them an oral exercise on factors that contribute to youth’s vulnerability to STIs, HIV and AIDS²⁸. I asked them to respond verbally, and concluded session six by cautioning them on factors that increase risk.

I started my summary by referring to the first part of Session 6. It was not possible to present and examine the results of other sessions where learners demonstrated their understanding and application of the topics of sessions of intervention to real life situations and HIV prevention through games and role-plays. The purpose of games and role-plays in the other sessions, such as sessions 4, second part of 6, 7, 8 and 9, was to allow learners to examine how they learn about men and women, to share their experiences of being female or male. Games and role-plays sensitised learners to these issues and made them aware of how the traditional identities of femininities and masculinities were constructed by society.

CONCLUSION

This chapter presented the design, process of intervention, data analysis and the results of the intervention phase of the study according to sessions; the themes that emerged from the units of meaning that were expressed by learners who participated in this study, as shown in Table 5.1.

The intervention conducted in phase 2 allowed me to engage with the participants informally, generated interesting conversations and helped me to have a better

²⁸ As outlined in Appendix 2.8.1 facilitator’s summary for end of session six, in Appendix 2.8.

understanding of young people. The debates that occurred allowed me to highlight differences and similarities in the views of the boys and girls. The most interesting part of this intervention was to see learners, girls and especially boys, excited when they openly expressed their views about sexuality and gender, including patriarchal issues.

They said they were happy to get this opportunity, where they were given a chance to express their views about issues such as sex, gender and rights. Most of them indicated that they did not get the opportunity to talk about such issues with their parents. This was to some extent the result of the type of families they lived in, such as nuclear families. Their parents seem to be either busy or afraid to talk with them about sexual issues. In contrast to extended families, that are still promoted in Zulu culture, where, for example *amaqhikiza* [older women] used to talk to girls about sexual matters.

Boys excelled when it came to terms used in the language of sex, as they kept on mentioning terms that boys use that were completely new and not known to most of the girls, or us as researchers. I admitted that, in relation to the intervention phase, they taught me a lot and particularly in these sessions. I did not know, for example, that condoms are known to boys as 'CDs'. Both boys and girls were eager to offer ideas about the opposite sex more tolerant. They seemed to be positive about the prospects for shared gender values and respect in their relations. The impact of the intervention phase in general terms was found to be greater on girls than boys. Girls demonstrated greater awareness of their rights during the course of the intervention. In the case of boys there were also some mindshifts. For instance, boys understood better that girls had rights but continued to believe in the importance of being heterosexually active and to dominate sexual decisions as a key element in the construction of their masculinity.

Belief in the inferiority of women is confirmed by various Zulu cultural practices. At marriage the woman leaves her house and family to stay with a man and join his family. Elderly Zulu people stress that it is better to educate boys rather than girls and that men must have male children to carry on the family name. However the former view has changed over time: both boys and girls are now educated. A girl is further expected to change her maiden surname and use that of her husband's family.

I for example am now known as Sisana Majeke, instead of my maiden surname 'Shongwe' because I joined my husband's family and on the day we got married I used

the Majeke family surname, and my mother-in-law also gave me a new name '*Nombasa*' meaning a crown, as a sign of welcoming me to the family. However, the young women of the 21st century who get married can now use double-barrel surnames, for example *Khanyi Dlomo-Mkhize*, and retain their identities. This shows that culture is not fixed but it is capable of changing with times and contexts.

The following chapter will present, discuss and analyse the data obtained during phase 3 or the evaluation phase, which will be compared with the data obtained during phase 1 to assess the changes that occurred as a result of the intervention.

CHAPTER SIX: EVALUATION PHASE RESULTS

INTRODUCTION

This chapter presents the results of the third or evaluation phase which is the last phase of this three-phased study. It was preceded by the orientation phase and the intervention phase. The time difference between the intervention phase and evaluation phase was nine months. In this third phase differences were evaluated between the data obtained from learners' in the first phase, before the intervention, and in the third phase, after the intervention. The evaluation was done with learners who had participated in all the three phases. The effectiveness of the intervention was assessed by comparing certain key indicators such as HIV and AIDS knowledge, gender attitudes and sexual behaviour. The results examined in this chapter will assist in answering one of the research questions of this study, "Is an HIV prevention intervention able to change youth's sexual behaviour?" This will help to determine if the impact that the intervention was positive or negative in its results, because key indicators, including age of sexual debut, number of sexual partners and condom use were some of the specific targets of the intervention.

In Chapter Four, the socio-demographic characteristics of the sample were discussed. The same socio-demographic characteristics discussed in Chapter Four apply in this chapter, since the same sample answered the same self-administered questionnaire in Phases 1 and 3 of this study.

In this chapter, data collected during the third or evaluation phase will be examined, discussed and compared to data obtained in the first phase, regarding outcomes such as sexual activity and age at sexual debut. The aim of this chapter is to report the findings as present in the answers to the questionnaires in the third phase, after the intervention, and compare them with the results of the first phase. This will allow me to assess the impact of the intervention and to address the last objective of this study which is "to assess the intervention programme by comparing the findings of the baseline data obtained in the first phase and those obtained in the third phase after the intervention". If the intervention has had a positive impact, learners who participated in this study would make better and safer sexual decisions and fewer girls or boys would be 'forced' to have sex.

The major findings that emerged from the evaluation included the following major results, ranked in order of importance below, which will be systematically explained in the body of this chapter.

The most unexpected and worrying finding was that there was a small decrease in abstinence. This was reported more amongst girls than boys in the third phase. This may suggest that girls divulged more information than boys in the third phase.

There was a slight increase in Phase 3 in the awareness of learners about the danger of HIV and AIDS. More girls than boys reported being scared of HIV and AIDS as their reason for abstaining from sexual activity.

There appeared to be an improvement in condom use in the third phase, compared to the first phase. Among those who became sexually active during the course of the study, the rate of condom use was higher. Over 90% of those who reported themselves as sexually active in the third phase reported used condoms, compared with 16.1 % of those who were sexually active before the intervention. Most of the 90% (though not all) reported that their use of condoms was consistent.

In the third phase there was an increase in one-partner relationships among the sexually-active learners, compared to the first phase.

There was a positive change in the attitudes of learners towards gender, HIV and AIDS prevention in the third phase, as compared to the first phase.

In the third phase after the intervention, most girls reported having had their first sexual experience with partners of more than 19 years of age. None of the boys reported the same behaviour. The same trend was observed in the first phase where more girls than boys reported having had their first sex with significantly older sexual partners.

An unexpected finding was that a small but significant larger number of boys were sexually abstinent in the third phase compared to the numbers observed in the first phase.

The first section of this chapter will compare the socio-demographic variables of the third and the first phases to expose significant outcomes.

COMPARISON OF SOCIO-DEMOGRAPHIC VARIABLES TO SPECIAL OUTCOMES

This first section will look at socio-demographic data and then compare significant outcomes of the third phase to those of the first phase. From the outset it was assumed that socio-economic, historical and other factors would influence the ways in which the intervention impacted on the young people involved. The variable in which I was most interested was gender and this next section therefore highlights gender in relation to the intervention. I also identified other variables and will examine their influence on the way in which the intervention was internalized by participants. In this section, I present tables, such as Table 6.2, which contrast the responses of participants in third phase, with their responses in the first phase, as a means of evaluating whether there was a change and whether the various goals of the intervention were achieved.

SOCIO-DEMOGRAPHIC VARIABLES AND SEXUAL ACTIVITY

Table 6.1 Sexual Activity by gender (n = 175)

	Four groups / categories of sexual activity in phase 3				
	Continuing sexual activity	Newly abstaining	Newly sexually active	Continuing abstaining	Total
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female	19 17.6%	09 08.3%	27 25%	53 49.1%	108 100%
Male	32 47.8%	09 13.4%	11 16.4%	15 22.4%	67 100%
Total	51	18	38	68	175
Percentage	29.1%	10.3%	21.7%	38.9%	100%

The participants were asked in the third phase to answer the same question as they had in the first phase, that is: “Have you ever had sex?” The data obtained in the first phase from learners regarding their sexual activity, was divided into two categories: the abstaining and the sexually active. The information obtained in the third phase regarding the learners’ sexual activity was divided into four themes, as shown in Table 6.1 above. ‘Continuing sexual activity’ refers to learners who reported themselves to be sexually active before and after the intervention. ‘Newly abstaining’ refers to learners who reported themselves as sexually active before the intervention and celibate after the intervention. ‘Newly sexually active’ refers to learners who reported themselves as abstaining from sexual activity before the intervention and sexually active after the intervention. ‘Continuing abstaining’ refers to learners’ celibate before and after the intervention. The Pearson Chi-square test was performed to examine the association between gender and these four categories of sexual activity. The results were significant: there was a close association between gender and these four categories of sexual activity reported by learners in the third phase, after the intervention ($p = <0.001$).

The findings of the third phase indicated that all learners in the four groups of sexual activity shown in Table 6.1 had the same high median HIV and AIDS knowledge score of 22.0000. However, that did not seem to influence their choice of sexual conduct. A high HIV and AIDS knowledge score was not associated with the sexual behaviour of learners. Slight but insignificant differences were evident. There was no need therefore to do post hoc tests to check for differences in the four groups of sexual activity.

In the first phase, half of the learners, 88 (50.3%), reported that they were abstinent compared to 87 (49.7%), learners who reported they were sexually active. Less than half the learners, 86 (49.1%), reported in the third phase that they were abstinent, after the intervention, compared to more than half of the learners, 89 (50.9%) who reported they were sexually active.

The following section will examine and compare groups of learners according to those who reported they were abstinent and those who reported they were sexually active, prior to and after the intervention in relation to gender, as shown in Table 6.2 below.

Table 6.2 Comparison of sexual activity in Phases 1 and 3 by gender (n = 175)

Have you ever had sex?								
	Phase 1			Phase 3				
	Two groups/categories of sexual activity in phase 1			Four groups/categories of sexual activity in phase 3				
	Yes	No	Total	Continuing sexual activity	Newly abstaining	Newly sexually active	Continuing abstaining	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	40 37%	68 63%	108 100%	19 17.6%	09 08.3%	27 25%	53 49.1%	108 100%
Male	47 70.1%	20 29.9%	67 100%	32 47.8%	09 13.4%	11 16.4%	15 22.4%	67 100%
Total/ Percentage	87 49.7%	88 50.3%	175 100%	51 29.1%	18 10.3%	38 21.7%	68 38.9%	175 100%

ABSTINENCE FROM SEXUAL ACTIVITY IN RELATION TO GENDER

Table 6.2 shows that in the third phase, the group of learners who reported they were abstinent was divided into two groups: the ‘Newly abstaining’ and the ‘Continuing abstaining’ groups. In the first phase there was only one group, ‘Abstaining’. 77.9% of those girls who abstained in Phase 1 continued to abstain in Phase 3. The figure for boys showed that 75% of those boys who abstained in Phase 1 continued to abstain in Phase 3. In other words, the rate of continuing to abstain was almost identical across the gender

divide. Both boys and girls who participated decided to continue abstaining for unknown reasons, which may have included their ability to prevent HIV infection.

An important finding in Table 6.2 is that abstaining from sex was chosen more actively by males (13.43%) than by females (8.33%) as 9 boys out of 67 and 9 girls out of 108 reported a cessation of sexual activity from Phase 1 to Phase 3. This was surprising, as boys are generally expected to be, and are, more sexually active than girls. Reasons for abstention had been given during Phase 1 and during Phase 3 and the learners provide some clues that might explain this development. A common explanation for abstention in Phase 1 was “Waiting to prove love to the right future partner”. This was reported by large numbers of learners in both first and third phases. However, in Phase 3, significantly fewer girls reported this as their main reason for abstaining. The number decreased from 33 (30.55%) girls in Phase 1 to 24 (22.22%) in Phase 3. There was, however, an increase from 12(17.9%) in the first phase to 18(26.86%) in the third phase, in the number of boys reporting this as their first reason for abstaining. There was a significant change in the prioritisation order of the reasons as reported by learners in the first phase compared to those reported in the third phase.

Another reason for abstaining was “fear of pregnancy,” reported by more girls (19 - 17.6%) than boys (5 - 4.6%) in the first phase. In the third phase, only a few learner ranked this reason the third most important for abstaining from sexual activity: eleven (17.7%) girls and three (12.5%) boys. This shows that pregnancy was the least worry in the minds of learners after the intervention, (perhaps because of the increased condom use reported earlier) as opposed to the first phase, where it was reported as the second most important reason for being abstinent.

In contrast, in the third phase other reasons were reported by the majority of (30 - 34.9%) learners, for abstaining from sexual activity. More girls (27 - 43.6%) compared to boys (3 - 12.5%), reported the following as secondary reasons for abstaining: “I am scared of HIV and AIDS”; “ I am waiting for marriage”; I never trust a man when it comes to sex”;

“I am too young and concentrating on my school work”; “I want to get my education first”; “I do not have a boyfriend because I do not want sex”; “I do not want to be hurt and disappointed when the boy decides to dump me for other girlfriends”. Only 19 (21.6%) learners reported the above reasons for abstaining from sexual activity in the first phase, before the intervention: 16 (23.65%) girls and 3 (15%) boys.

One of the positive changes effected by the intervention was the increase in the number of learners, mainly girls, who reported “I am scared of HIV and AIDS”. At Phase 1, only three (4.4%) girls and two (10%) boys reported this. In Phase 3, the numbers had increased to 16 girls (25.8%), but only two boys (8.3%).

When comparing reasons other than the fear of HIV and AIDS reported by learners in the first and the third phases, more girls (8 - 11.8%) reported “I am waiting for marriage” compared to one boy (5%). Marriage was seen by these learners as the time when they would be ready, in the first phase. Five (7.4%) girls in the first phase reported, “I never trust a man when it comes to sex”; “I am too young and concentrating on my school work”, “I do not have a boyfriend because I do not want sex”. However, in the third phase, in addition to fear of HIV and AIDS, stated by 16 girls (25.8%), and two boys (8.3%), as the strongest reason, other reasons were stated for abstaining from sexual activity. In the third phase, nine (14.1%) girls stated other reasons that were the same as those stated by five (7.4%) girls in the first phase. One (1.85%) girl reported that she was waiting for marriage: “I am waiting for marriage when I will be an adult, married to my husband and when I do it, it will be special.” Another girl (1.85%) stated in the third phase “I do not want to be hurt and disappointed when the boy decides to dump me for other girlfriends” as her reason for abstaining. Only one (4.2%) boy reported education as a reason for abstaining from sexual activity: “I want to get my education first”.

The changes described above cannot all be attributed to the intervention, although it is likely that it, in conjunction with other HIV messages, in the media and at school, could be credited with some of the positive changes. One of the difficulties when trying to

establish the influence of the intervention is the nature of the data itself, as it is all self-reported. There is necessarily, some speculation in discussing the issue of causality. It is possible, for example, that the learners' knowledge and understanding of HIV and AIDS was strengthened by the intervention which could have created a mindshift that made them, particularly the girls, realise that they are at risk of contracting HIV if they engage in unsafe sexual activity.

The following section will compare the findings of groups of learners who reported sexual activity, prior to and after the intervention, in relation to gender, as shown in Table 6.2 above.

SEXUALLY ACTIVE LEARNERS

In the first phase, almost half of all learners, 87 (49.7%), reported that they were sexually active. After the intervention the number of sexually active had risen by two to 89 (50.9%), marking a slight increase in the overall percentage. In the third phase, the group of learners who reported that they were sexually active were divided into two groups, the newly sexual active and continuing sexual active groups, as shown in Table 6.2.

Among the learners who had changed from what they had reported in the first phase, girls were more likely to have a negative change. Twenty-seven girls (25%) compared to 11 boys (16.4%) reported themselves as sexually active for the first time in the third phase. This is referred to as the 'Newly sexually active' group, as shown in Table 6.1. By contrast, among those learners who had not changed from the first phase, boys were more likely to have a negative change, as more boys 32 (47.8%) compared to girls, who seemed to display a positive change. Few girls (19 (17.6%)) reported that they were continuing to be sexually active in the third phase, and hence were referred to as the continuing sexual activity group.

In fact, 19 out of the total of 40 girls (47.5% of girls) who reported they were sexually active in Phase 1 continued to report themselves as sexually active in Phase 3. The 32 boys (68.1%) who were sexually active at Phase 1 continued to be sexually active in

Phase 3. In other words, the rate of continuing sexual activity was 20.6% higher in boys than girls.

In the following section, the sexual decision-making of the learners and the reasons given in the third phase for becoming sexually active will be compared with those that were reported in the first phases of the study. Thereafter, the possible explanations of why boys and girls were reporting that they were as sexually active as they were before the intervention will be outlined. I aim to determine whether there were any changes after the intervention and to ascertain what impact the intervention had on the learners' sexual decision-making skills.

As in the first phase, the group of 89 (50.99%) learners who reported that they were sexually active in the third phase were questioned regarding their reasons for becoming sexually active, using the same self-administered questionnaire as was used in the first phase²⁹. Their responses, as outlined in the following section, assisted me to assess their sexual decision making skills. The aim of this chapter is to report the findings reported by learners in the third phase, and compare them with the results of the first phase, to determine changes, whilst indicating either the positive or negative impact of the intervention. For instance, if the intervention had a positive impact, boys and girls would be more enlightened and would make safer decisions regarding their sexual relations.

SEXUAL DECISION MAKING IN RELATION TO SEXUAL ACTIVITY

In the first phase, before the intervention, close to half of the learners, 87 (49.7%), reported that they were sexually active. There was a small change after the intervention. The number of sexually active participants increased by two to 89 (50.9%).

In the following section, learners who reported that they were sexually active before and after the intervention will be compared in relation to gender, in order to determine if it was their decision to engage in sexual activity, as shown in Table 6.3 below.

²⁹ See attached Appendix 1: Questionnaire for first and third phases of the study.

Table 6.3 Comparison of sexual decision-making by gender in relation to sexual activity in Phases 1 and 3

Was it your choice or decision to have sex?								
	Phase 1 (n=87)			Phase 3 (n=89)				
	One group/category of sexual activity in phase 1			Two groups/categories of sexual activity in phase 3				
				Continuing sexual activity		Newly sexually active		
	Yes	No	Total	Yes	No	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	19 47.5%	21 52.5%	40 100%	19 41.3%	0 0%	27 58.7%	0 0%	46 100%
Males	38 80.9%	9 19.1%	47 100%	32 74.4%	0 0%	11 25.6%	0 0%	43 100%
Total/ Percentage	57 65.5%	30 34.5%	87 100%	51 57.3%	0 0%	38 42.7%	0 0%	89 100

The two most significant findings are: firstly, in the third phase a new finding was obtained from 89 (100%) learners: both girls and boys who reported they were sexually active indicated that it was their own decision to engage in sexual activity. This should be compared to the first phase, where only 19 girls (47.5%)) compared with 38 boys (80.9%) reported that it was their choice to be sexually active. Secondly, none of the learners reported in the third phase that the decision to be sexually active was not their own; in contrast to 21 girls (52.5%) and 9 (19.1%) boys in the first phase, who had indicated that it was not their own decision to engage in sexual activity. These responses indicate that learners, who reported that they were sexually active in the third phase, had actively consented. Amongst learners who had become sexually active for the first time, as well as those who were continuing to be active, gender power inequalities may have influenced them; such reasons were given by 27 girls (58.7%) and 11 (25.6%) boys. The

most important point is that in Phase 3, a greater number of girls indicated that they were participating in sex willingly compared to Phase 1. This suggests that the intervention gave them a much greater sense of their power to decide.

My interpretation of the overall effect of the intervention will be made based on the reasons offered by learners as influencing them to engage in sexual activity after the intervention, as they will be outlined in the following section.

Table 6.4 Reasons for sexual activity in Phase 3 by gender (n =89)

	What was your reason for becoming sexually active?				
	Phase 3 (n=89)				
	Pressure from friends	Prove love To partner	Pressure from partner	Other	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female					
Newly sexually active (From Phase 3)	0 0%	2 7.4%	23 85.2%	2 7.4%	27 100%
Continuing sexual activity (Phase 1 and 3)	0 0%	5 26.3%	14 73.7%	0 0%	19 100%
Total/ Percentage	0 0%	7 15.2%	37 80.4%	2 4.4 %	46 100%
Male					
Newly sexually active (From Phase 3)	6 54.5%	5 45.5%	0 0%	0 0%	11 100%
Continuing sexual activity (Phase 1 and 3)	20 62.5%	10 31.3%	0 0%	2 6.2%	32 100%
Total / Percentage	26 60.5%	15 34.9%	0 0%	2 4.6%	43 100%

When comparing reasons reported by learners for becoming sexually active, there were significant differences in the prioritisation order between reasons given by the girls and the boys. “Pressure from partner” was reported by 37 girls (80.4%). Not even a single boy gave this as a reason for having sex. This should be compared with the reasons given in Phase 1 when three (15.8%) girls and two (5.3%) boys reported pressure from a

partner as their reason for having sex. The 23 girls (85.2%) who were newly sexually active were more likely to cite partner pressure as a reason for having sex than those 14 (73.7%) who were continuing with sexual activity.

These findings of pressure from partners as a reason for becoming sexually active echo the findings of previous studies, which showed that sexual relations often occur within the context of male domination and may involve, for example, boys threatening to leave their girl friends if they do not agree to have sex (Morrell, et al., 2002: 27; Thorpe, 2002: 62). Those who had been sexually active at Phase 1 appeared to be less vulnerable to partner pressure although nearly three quarters still cited this as their reason for being sexually active. It is possible to suggest on the basis of this finding that the intervention contributed to an increase in the sexual confidence of girls. My findings also suggest that gender power inequalities in heterosexual relations still exist: girls can face male threats of desertion, and even violence if they do not agree to have sex with them. Gupta (2000:5) notes that gender-power inequalities typically favour men, and males may feel they have greater control over females, particularly in sexual decision-making.

The major pressure experienced by boys was “pressure from [presumably male] friends”. The majority of boys, 26 (60.5%) compared to none of the girls, cited this as their main reason for becoming sexually active. This should be contrasted with the responses at Phase 1 where equal percentages 8 (21.1%) boys and 4 (21.1%) girls, reported this as their reason for becoming sexually active. Boys seem to be susceptible to peer pressure. A number of studies (Campbell, 2003:183, Harrison, Cleland, Gouws and Frohlich, 2005:259, Pattman, 2002:35, Preton-Whyte and Zondi, 1992: 10, Thorpe, 2002:61, Zakwe, 2005:144) have shown that young men are likely to be influenced by their friends and peers, especially in the area of sexual performance. During the intervention phase, most boys stated “Our friends usually convince us to have sex to prove that we are *sesingamadoda* (mature males). They say sex gives you power as a male.” Such views, reported in the intervention phase, seem to indicate that boys are under pressure from their peers to engage in sexual activity, whether they are ready for it or not, which could make males and their partners vulnerable to HIV infection.

In the first phase, “wanting to prove love to my partner” was reported by most learners as their main reason for becoming sexually active. In Phase 3, only 15 (34.9%) boys and seven (15.2%) girls cited this as a reason for being sexually active. These figures are down from 26 (68.4%) boys and 11 (57.9%) girls who reported this in the first phase. This slight change could be regarded as a positive effect of the intervention. These findings indicate that learners no longer accepted the convention that proving love involved having sex. But this development is outweighed by high levels of pressure from peers (boys) and partners (girls).

Given the context of poverty³⁰ in which this study was undertaken, it could be expected that many girls would be having sex for transactional reasons – to obtain one of the three ‘C’s (cell phones, cash or clothes). But only 2 (7.4%) girls, who were newly sexually active after the intervention and 2 (6.2 %) boys, who were sexually active before and after the intervention stated this as their reason in the third phase.

These findings do not show dramatic changes in behaviour across the cohort but they do show important shifts in sexual decision-making. The study indicates that it is a slow and difficult process to change sexual behaviour. Later in this chapter, I will examine other indicators of safer sex that were also measured in this study. These include the number of sexual partners and condom use. I will also examine the attitudes of learners who were not sexually active.

There were significant differences after the intervention between females and males: a slight positive change in the males, as compared to the negative change in the females was evident regarding the newly abstaining group. A greater negative change in the females as compared to males took place regarding the newly sexually active group..

The above findings show that there were both positive and negative changes regarding sexual behaviour of the participants. The reasons for such changes could either relate to the impact of the intervention or to other factors.

³⁰ See Appendix 11, which deals with social class, based on parents’ occupations, type of housing and number of occupants of houses.

There was a slightly increased level of sexual activity in females after the intervention and a slight decrease in males. While this shift was unexpected, multiple factors could be used as possible explanations for these changes. The intervention may have increased both female, and to a lesser extent, male assertiveness. They could have been exhibiting more confidence about talking about sex and therefore the data obtained in the third phase may reflect confidence rather than changes in sexual conduct. Learners' knowledge of their rights could have influenced their attitudes towards exploring their sexuality, particularly amongst the females. Since this study is based on self-reported sexual behaviour, it cannot always be clear whether a change occurred before the intervention or as a result of the intervention.

The results from the third phase will be discussed in relation to other outcomes, such as age at first sexual experienced, as outlined in the following section.

AGE OF SEXUAL DEBUT

The group of 38 (42.7%) learners who reported in the third phase that they were sexually active for the first time will now be discussed in relation to the age of sexual debut. This is of great concern because 27 girls (71%) compared to 11 (29%) boys who participated in this study reported that they were sexually active for the first time in the third phase. This group of 38 (42.7%) learners will also be discussed in relation to other outcomes, such as condom use, to determine whether they engaged in safer sex or dangerous sexual practices that could put them at risk of contracting the HIV infection.

The information that I am going to present here relates to girls and boys who reported in the third phase that they were sexually active for the first time. Their date of sexual debut can, within limits, be fixed. The age of sexual debut will also be divided into three types of age category. The reports of learners who claimed in the third phase that their sexual debut had recently taken place were asked the following question: "How old were you when you first had sex?" The same question was asked of learners who reported that they were sexually active in the first phase and its findings were presented in Chapter 4. There was the 'Children' category, if learner reported to first had sexual activity at 12 years or below, 'Early or Young Teenage' category if it was at 13 to 16

years of age and the 'Late Teenage' category for those who reported having had their sexual debut at the age of 17 to 19. (The age of the learners who participated in this study was between 13 and 19 years.) Only 11 (12.6%) learners reported having had their first sexual activity at the age of 12 years or below. The general trend of age of sexual debut of 87 (49.7%) learners as presented earlier in Chapter 4, was that 56 (64.4%) reported their sexual debut to have been between 13 - 16 years. 20 (23%) learners reported that they delayed their sexual debut to between 17 and 19 years of age.

Table 6.5 below shows the participants who reported sexual activity for the first time in the third phase, and excludes those who reported they engaged in sexual activity prior to the intervention, because their date of sexual debut would not have changed. In the third phase, in addition to the above three types of age categories, the age of sexual debut of learners who reported to be newly sexually active is indicated.

SEXUALLY ACTIVE LEARNERS: SOCIO-DEMOGRAPHIC PROFILE IN RELATION TO AGE OF SEXUAL DEBUT

Table 6.5 Age of sexual debut / first sexual activity of the newly sexually active learners by gender (n = 38)

	Age of sexual debut phases 3			Total
	Child ≤ 12 years	Young teen 13-16 years	Late teen 17 to 19 years	
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female: Newly sexually active	0 0%	16 59.3%%	11 40.7%	27 100.0%
Male: Newly sexually active	0 0%	5 45.5%	6 54.5%	11 100.0%
Total/ Percentage	0 0%	21 55.3%	17 44.7%	38 100%

In the first phase, less than half (87 - 49.7%) of learners reported having had sexual activity, compared to more than half (89 - 50.9%) of the learners who reported that they were sexually active in the third phase. This section will present the age of sexual debut

of the 38 (42.7%) learners that reported they were sexually active for the first time in the third phase, as shown in Table 6.5. I shall not consider the 51 (57.3%) learners that were continuing to be sexually active before and after the intervention, as their already reported age of sexual debut in the first phase will not have changed.

The age of sexual debut of learners sexually active for the first time in the third phase, as shown in Table 6.5, will be compared to the age of sexual debut of learners who reported themselves to be sexually active in the first phase. The aim of comparing ages of sexual debut of learners is to determine if the age pattern of sexual debut of learners who have just started to be sexually active in the third phase is different from the pattern of age of sexual debut already established in Phase 1. The general trend of sexual debut, taking the sample of sexually active learners as a whole or in Phases 1 and 3 will be examined.

The pattern of the age of sexual debut of learners in the third phase is different from the pattern established in Phase 1. This is more evident in the 'Child' category than in the 'Young Teen' and 'Late Teen' categories. In phase three, none of the learners who were newly sexually active was in a position to claim that his or her age of sexual debut was 12 years of age or younger.

The findings of the third phase show that 38 (42.7%) learners who reported they were newly sexually active in the third phase was that 21 (55.3%) learners (16 (59.3%) females and only 5 (45.5%) males) reported that they became sexually active between 13 - 16 years old. In the first phase, almost a similar trend of age of sexual debut emerged, as a majority of learners, 56 (64.4%) reported that they had become sexually active when they were 13 - 16 years old. The figures here were 30 (63.9%) boys and 26 (65.99%) girls. In the third phase 17 (44.7%) learners (11 - 40.7% girls and 6 - 54.5%) boys) reported that their sexual debut had occurred between 17 and 19 years of age. The first phase revealed almost the same number of learners as in the third phase. In the first phase, 20 (23.0%) learners (11 - 23.4 boys and 9 - 22.5% girls) reported they had delayed their sexual debut until they were 17 - 19 years, - the Late Teen category group.

The Pearson chi-square test was performed and suggested there was significant negative change in the third phase in females ($p = 0.025$). This negative change could be associated with the fact that 16 (54.5%) females compared to 5 (45.5%) males reported that they were newly sexually active in the 'Young Teen' period in the third phase. It is not easy to find the reason why the majority of learners, especially females, reported having started to become sexually active in the third phase, after the intervention. Multiple factors could have shaped their sexual behaviour. The following section will examine some possible explanations for this finding.

The relatively large number of participants who became sexually active and their relatively young age of sexual debut seem to indicate that the intervention had an unexpected and undesirable effect. Learners' knowledge and understanding of sexual issues may have been strengthened by the first part of session five of the intervention phase, an exercise aimed at encouraging female and male learners to open up and talk freely among themselves about terms used in the language of sex and sex-related issues, as explained in Chapter 5. This may have given them a greater confidence about sex which they then translated into actual physical sexual activity. In the first phase, before the intervention, they might not have been aware that anal and oral sex were considered to be sexual activities, and so did not admit to them as part of sexual activity until in the third phase after intervention.

The findings of previous researchers such as Bearman and Bruckner, (2005:2) show that some adolescent females have anal and or oral sex to preserve their virginity and prevent pregnancy. Such views suggest that females may substitute oral or anal or other sexual practices for vaginal intercourse. However, these are also of great concern as they are high risk behaviours for contracting sexually transmitted infections, including HIV.

In the next section, I will compare the age of sexual debut of sexually active learners and the age of their sexual partners.

AGE OF SEXUAL DEBUT OF SEXUALLY ACTIVE LEARNERS AND AGE OF SEXUAL PARTNERS

There were highly statistical significant gendered differences in the choice of sexual partner, by age. There was a significant variation in terms of age difference between female learners and their male partners. Females tended to have older partners, whereas males tended to have sexual partners either of similar age or younger. In the third phase, 13 (68.4%) females, between 17 and 19 years were the only learners in the 'continuing' group who reported to be sexually active in both the first and third phases, with a partner older than 19 years of age. In contrast, in the third phase, none of the males reported having his sexual debut with a significantly older sexual partner of 20 years and older. The same trend was observed in the first phase where more females, (14 - 35%) than males (4 - 8.5%) reported having had sex, for the first time, with significantly older sexual partners of more than 19 years of age. However, the majority of males (19 - 59.4%) who had reported having had sex in the first and third phases, said their sexual partners' ages were within the range of 15 to 16 years of age at their first sexual encounter. This compares to 3 (15.8%) female learners who reported that they had their sexual debut with boys who were the same age as them, 15 - 16, in the first phase. In addition, amongst the other learners in the third phase, 6 (31.6%) girls and 13 (40.6%) boys 13 - 16, who were continuing to be sexually active, reported that their ages and those of their sexual partners at their first sexual encounter were within the same range.

The timing of sexual debut is important because an early sexual debut has been identified as an HIV risk factor. These findings seem to indicate a significant positive trend: in the newly sexually active group, none of the learners reported being sexually active for the first time with a partner older than 19 years of age. The exception was 13 (68.4%) females, 17 - 19 years old, who were the only learners in the continuing group who reported a partner older than 19, as the reported age of their partners at their sexual debut in the first phase, had not changed. Both girls (27 - 100%) and boys (11 - 100%), between 15 and 19, who were newly sexually active in the third phase, reported that their ages and those of their sexual partners were within the same age group. In the first phase, before

the intervention, more girls (14 - 35%) than boys (4 - 8.5%) reported older sexual partners of more than 19 at their sexual debut.

The age difference between girls and their male partners, as reported in the first phase as well as by girls continuing to be sexually active in the third phase, contributes to gender-power disparity. It brings with it a patriarchal notion of being dominated by the older male, accompanied by social pressure to maintain a relationship with that male partner. This contributes to gender-power inequalities that would inhibit a woman's ability to negotiate sexual matters, making both men and to larger extent women more easily exposed to HIV infection.

My findings here are similar to other studies (Leclerc-Madlala, 2002:31; Harrison, Xaba, Kunene and Ntuli, 2001:69; Hunter, 2002:99) showing that adolescent girls commonly have sexual relationships with older men for various reasons, including economic ones. Similar patterns of association between the age of sexual debut and the location of home area, as well as other factors in the socio-demographic profiles of participants were found in both the first and third phases of this study, as outlined in Chapter 4. They will not be discussed in this chapter since there were no significant changes.

In the following section I shall examine the role played by partners in initiating sexual activity for learners who reported themselves to be sexually active in the third phase, as shown in Table 6.6 below. The balance of power in negotiations between partners will be compared with the situation as reported in the first phase, and later these roles will be compared with other outcomes, such as condom use and negotiation for condom use, to determine the learners' negotiation skills with the aim of revealing changes in these skills that might indicate the effect of this study.

ROLES OF PARTNERS IN INITIATING SEXUAL ACTIVITY

Table 6.6 Initiation of sexual activity among sexually active learners by gender (n =89)

Who initiated sexual activity? : Phase3			
	Me	Partner	Total
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female			
Newly sexually active (From Phase 3)	2 7.4 %	25 92.6%	27 100.0%
Continuing sexual activity (Phase 1 and 3)	4 21.1%	15 78.9%	19 100%
Total/ Percentage	6 13.0%	40 87.0%	46 100%
Male			
Newly sexually active (From Phase 3)	11 100%	0 0%	11 100.0%
Continuing sexual activity (Phase 1 and 3)	29 90.6%	3 9.4%	32 100%
Total/ Percentage	40 93.0%	3 7.0%	43 100%

Eighty-nine learners, who reported that they were sexually active in Phase 3, completed the same questionnaire as their sexually active colleagues in Phase 1. They were asked to indicate who played the leading role in sexual activity. There was a significant association between gender and initiation of sexual activity: the vast majority of sexual interactions were initiated by boys: 40 (93.0%) compared to 6 (13.0%) of the girls reported having initiated sexual activity in the third phase, as shown in Table 6.6. The same trend was found in Phase 1: 39 (83.0%) of the boys and only 7 (17.5%) of the girls reported having initiated sexual activity in the first phase. Gender was strongly associated with initiation of sexual activity. The above findings seem to indicate that the gender-based skill-building intervention that was conducted in this study was not effective in changing the male-dominated way in which sex was negotiated.

However, there seemed to be a slight shift from male domination, as both boys and girls seem to have played a role in initiating sexual activity before and after the intervention. There were seven (17.5%) and six (13.0%) girls in the first and third phases respectively who reported having initiated sexual activity. In addition, almost similar proportions – eight (17.0%) and three (7.0%) boys in the first and third phases respectively, compared to most 33 (82.5%) and 40 (87.0%) girls in the first and third phases respectively, reported their partners as having initiated sexual activity.

The Pearson chi-square test was performed in the third phase and suggested a slight but statistically significant association between gender and initiation of sexual activity ($p = < 0.001$). These findings could be associated with mind-shifts concerning gender norms in sexual relationships of school-going youth of northern KwaZulu-Natal.

There was a significant variation by social class, with more 38 (54.3%) learners from the lower economic class than 8 (47.1%) from a higher economic class reported having initiated sexual activity. The class variable that was significantly in relationship to the initiation of sexual activity was that of occupational group, in Phase 3, but not in Phase 1. A total of 36 (20.6%) learners, who reported having initiated sexual activity also reported homes with single parents or overcrowded homes. Only 10 (7.4%) learners who initiated sexual activity reported that they were from families with both parents and no overcrowding. There seemed to be no significant association between the socio-demographic profiles of learners who initiated sexual activity and those of the other learners who participated in this study. Regardless of class, religion, grade at school, school area or ethnic background, learners are equally likely to initiate sex.

Most of the findings of this study are consistent with those of previous studies conducted in KwaZulu-Natal schools where boys demonstrated power over women in relation to sexual matters (Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and Devries, 2002:70; Thorpe, 2002:62).

The major finding of this study has been that gender makes a great deal of difference and boys continue to take the lead in sexual matters³¹. The findings of the first and third phases of this study suggest that significantly higher proportions of responses were obtained from male learners: the majority of boys, 40 (93.0%) compared to 6 (13.0%) girls reported having initiated sexual activity in the third phase, after the intervention³². The significant element was the learner's gender, irrespective of religious affiliation, grade at school, rural or peri-urban school area or parents' occupational class.

It is clear that there were other significant socio-cultural factors, such as Zulu culture which might undermine other factors, and weaken the impact of the intervention. No boys and few girls were able to apply the principles of equal respect in sexual relations, although they were sensitised during the intervention phase. There were no changes in their conception of masculine and feminine identities: the number of girls who initiated sexual activity remained low, and even decreased from seven (17.0%) to six (13.0%) females in the first and third phases respectively. The number of boys who initiated sexual activity increased from 39 (83.0%) to 40 (93.0%) males in the first and third phases respectively.

More boys than girls from the lower class than those from the higher class and more learners from homes with single parents and overcrowded homes reported that they initiated sexual activity in the third phase.

Having outlined sexual activity and decision making, the reasons that were given by learners for becoming sexually active, the following section will examine the number of sexual partners learners were involved with in Phase 3, to see if the intervention made a positive impact in this area.

³¹ As shown in Table 6.6

³² As shown in Table 6.6.

NUMBER OF SEXUAL PARTNERS IN RELATION TO GENDER

Learners were requested in the first and third phases to indicate the number of sexual partners that they had had in the past four months. They were also asked, as part of the special outcomes measured in relation to sexual behaviour, questions relating to gender in order to determine their attitudes towards the number of sexual partners that men and women have.

Table 6.7 Number of sexual partners for sexually active learners at the time of data collection at Phase 3 by gender (n=89)

Number of sexual partners at the time of data collection in Phase 3					
	Zero	One	Two	Three and more	Total
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female					
Newly sexually active (From Phase 3)	0 0%	27 100.0%	0 0%	0 0%	27 100.0%
Continuing sexual activity (Phase 1 and 3)	0 0%	17 89.5%	2 10.5%	0 0%	19 100%
Total/ Percentage	0 0%	44 95.7%	2 4.3%	0 0%	46 100%
Male					
Newly sexually active (From Phase 3)	0 0%	11 100%	0 0%	0 0%	11 100.0%
Continuing Sexual activity (Phase 1 and 3)	0 0%	27 84.3%	5 15.7%	0 0%	32 100%
Total Percentage	0 0%	38 88.4%	5 11.6%	0 0%	43 100%

Learners in Phase 3, were asked the same question as in Phase 1 “How many sexual partners do you have at present?” See Table 6.7.

These results are a strong endorsement of the success of the intervention as they show a significant increase in single-partner relationships. Eighty-two (92.1%) learners reported monogamous relationships in the third phase, after the intervention, compared to 63

(72.4%) in the first phase. This positive change could be attributed to the intervention. A significant finding was obtained in the third phase as shown by 27 (100%) girls and 11 (100%) boys who were newly sexually active for the first time who reported that they had one-partner relationships. This should be compared to 38 (35.2%) girls and 25 (37.3%) boys who reported having one partner relationships in the first phase.

There is a reduction in the number of learners that reported having more than one sexual partner from 31 (35.6%) learners in the first phase to 7 (7.9%) learners that reported having two partners in the third phase. In the third phase a relatively small number of girls 2 (10.5%) and boys 5 (15.7%) who stated that they were sexually active before and after the intervention reported that they had two partners in the third phase.

This should be compared to the high number of multiple partner relationships that were reported in the first phase, where 13 (19.4%) boys and 4 (3.7%) girls reported that they had had two-partner relationships, with boys being more likely to report two sexual partners than girls. There were two extreme cases of ten-partner relationships, reported by one girl and 14-partner relationships reported by one boy in the first phase, as outlined in Chapter 4. The most significant finding of this study was a major decline in multi-partner sexual relationships among participants. Relationships involving more than two partners all but disappeared between the first and third phase. This reduction of the number of partners is obviously significant in reducing the risk of HIV infection.

The Pearson chi-square test showed a statistically significant association between gender and number of sexual partners of sexually active learners in the third phase ($p= 0.004$).

NUMBER OF SEXUALPARTNERS IN THE PAST FOUR MONTHS IN RELATION TO GENDER

Table 6.8 Number of sexual partners for sexually active learners in the last four months by gender (n=89)

Number of sexual partners in the last four months in phase 3						
	Zero	One	Two	Three	Four and more	Total
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female						
Newly sexually active (From Phase 3)	0 0%	27 100.0%	0 0%	0 0%	0 0%	27 100.0%
Continuing sexual activity (Phase 1 and 3)	0 0%	16 84.2%	3 15.8%	0 0%	0 0%	19 100%
Total/ Percentage	0 0%	43 93.5%	3 6.5%	0 0%	0 0%	46 100%
Male						
Newly sexually active (From Phase 3)	0 0%	10 90.9%	1 9.1%	0 0%	0 0%	11 100.0%
Continuing sexual activity (Phase 1 and 3)	0 0%	14 43.8%	11 34.3%	7 21.9%	0 0%	32 100%
Total/ Percentage	0 0%	24 55.8%	12 27.9%	7 16.3%	0 0%	43 100%

The time difference between the intervention phase and third phase was nine months. In this section I examine changes in the number of sexual partners that learners had in the first and third phases. This will assist in determining if the impact of the intervention was positive or negative, because the number of sexual partners is part of sexual behaviour.

The period in terms of the time frame after the intervention creates a major difference between these two Tables, even though they appear to be measuring similar trends or in the number of sexual partners. Table 6.7 displays data obtained from participants in relation to the number of their sexual partners in the third phase, about nine months after

the intervention was conducted; Table 6.8 outlines data obtained from participants in relation to their sexual partners in the last 4 months but in the period nine months after the intervention. The purpose was to determine change in the numbers of sexual partners that participants during these two periods.

In the third phase, after the intervention there was a striking increase in 'faithfulness' with participants showing a marked preference for single-partner relationships, as is nevident in Table 6.8

A completely new and significant finding was obtained in the third phase. There was striking reduction in the number of sexual partners. Most learners, 43 (93.5%) girls and 24 (55.8%) boys, reported only one sexual partner in the last four months, as shown in Table 6.8. Amongst those who were continuing to be sexually active before and after the intervention, 12 boys (27.9%) and three girls (6.5%) reported two sexual partners in the third phase. Nevertheless, 7 (21.9%) boys, particularly those who were continuing to be sexually active before and after the intervention, reported sexual activity with three sexual partners in the past four months, in the third phase. None of the girls and none of the newly sexually active boys reported three sexual partners in the third phase. However, an association was again found between the number of sexual partners and gender, with males being more likely to have more sexual partners than females. One boy (9.1%), compared to no girls, among those who were newly sexually active in the third phase, reported having had sex with two sexual partners in the past four months. This should be compared to the majority of learners, boys in particular, where as many as 25 (53.2%) compared to seven (17.5%) girls among those who were sexually active in the first phase, reported sexual activity with more than one sexual partner in the past four months.

These findings seem to indicate a positive change that could be attributed to the skills sessions of the intervention phase. All 27 girls (100.0%) and 10 boys (90.9%) who reported themselves newly sexually active in the third phase, stated that they had only one sexual partner in the past four months (see Table 6.8). In addition, there was a

reduction in the number of sexual partners reported by boys and even more by girls in the third phase, compared to the numbers of sexual partners reported in the first phase.

ATTITUDES TOWARDS THE NUMBER OF SEXUAL PARTNERS THAT WOMEN AND MEN SHOULD HAVE

In addition to the actual number of sexual partners that learners' claimed to have, as already outlined above, they were also asked to respond to questions relating to the gendered ideals of heterosexual relations. The aim was to determine, as part of the special outcomes measured in relation to sexual behaviour, their attitudes towards the number of sexual partners of men and women. The findings of third phase will be compared to those of the first phase to check if the effect of the intervention was positive or negative.

Table 6.9: Attitudes of learners towards the number of sexual partners by gender (n=175)

Is it acceptable for a girl or woman to have more than one sexual partner?			
Phase 3			
	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Females	27 25.0%	81 75.0%	108 100.0%
Males	22 32.8%	45 67.2%	67 100.0%
Total/ Percentage	49 28.0%	126 72.0%	175 100.0%

There was a positive change in the third phase after intervention in the attitudes of learners towards the number of sexual partners that women should have. A high number of learners (126 - 72.0%) reported in the third phase that it is not acceptable for a girl to have more than one sexual partner, whereas a low number of learners (105 - 60.0%) who reported that it is not acceptable for a girl to have more than one sexual partner in the first phase. Gender was found to be associated with attitudes and norms towards the number of sexual partners, as girls were more likely to oppose multiple sexual partners than boys.

A high percentage of girls (81 - 75.0%) compared to boys (45 - 67.2%) reported in the third phase that it is not acceptable for a girl to have multiple sexual partners. A similar trend occurred in the first phase, as the majority of girls (73 - 67.6%) compared to boys (32 - 47.8%) reported that it is not acceptable for females to have multiple sexual partners. However, more boys (33 - 49.3%) in the first phase and 26 (38.8%) in the third phase, than girls (21 - 19.4%) in the first phase and six (5.6%) in the third phase indicated that it is 'right' for a boy to have more than one sexual partner.

The McNemar chi-square test indicated that there was a statistically significant positive change towards "No, it is not acceptable for a girl or a woman to have more than one sexual partner" as reported by females in the third phase ($p < 0.001$). This positive change was stronger among females than among males in the third phase as evident in Table 6.9. In the McNemar chi-square test there was a similar statistically significant positive change towards the "Yes, it is right" response that was noted amongst males ($p = 0.002$). This was due to the fact that most males changed their response from saying "Yes" in the first phase to saying "No it is not acceptable for a girl or woman to have more than one sexual partner" in the third phase. This positive change marked an increase in the number of boys and girls who reported it is not acceptable for a girl to have more than one sexual partner, and may be shaped by the impact of the session on HIV and AIDS that was part of the intervention. This session strengthened learners' awareness that more than one sexual partner increases HIV risk, in addition to the moral value that they had before the intervention.

These views of young people are interesting but one needs to be cautious when interpreting them. It is difficult but important to distinguish between the views that are reported by people and their actual life choices. It is possible for someone to believe in monogamy but to practice polygamy. These views reported by participants may not be reflections of what happens between them and their partners. This section however will be looking at attitudes, not behaviour of learners.

Significantly more males (53 - 79.1%) out of 67 males, compared to 59 females (54.6%) out of 108 females, reported in the first phase that it is common and acceptable for men to have more than one sexual partner. However, there seemed to be consensus between females and males – 71 (65.7%) females and 44 (65.7%) males in the third phase that it is common and acceptable for men to have more than one sexual partner.

Two significant reasons were offered for men to have more than one sexual partner. The first reason, reported by 20 (29.9%) of the 67 males and by 21 (19.4%) of the 108 females was: “African culture supports polygamy for real men”. The second reason was *amasoka* [a womanizer], which was reported by 20 (29.9%) males out of the 67 and 20 (18.5%) of 108 female learners.

Other reasons were given by males (11 - 10.2%) such as, “A man should have more than one sexual partner to avoid disappointment and because men do not trust women” as reported by one male learner. Another male learner reported, “I have pressure from my friends and I am required to prove that I am a man by having more than one sexual partner ...” Six females (9.0%) reported other reasons, such as “Men are unfaithful and they want to abuse women.” These findings show that there are different reasons that influence men to have more than one sexual partner. Traditional reasons may promote the risk of spreading HIV infection, if safe sexual practices are not followed

Attitudes and behaviour such as sexual experimentation are common among youth; this is a phase of the lives of young people in which they are developing their identities and this involves exploration. As was reported by one of the male learners in session six of the intervention phase experimentation puts them at risk of STIs and HIV.

HIV AND AIDS AND PREVENTION OF TRANSMISSION OF HIV INFECTION

This section focuses on the perceptions and attitudes of learners towards HIV and AIDS, the risk of contracting HIV and the prevention of HIV infection. The perceptions and attitudes of learners will be examined and compared with those stated in the first phase.

HIV AND AIDS KNOWLEDGE AND RISK OF HIV INFECTION

Learners were asked to answer the same questions relating to HIV and AIDS in the first and third phases to determine their knowledge of and attitudes towards HIV and AIDS. These questions included basic information about the meaning of and differences between HIV and AIDS, whether there is there a vaccine for HIV or a cure for AIDS, modes of transmission of HIV, factors which make people vulnerable to HIV infection and methods of preventing HIV infection.

I shall compare the learners' attitudes towards the risk of contracting HIV infection in the first and third phases, to determine the impact of the intervention as learners, in the third phase were asked to respond to the same questions as in the first phase. The majority of learners, 89 (50.9%) girls compared to 33 (18.9%) boys, in total 70% of 175 learners, reported in the third phase that they thought that their partners had other sexual partners. This can be compared to 64 (59.3%) of 108 girls and 37 (55.2%) of 67 boys in the first phase who reported this. When learners were asked to answer the following question they responded as recorded below:

Question: "suppose you had confirmed that your partner had other sexual partners and you think your sexual partner puts you at risk of getting HIV infection, would you continue having sex with him / her, without protection?" The majority of learners, 97 (89.8%) girls and 53 (79.1%) boys indicated in the third phase that they would not continue having sexual activity without protection, compared to 89 (82.4%) girls and 44 (65.7%) boys who answered "no" to the same question in the first phase. Eleven (10.2%) girls and 14 (20.9%) boys indicated that they would continue having sexual relations without protection in the third phase. This is compared to 19 (17.6%) girls and 23 (34.3%) boys who answered "yes" to this question in the first phase before the intervention. Eight (42.1%) girls and 9 (39.1%) boys changed from saying "yes" in the first phase to saying "no". There was a statistically significant change in a positive direction ($p < 0.001$) in both female and male learners from first phase to the third phase.

However, the above findings should be interpreted with caution because they have a limitation as they are reporting about a speculation about learners' attitudes, rather than how they would actually prevent exposure to contracting HIV infection.

The intervention phase of this study had a positive impact, as shown by a change in a positive direction for both gender groups: there was a decrease in the percentages from the first phase to the third phase of those reporting that they would continue having sex with their partners without protection, even though they had already heard that their partners had other partners. This is one of the most important findings obtained in the third phase. It suggests that the intervention assisted in creating a positive change in the attitudes of learners and made them realise the risk of contracting HIV infection if they engaged in unprotected sexual activity. In the third phase, learners were asked to answer the same question as in the first phase "Did you know that having sex with somebody who has sexually transmitted infections (STIs) increases the risk of becoming HIV positive?". In the third phase, 103 (95.4%) girls and 61 (91.0%) boys reported that they were aware of the risk of contracting HIV infection that accompanied having sex with an HIV positive partner. This should be contrasted with the 99 boys (56.6%) and 62 girls (35.4%) who had reported in the first phase that they were not aware of the increased risk of contracting HIV infection if they had unprotected sex with an HIV positive partner.

There was an almost equal increase in the percentages of learners: from 39 (58.2%) boys in the first phase to 65 (97.0%) boys in the third phase, and from 63 (58.3%) girls in the first phase to 105 (97.2%) in the third phase, who reported 14 - 20 as the age group which they regarded at the highest risk of being infected with HIV. This seems to indicate that the intervention has made them realise that young, sexually active people of their age-group are extremely vulnerable to HIV infection.

A Wilcoxon Signed Ranks test was done to compare the HIV and AIDS knowledge scores obtained by participants in the first and third phases. This test showed that there was significant improvement in the HIV and AIDS knowledge scores by the third phase.

160 (91.4%) learners improved in the HIV and AIDS knowledge score in the third phase compared to the first phase. The remaining 15 (8.6%) learners obtained the same HIV and AIDS knowledge score in the third phase as they obtained in the first phase.

None of the learners obtained a lower score in the third phase than in the first phase. The median change in HIV and AIDS knowledge score improved or increased on average by four points. The HIV and AIDS knowledge score of learners improved or increased by a maximum of 16 points. This means that there was a highly significant change in HIV and AIDS knowledge scores in the majority of female and male learners in the third phase ($p < 0.001$).

COMPARISON OF CHANGE IN HIV AND AIDS KNOWLEDGE AND SOCIO-DEMOGRAPHICS OF LEARNERS

Socio-demographic variables were examined to find out what determines change in the HIV and AIDS knowledge score. There was no correlation between the change in HIV and AIDS knowledge score and gender or any other socio-demographic factor. However there was a significant correlation between the change in HIV and AIDS knowledge and the learner's religion, grade and high school area.

WAYS IN WHICH RELIGION, GRADE AND SCHOOL AREA WERE SIGNIFICANT

RELIGION

The learners who belonged to the Nazareth Church showed the most significant change in their HIV and AIDS knowledge in the third phase, compared to learners who belonged to other religions ($p = 0.049$). These learners obtained a greater change in HIV and AIDS knowledge score (mean score = 6.5) in the third phase than in the first. Next came learners who belonged to the Roman Catholic Church (mean score = 5.0), then lastly those belonging to other Christian churches (mean score = 4.6).

GRADE

Learners in lower grades had a greater change in HIV and AIDS knowledge score than those in the higher grades in the third phase than in the first phase ($p < 0.001$). Learners in Grade 8 obtained the highest (mean score = 8.00) change in HIV and AIDS knowledge, followed by learners in Grades 9 and 10 who obtained a lesser change in HIV and AIDS knowledge score (mean score = 5.00). Lastly, the learners in Grade 11 obtained the lowest change in HIV and AIDS knowledge score (mean score = 3.00) in the third phase than in the first phase. These findings may be explained by the fact that the higher grade learners already knew most of the information about AIDS from Life Orientation lessons and therefore could not improve, whereas the younger learners did not know much and could improve a lot via the knowledge they received in the intervention.

HIGH SCHOOL AREA

The learners attending rural high schools recorded the greatest improvement in their HIV/AIDS knowledge scores after the intervention ($p = 0.039$). These learners obtained the highest improvement scores in HIV and AIDS knowledge (mean score = 5.90), which should be compared with the learners from peri-urban high schools who obtained the lowest change in HIV and AIDS knowledge score (mean score = 4.70). One explanation for such findings may be that the learners from peri-urban high schools were already informed about HIV and AIDS, probably by the media and could not improve, whereas those from rural high schools could improve a lot via the knowledge they received in the intervention.

OTHER SOCIO-DEMOGRAPHICS, INCLUDING GENDER OF LEARNERS

Other socio-demographics did not have any significant association with the change in HIV and AIDS knowledge score in the third phase. However, even though it was not statistically significant, it is worth mentioning that male learners showed more improvement in their HIV and AIDS knowledge than females ($p = 0.473$). An important conclusion, therefore, is that the intervention had its greatest impact amongst those whose

knowledge levels were relatively low. It made little impact amongst those who already were well-informed.

GENDER ISSUES KNOWLEDGE

Learners who participated in this study were asked in the first and third phases to indicate whether they agreed or disagreed with statements relating to gender issues. This would determine the effect of the intervention, by assessing if there had been any change in their knowledge and attitudes towards gender issues in the third phase. There were sections on basic information on gender issues, such as the meaning of and differences between gender and sex, gender equality, rights of girls and boys, negotiation of sexual issues and sexual decision-making in heterosexual relationships.

Learners showed a significant improvement between phase one and phase three in their knowledge and understanding of most statements relating to gender issues. Their responses to the following statements are offered below:

Statement: “Young girls and boys should get the same sexuality education.” The intervention had a statistically significant and positive influence in changing this aspect of gender issues, particularly on females ($p < 0.001$). Most girls (107 - 99.1%) and to a lesser extent males (63 - 94.0%) boys ($p = 0.004$), agreed with this statement in phase three. Only one girl (0.9%) and four boys (6.0%) disagreed with this statement in phase three. In phase one, however 89 (82.4%) girls and 51 (76.1%) boys agreed with the same statement and 19 (17.6%) girls and 16 (14.8%) boys disagreed with it.

Statement: “Young women should be passive, submissive and dependent on men for money” The intervention had a statistically significant influence in changing perceptions of most learners here. This was particularly true for the females ($p = 0.005$), as most girls (97 - 89.8%) disagreed with this statement in the third phase, after the intervention compared to 81 (75.0%) girls who had disagreed in the first phase. The intervention had significant and positive changes in males ($p = 0.020$), as more than half of them, 48 (66.7%), disagreed with this statement in the third phase, while less than half, 33 (49.3%) disagreed with the same statement in the first phase.

Statement: “Men are the ones who make decisions at home since they are superior to women”: In females, the intervention had a significant influence ($p=0.003$) on their perceptions, as 96 (88.9%) girls disagreed with the statement in the third phase, compared to 77 (71.3%) girls who had disagreed in the first phase. In males there was no statistically significant change after the intervention because similar numbers of males to the first phase had positive, (21 - 51.2%), or negative change (16 - 61.5%) in this aspect of gender issues ($p=0.511$).

Learners’ responses to other questions relating to gender issues showed a borderline or no significant change between their views in the first and third phases. Their responses to the following statements are given as examples:

Statement: “Is it right for a boy to demonstrate his manhood by beating his girlfriend?” The intervention had no effect on the responses given by learners to this statement: almost equal proportions – 11 (10.2%) girls agreed and 97 (89.8%) disagreed with this statement in the first phase, compared to 10 (9.3%) girls agreeing and 98 (90.7%) girls disagreeing in the third phase. Only 9 (81.8%) girls changed their views in the third phase after the intervention, meaning that they had a positive change. An almost equivalent number of females had a negative change: 8 (8.2%) girls changed their views from disagreeing, as they responded in the first phase to agreeing ($p=1.000$).

Similarly, almost equal proportions (24 - 35.8%) boys agreed and disagreed (43 - 64.2%) with this statement in the first phase compared to 23 (34.3%) boys who agreed and 44 (65.7%) boys who disagreed in the third phase. Sixteen (66.7%) boys changed their views from agreeing with this statement in the first phase to disagreeing in the third phase. Fifteen (34.9%) boys changed their views from disagreeing to this statement in the first phase to agreeing in the third phase ($p=1.000$); a negative change.

Statement: “A girl has a right to say “No” to sex and decide when, with whom and how to have sex.” There was a statistically significant improvement in females’ response to

this statement between first phase and third phase. Ninety-six (88.9%) girls agreed and 12 (11.1%) girls disagreed in the first phase. A hundred (92.6%) girls agreed and 8 (7.4%) girls disagreed with the same statement in the third phase. The intervention had a positive change in that a higher percentage of females, 11 (91.7%) girls changed their views from disagreeing to agreeing in the third phase. A lower percentage of females had a negative change as seven (7.3%) girls changed their views from agreeing in the first phase to disagreeing in the third phase ($p=0.481$). Fifty (74.6%) boys agreed and 17 (25.4%) boys disagreed with this statement in the first phase. Fifty-two (77.6%) boys agreed and 15 (22.4%) boys disagreed with the same statement in the third phase. The intervention had no statistical significant change ($p=0.839$) in males' knowledge and understanding of this question, because a similar number of males had either a positive or negative change. Thirteen (76.55) boys disagreed in the first phase but agreed in the third phase. Some males had negative change: 11 (22.0%) boys changed their views from agreeing in the first phase to disagreeing in the third phase.

Statement: "Men need to be more sexually experienced than women". The intervention had a statistically significant more positive change ($p=0.020$) in females' understanding of this individual statement than males. Seventy-five (69.4%) girls disagreed and 33 (30.6%) girls agreed in the first phase. Ninety (83.3%) girls disagreed and 18 (16.7%) girls agreed with the same statement in the third phase. The intervention caused a positive change in females because 26 (78.8%) girls changed their views from agreeing in the first phase to disagreeing in the third phase. This is compared to 11 (14.7%) girls who had a negative change, from disagreeing in the first phase to agreeing in the third phase.

There was no statistically significant change in males' understanding of this statement between first and third phases. Almost equal numbers of males had positive or negative changes. More than half, 37 (55.2%) boys agreed, while less than half, 30 (44.8%) boys disagreed with the same statement in the third phase. This is compared to 36 (53.7%) boys who agreed while 31 (46.3%) disagreed in the first phase. Thirteen (36.1%) boys changed their views from agreeing in the first phase to disagreeing in the third phase. An

almost equivalent number of boys, 14 (45.2%) changed their views from disagreeing in the first phase to agreeing in the third phase.

Statement: “Women should be virgins until they get married”. More females, (88 - 81.5%) agreed, compared to 20 (18.5%) girls who disagreed in the first phase. A similarly high number – 86 (79.6%) girls – agreed in the third phase, compared to 22 (20.4%) girls who disagreed. The intervention did not have a statistically significant change in females ($p=0.864$) because equal proportions of females changed their views, either from agreeing to disagreeing. Eighteen (20.5%) girls changed their views from agreeing in the first phase to disagreeing with the same statement in the third phase, after the intervention. This may indicate a positive change in girls’ understanding of equal gender respect as a result of the gender-based skills building intervention. However, an almost equal number of females, 16 (80.0%) changed their views from disagreeing in the first phase to disagreeing in the third phase. Zulu cultural norms may have been internalised by the, girls as a result of their socialisation by ‘*amaqikiza*’ (elder women).

A Wilcoxon Signed Ranks test was done to compare the gender issues and knowledge scores obtained by participants in the first and third phases. This test showed that there was a highly statistical significant increase in gender issues score (combined estimates, for girls and boys separately of knowledge scores on gender issues) between phases 1 and 3 ($p < 0.001$). Phase 1 median score was 16, with a range of 5-22 compared to phase 3 median score: 26; its range was 10-23, higher than that of phase 1.

IS THERE A RELATIONSHIP BETWEEN CHANGES IN HIV AND AIDS KNOWLEDGE SCORE AND CHANGES IN OTHER OUTCOMES?

COMPARISON OF CHANGE IN HIV AND AIDS KNOWLEDGE SCORE AND CHANGE IN GENDER ISSUES SCORE

Learners who participated in this study were asked to answer the same questions relating to HIV and AIDS knowledge and gender issues in the first and third phases. The time difference between the intervention phase and third phase was nine months. There was a

weak positive Pearson's correlation, which was statistically significant ($r=0.325$, $p<0.001$) between change in HIV and AIDS knowledge score and change in gender issues score between the first and third phases. This suggests that as their knowledge increased, so did their gender issues awareness.

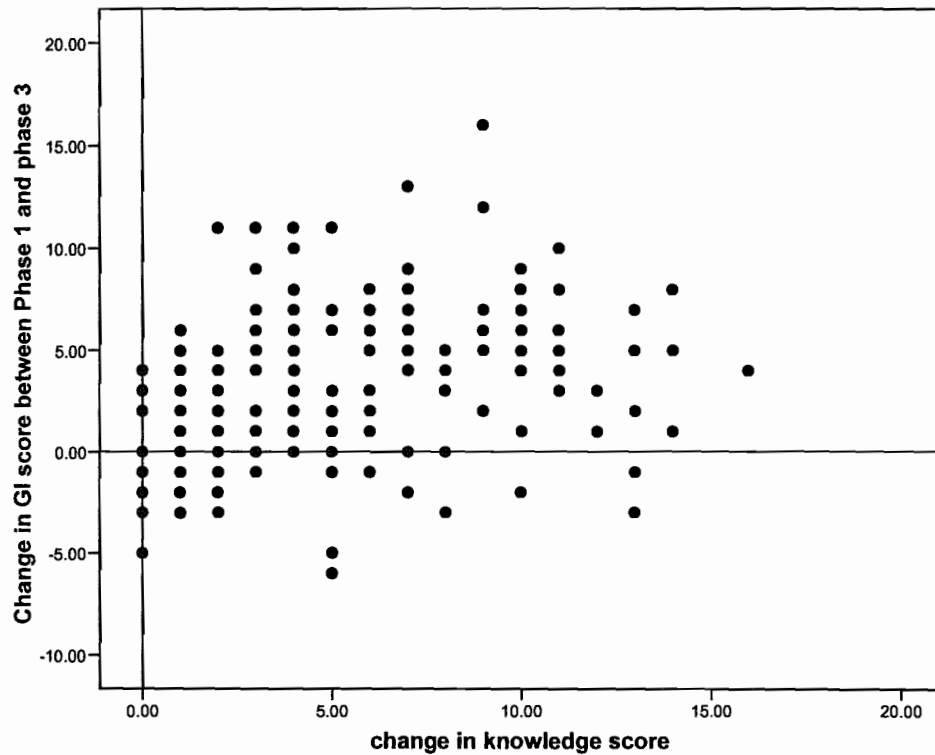


Figure 4: Scatterplot Graph with four quadrants for Pearson Correlation test of change in HIV and AIDS knowledge and gender issues (GI) scores between phases 1 and 3.

Figure 4 shows that according to the Pearson correlation test, participants tended to show no change or an improvement in their HIV and AIDS knowledge score. A few participants decreased in gender issues (GI) score, but the majority increased. The four quadrants shown here demonstrate that the vast majority of participants showed an increase in HIV and AIDS knowledge and gender issues scores, while a handful showed an increase in HIV and AIDS knowledge score, but a decrease in the gender issues score.

No respondent decreased in both, or decreased in HIV and AIDS knowledge score and increased in gender issues score. Therefore, we can conclude that although there was a slight trend for the two scores (HIV and AIDS knowledge and gender issues scores) to increase together, the HIV and AIDS knowledge score actually increased more than gender issues score.

IS THERE A RELATIONSHIP BETWEEN CHANGES IN HIV AND AIDS KNOWLEDGE SCORE AND GENDER ISSUES SCORE BY GENDER?

Figure 4, shows that there was a relationship by gender between the change in HIV and AIDS knowledge score and gender issues score. The increase in HIV and AIDS knowledge score and gender issues score occurred at a faster rate in girls than boys.

The findings seem to indicate that the gender-based intervention of this study did not manage to change learners' understanding of some gender issues, especially in males. It nevertheless had a high level of positive effect in increasing learners' understanding of HIV and AIDS in the third phase. This was a disheartening finding, which may be accounted for by the fact that gender beliefs take a long time to change: these concepts were relatively new to learners whereas they had been obtaining information about HIV and AIDS from many other sources prior to and during the intervention. Learners had already learnt about HIV and AIDS through the media and other sources whereas there was no supporting learning experience for the gender component of the intervention. In addition, the difference between HIV and AIDS knowledge and gender consciousness is that the former is about facts while the latter is about understanding, orientation and attitudes. It is a slow and difficult process to change attitudes and sexual practices.

COMPARISON OF CHANGE IN HIV AND AIDS KNOWLEDGE SCORE AND SEXUAL BEHAVIOUR OF LEARNERS

The main purpose of this section was to find an answer to the question: does an improvement in HIV and AIDS knowledge influence the sexual behaviour of learners? Sexual behaviour was measured by (1) sexual activity of four groups in phase 3 and two

groups in phase 1; (2) the number of sexual partners and (3) condom use. This is in relation to the Abstain, Be faithful and Condomise (ABC) plan HIV prevention approach.

The change in HIV and AIDS knowledge score was found to be associated with a significant change in sexual behaviour ($p < 0.001$). Learners in all four groups of sexual activity showed an improvement in their HIV and AIDS knowledge score in the third phase. This is an important finding that reflects other similar studies which find that an increase in knowledge does not automatically lead to changes in attitude or behaviour (Reddy et al., 2003:54; Taylor et al., 2002:71; Thorpe, 2002:63; Selikow, Zulu and Cedras, 2002:24)

CHANGE IN HIV AND AIDS KNOWLEDGE IN RELATION TO FOUR GROUPS OF SEXUAL ACTIVITY OF LEARNERS

Table 6.10: Mean change in HIV and AIDS knowledge score by four sexual activity groups in Phase 3 (N = 175)

sexual activity group	Mean	N	Std. Deviation
continuing sexual activity	6.1250	56	3.94075
newly abstaining	7.9355	31	3.58641
newly sexually active	3.2750	40	2.59178
continuing abstaining	3.5833	48	3.09312
Total	5.0971	175	3.79303

Table 6.10 shows the mean change in HIV and AIDS knowledge score by sexual activity group. There was a statistically significant difference between the mean change in HIV and AIDS knowledge score and the four sexual activity groups ($p < 0.001$). Post hoc tests showed that both the continuing sexual activity group and newly abstaining group had higher mean changes in their HIV and AIDS knowledge score than the newly sexually active group and the continuing abstaining group.

The newly abstaining group showed the highest change (mean 7.9) in phase 3. This seems to indicate that this group started off with the low levels of knowledge of HIV and

AIDS in phase 1 and benefitted most from this study. This group was followed by the continuing sexual activity group with a high change (mean 6.1). This suggests that this group started off with below-average knowledge of HIV and AIDS and benefitted to some extent from the intervention. The group with the second lowest change (mean 3.6) was the continuing abstaining group, perhaps because this group started off with a high knowledge level of HIV and AIDS in phase 1. The lowest improvement was found in newly sexually active group (mean 3.3); this suggests that they started off with a high knowledge level of HIV and AIDS in the first phase, before the intervention and have benefitted the least from the intervention.

DOES CHANGE IN THE HIV AND AIDS KNOWLEDGE SCORE INFLUENCE CHANGE IN SEXUAL ACTIVITY?

The degree of increase in HIV and AIDS knowledge score was dependant on the participant's gender as well as changes in sexual activity. The four groups of sexual activity mentioned above were divided into two groups, categorised as negative or positive change. The newly abstaining group was regarded as having had a positive change, while continuing sexual activity group was regarded as a negative change.

WHAT ARE THE FACTORS RELATED TO POSITIVE CHANGE IN SEXUAL BEHAVIOUR?

Gender on its own is not significant ($p = 0.767$). There is a positive non-significant trend showing that as one unit increases in knowledge score, the likelihood increases of its having a positive change in sexual activity, the odds being 1:1.

Table 6.11: Variables in the Equation

		B	S.E.	Wald	Df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Step 1(a)	q3(1)	.179	.603	.088	1	.767	1.196	.367	3.898
	chknscore	.096	.053	3.320	1	.068	1.100	.993	1.220
	chknscore by q3(1)	-.158	.093	2.898	1	.089	.854	.711	1.024
	Constant	-.383	.299	1.640	1	.200	.682		

A variable(s) entered on step 1: q3, chknscore, chknscore * q3.

There was a slight non-statistical but significant interaction between gender and knowledge score ($p = 0.089$), indicating that as the males' HIV and AIDS knowledge score increased, they were less likely than females to show positive sexual activity change. The conclusion is that gender does not significantly influence change between knowledge score and sexual activity, but there is a slight indication that males and females make slightly different associations between change in HIV and AIDS knowledge and change in sexual activity.

COMPARISON OF CHANGE IN HIV AND AIDS KNOWLEDGE SCORE AND NUMBER OF SEXUAL PARTNERS OF LEARNERS

The number of sexual partners that learners reported having was examined as another specific outcome in order to answer the question: "Does an improvement in HIV and AIDS knowledge in the third phase influence the number of sexual partners of learners?" It was expected that with increased HIV and AIDS knowledge, participants would have fewer sexual partners.

According to the Spearman's non-parametric correlation (ρ), there was a statistically significant but weak negative correlation between improvement in HIV and AIDS knowledge score and change in number of sexual partners in the third phase ($\rho = -0.220$, $p=0.003$). This means that as change in the HIV and AIDS knowledge score increased there was a corresponding trend for numbers of sexual partners to decrease.

The number of sexual partners reported by learners in the third phase also decreased compared to the number of sexual partners reported in the first phase, but this was not statistically significant ($p = 0.380$).

The sexually active participants were divided into two groups, categorised as 'negative' or 'positive' change. Reduction in the number of sexual partners was regarded as a positive change; an increased number of sexual partners or no change in the number of sexual partners was regarded as negative change. There was significant correlation between change in HIV and AIDs knowledge score and gender with regard to positive change in the number of sexual partners. Males were more likely than females to show positive change in the number of sexual partners. This was shown by the example of one boy who reported that he had 14 sexual partners in the first phase; the highest number of sexual partners was two in the third phase and three in the past four months, as reported in the third phase. These findings seem to show that there was some trend towards a relationship between HIV and AIDS knowledge and reduction in the number of sexual partners. This implies that the intervention could help to reduce the risk of HIV by reducing the number of sexual partners.

In conclusion, these findings seem to show that gender had an influence on the changes. Although the HIV and AIDS knowledge score increased for both sexes, it affected males and females differently.

The following section focuses on the analysis of data obtained from learners, as they were asked to answer the same questions relating to HIV prevention in the first and third phases. These questions included sections on HIV prevention such as the use of condoms, negotiation for condom use, risk of HIV infection, ways of HIV prevention and roles of stakeholders, such as parents, in HIV prevention. This was done to determine and compare learners' knowledge and perceptions and practices in relation to condom use and other measures of HIV prevention in the context of gender, in the first and third phases of this study. I intend to check the impact of the intervention on learners' sexual practices.

COMPARISON OF CHANGE IN CONDOM USE BETWEEN PHASE 1 AND PHASE 3

CONDOM USE IN RELATION TO SEXUAL BEHAVIOUR AND GENDER

Table 6.12: Comparison of change in condom use between Phase 1 and Phase 3
by sexual activity group and gender (N=89)

Do you use a condom during sexual activity?								
	Phase 1 (n=87)			Phase 3 (n=89)				
	One group/category of sexual activity in phase 1			Two groups/categories of sexual activity in phase 3				
				Continuing sexual activity		Newly sexually active		
	Yes	No	Total	Yes	No	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	5 12.5%	35 87.5%	40 100.0%	13 28.3%	6 13.0%	25 54.3%	2 4.4%	46 100.0%
Males	9 19.1%	38 80.9%	47 100.0%	17 39.5%	15 34.9%	10 23.3%	1 2.3%	43 100.0%
Total/ Percentage	14 16.1%	73 83.9%	87 100.0%	30 33.7%	21 23.6%	35 39.3%	3 3.4%	89 100.0%

The most significant finding is that in the third phase, there was increased condom use as much as over 90% of the newly sexually active learners reported condom use during sexual activity. This indicates a high rate of success of the intervention. Even though the number of learners who reported sexually activity increased from 87 (100.0%) in the first phase to 89 (100.0%) in the third phase, there is an improvement in condom use. There is an increase from 14 (16.1%) learners who reported using condoms in the first phase to 65 (73.0%) learners who reported using condoms in the third phase.

Another important finding of the third phase that indicates the positive impact of the intervention is the high number of girls, 25 (54.3%) and boys 10 (23.3%) who reported that they were newly sexually active by the third phase, and were using condoms. This can be compared to 17 (39.5%) boys and 13 (28.3%) girls who reported that they were sexually active before and after the intervention and stated they were using condoms in the third phase. A small number of boys (9 - 19.1%) and girls (5 - 12.5%) among those who reported being sexually active in the first phase, reported they were using condoms.

The majority of sexually active learners 73 (83.9%) in first phase reported that they were not using condoms, compared to 21 (23.6%) who were continuing to be sexually active in the third phase. Only 3 (3.4%) learners, who were newly sexually active in the third phase after the intervention, reported that they were not using condoms.

The findings of this study seem to indicate that in the third phase, the highest level of non-use of condoms was amongst boys. Over a third of boys, 16 of the 43 (37.2%) boys, compared to 6 (17.4%) girls, who were sexually active, were not using condoms in third phase.³³ This finding that shows that the intervention was unable to change the ideas about “flesh to flesh” sex that remains strong among boys even in the third phase. These learners remain exposed to HIV infection for boys as well as girls. The findings of this study concur with those of other studies. Campbell (2001:276) conducted research in a Johannesburg gold mine amongst male black workers, that repeatedly indicated that men preferred “flesh to flesh” sex. They emphasised the role played by masculinities in the way men construct their identities, making sexual satisfaction and pleasure overcomes their risk of contracting HIV (Campbell, 2001:280).

³³ As shown in Table 12

REASONS FOR CONDOM USE

Reasons given by learners who reported never having used condoms, even though they were sexually active, included “Mistrust of condoms” reported by 15 (62.5%) learners in the third phase, followed by “wanting flesh to flesh” reported by 9 (37.5%) learners. Not a single learner mentioned forgetting to use a condom in the third phase. The reason for not using condoms stated by sexually active learners in the first phase, in 31 (42.3%) of cases was “wanting flesh to flesh.” Other reasons included “Forgetting to use condoms” and “Not trusting condoms because they burst”. More males than females expressed the latter reason for not using condoms in the first phase.

This study seems to have caused a positive change, as marked by the improvement in the use of condoms in the third phase and some difference in the opinions reported by learners about condoms, such as the reduction in “wanting flesh to flesh.” This suggests that the intervention increased learners’ awareness of HIV in unprotected sexual activity. A minority of learners seemed to have a negative attitude towards condoms: a few learners reported “mistrust of condoms” as their reason for not using condoms in first and third phases. The process of changing attitudes and sexual practices is very slow in the case of adolescents and requires more time.

A significant finding was obtained in the third phase as most learners, 65 (73.3%) out of 89 who were sexually active, stated that they knew how to use condoms properly, and were using them, as shown in Table 6.11. This can be contrasted to the 14 learners (16.1%) out of 87 who were sexually active and who reported knowing how to use condoms properly in the first phase. High proportions of girls 34 (89.5%) and boys 23 in the third phase (85.2%) who reported using condoms, reported that they use them consistently. This can be compared to the 6 (67.0%) boys and four (80.0%) girls who reported using condoms consistently in the first phase.

Very few learners, 4 (10.5%) girls and 4 (14.8%) boys, reported that they used condoms inconsistently in the third phase, compared to three (33.0%) and only one (20.0%) girl that reported using condoms inconsistently in the first phase. Gender was marked as a

predictor of failure to use condoms, as boys were more likely to report never having used condoms in the first and third phases.

The intervention as a whole had a positive impact as shown by a decrease in the number of sexually active learners who reported never having used a condom. Thirty-five (85.5%) of 40 girls and 38 (80.9%) 47 boys reported never having used condoms in the first phase; only eight (17, 4%) of 46 girls and 16 (37.2%) of 43 boys reported never having used the condoms in the third phase, as shown in Table 6.12.

COMPARISON OF REASONS FOR CONDOM USE BETWEEN PHASES 1 AND 3

The most significant finding was that females tended to use condoms to protect their partners rather than themselves, compared to males who tended to use condoms to protect themselves rather than their female partners. Twenty-one (55.3%) of 38 girls and 19 (70.4%) of 27 boys reported that it was “To protect self from STIs, HIV and AIDS” as their main reason for using condoms in the third phase. Four (80.0%) girls and three (33.3%) boys reported this as the main reason for using condoms in the first phase. “To protect partner from STIs, HIV and AIDS” was stated by 9 (23.7%) girls and four (14.8%) boys as their reason for using condoms. Only 2 (22.2%) boys and none of the girls stated this as the reason for using condoms in the first phase. “To prevent pregnancy” was stated as the reason for using condoms by only four (10.5%) girls and three (17, 6%) boys in the third phase and almost the same proportion – four (80.0%) girls and three (33.3%) boys in the first phase. Only four (10.5%) girls and one (5.9%) boy in the third phase and only three (21.4%) boys and none of the girls in the first phase stated other miscellaneous reasons for using condoms, such as “I feel very comfortable” and “I am encouraged by my friends to use condoms”. The latter was reported by one male learner.

The intervention phase of this study had a positive effect as the majority of learners reported that they were using condoms to protect themselves and their partners from STIs including HIV and AIDS in the third phase, compared to the few boys and

girls that reported these reasons for using condoms during sexual encounter in the first phase.

CONDOM USE IN RELATION TO DEMOGRAPHICS OF LEARNERS

CONDOM USE IN RELATION TO AGE OF LEARNERS

No significant association was found between condom use and age of learners in Phase 3: similar proportions of responses were from 13 to 16 year olds and those 17 to 19 years of age. Older learners had a negative change in condom use, compared to younger ones who had positive change in condom use. Older girls and especially, older boys might be expected to have more knowledge and power to use condoms. Another possible reason could be that girls are having sex with older men and have little or no say in sexual matters due to gender-power inequalities. Other demographics, such as gender, language, grade, religion and home location were not associated with change in condom use. The only demographic characteristic that was associated with change in condom use was age.

The results of this study suggest that the majority of learners who were sexually active during the first phase were not using condoms during sexual encounters, and even those who reported using them were not doing so consistently. In contrast, the majority of learners who were sexually active in the third phase reported using condoms correctly and consistently during sexual activity. Thus, a major positive result of the intervention of the study is that the majority of learners who were sexually active reported consistent condom use in the third phase.

COMPARISON OF CHANGE IN HIV AND AIDS KNOWLEDGE SCORE AND CHANGE IN CONDOM USE IN RELATION TO SEXUAL ACTIVITY OF LEARNERS

Overall, according to a t-test, there was no significant difference in mean change in HIV and AIDS knowledge between those who showed an improvement in condom use and those who showed a negative change in condom use ($p=0.331$), in the third phase. There

was a slight trend suggesting an increase in HIV and AIDS knowledge in those who reported increased condom use, as opposed to those who showed a negative change in condom use, in the third phase.

HIV AND AIDS KNOWLEDGE SCORE VERSUS CHANGE IN CONDOM USE BY GENDER

When this change was examined in the third phase, females showed a positive association between change in HIV and AIDS knowledge and improvement in condom use ($p=0.101$). Those with a positive condom use change had a higher mean increase in their HIV and AIDS knowledge score. However in boys, the trend was reversed. There was a non-significant ($p=0.606$) trend of a higher mean increase in HIV and AIDS knowledge score in those who showed a negative change in condom use. These findings show that HIV and AIDS knowledge was not translated into practice amongst the boys. This could be based on the notion of manhood and the process of constructing males' social identity. This argument is borne out in other studies such as Campbell (2001:276).

However, there was a three-way interaction significance between the change in HIV and AIDS knowledge score and the following three predictors, namely sexual activity of the learner, number of sexual partners and condom use ($p = 0.048$).

NEGOTIATION FOR CONDOM USE IN SEXUAL RELATIONSHIP

Sixty-five learners out of 89 who were sexually active indicated condom use during sexual activity in the third phase. The following section will examine the ability of those 65 sexually active learners to negotiate for condom use with their sexual partners in the third phase.

Table 6.13 Negotiation for condom use by gender in Phase 3 (n=65)

Did you suggest the use of a condom to your partner? Phase 3			
	Yes	No	Total
Gender	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female			
Newly sexually active (From Phase 3)	24 96.0%	1 4.0%	25 100.0%
Continuing sexual activity (Phase 1 and 3)	12 92.3%	1 7.7%	13 100%
Total/ Percentage	36 94.7%	2 5.3%.	38 100%
Male			
Newly sexually active (From Phase 3)	9 90.0%	1 10.0%	10 100.0%
Continuing sexual activity (Phase 1 and 3)	10 58.8%	7 41.2%	17 100%
Total/ Percentage	19 70.4%	8 29.6%	27 100%

Table 6.13 shows a high number of learners who reported that they negotiated for condom use with their sexual partners, in the third phase. The most striking feature of the table is the high levels of initiative taken by female learners to suggest the use of condoms. Such levels are unusual and are usually explained with reference to gender inequalities. The only large percentage of participants who did not suggest condom use to their partners were boys who had already been sexually active in phase 1. This suggests that it is difficult to change sexual behaviour once sexual habits have become established.

There was a marked increase in the number of girls (36 - 94.7%) compared to boys (19 - 70.4%) who had suggested the use of condoms to their partners, as shown in Table 6.13. Learners who indicated that they suggested condom use to their partners in the third phase were asked the same question as in the first phase "How did your partner react or what did your partner say?" A very high percentage of boys (19 - 100.0%) and girls (32 - 88.9%) reported in the third phase that their partners agreed to use condoms. This can be

compared to only one (7.1%) girl and seven (50.0%) boys in the first phase who reported that they suggested the use of condom to their partners. A similarly high percentage of boys (5 - 35.7%) boys in the first phase compared to none of the girls reported that their partners agreed.

This study suggests that the intervention had an influence on the measureable variables of sexual activity, as shown by the general findings. Overall, there was a statistically significant change in condom use between phases 1 and 3, after the intervention ($p < 0.001$). This change leant towards the negative and especially in females as two (4.4%) girls compared to one (2.3%) boy among those who were not sexually active in phase 1 and in phase 3 became sexually active in phase 3, without using condoms.³⁴ This could be shaped by gender-power imbalances in decision-making. In boys there was no significant change in condom use ($p=0.081$).

Table 6.13 shows that girls far exceeded boys in suggesting the use of condoms to their partners. However, four (33.3%) of the sexual partners of girls refused to use a condom compared to none (0.0%) of the sexual partners of male learners. I suspect that this could be shaped by gender-power imbalances, putting girls at higher risk of HIV infection. Another possible reason for partners disagreeing about the use of condoms could be the inclusion of the sexual partners who were not part of the intervention.

The intervention inculcated in participants the idea that young, sexually-active learners are vulnerable to HIV infection. Yet such a revelation appears to have done little to reduce their willingness to have sex. There is thus a major contradiction in the way young people think about HIV and their own risk of contracting HIV.

³⁴ As shown in Table 6.13.

LEARNERS' ROLE IN HIV PREVENTION AND GENDER

Learners who participated in this study were asked to respond to the same questions in the first and third phases: "What do you think you can do to protect yourself from becoming HIV positive?" The aim of this was to determine their perceptions, knowledge and personal practices related to HIV prevention.

The significant findings obtained in the third phase were that more learners used condoms or abstained from sexual activity to prevent HIV than in the first phase. Learners reported different ways of protecting themselves and their partners from HIV in the first and third phases. "Abstaining from sex" was reported by 61 (56.5%) girls but only 22 (32.8%) boys in the first phase, compared to 62 (72.0%) girls and 28 (24%) boys in the third phase. The most significant finding was obtained in the third phase where the majority of learners, 46 (51.7%) girls and 43 (48.3%) boys who were sexually active phase reported that they use a condom to protect themselves.

It was observed in this study that there were significant variations by gender, where girls were more likely to report abstaining from sex, especially in the first phase; in the third phase as a number of boys also reported abstaining. Being faithful to one partner and making responsible sexual decisions were also stated in the first phase by more girls than boys as what they would do to prevent HIV infection. More males than females reported using a condom when having sex. Only females reported going for virginity testing, while only males reported sleeping with a virgin as what they would do to prevent HIV infection in the first phase. There are significant differences in terms of gender when it comes to virginity testing which involves young women/girls alone. The issue of virginity testing is outlined in Chapter 2.

The findings of this study suggest that children are socialised into traditional gender role patterns and internalise them at a very young age. In some areas, it is possible to give information and to see small shifts, not in the global population, but among small subsets of that population. It shows that it is very difficult to change sexual behaviour among those who are already sexually active. Gender remains important in how boys and girls 'hear' messages.

A further explanation may be found in the 'cultural' factors that influence constructions of femininity. Girls in Zulu culture are socialised to be submissive and sexually inexperienced. For parents to be respected in the community and to get full *lobola*, that is the prize paid by the man who wants to marry a woman in the form of, for example eleven cows or in the form of money and their daughter must be proved to be a virgin. Boys on the other hand are encouraged by elder boys and men to be sexually experienced and to talk openly about it as part of their masculinity. Girls are ashamed to talk openly about their sexual practices, especially to a stranger. They first need to trust that person before they can talk about their sexual practices, especially if that person is male.

My study however indicated that there was an area of overlap where girls and boys seem to think the same, but there were also areas where they think differently. Most learners, especially males but also some females, particularly in the third phase, perceived condom use positively. The low levels of condom use reported by females, especially in the first phase of this study and other studies, such as Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries (2002:71) is of major concern.

CONCLUSION

Some of the findings of the third phase show that the intervention had a degree of positive impact. Boys showed a higher HIV and AIDS knowledge score and a decrease in the number of sexual partners and girls showed improvement in the number of sexual partners: most girls opposed multiple sexual partners. When it comes to sexual behaviour, the findings show that adolescent school-going learners are sexually active and engage in unsafe sexual activity, as some learners reported inconsistent use of condoms, especially in the first phase and thus are at risk of contracting sexually transmitted infections. The intervention appears not to have managed to promote abstinence, as the number of learners who reported in the third phase that they were sexually active increased from the first phase. This seems to suggest that behaviour change is a long process and interventions are required to understand the pressures that influence behaviour to assist them to live healthier lives. The intervention however seems to have had some positive impact, as it was successful in promoting other safer sexual choices. There appears to be

a reduction in the number of sexual partners and an improvement in condom use in the third phase. My gender-based intervention succeeded in sensitising learners to gender and sexual negotiation issues: girls became more assertive. Most sexually active learners reported that they were using condoms in the third phase.

In addition, most of the learners who stated that they were sexually active reported consistent and correct condom use in the third phase as opposed to the low numbers of learners that reported this in the first phase. This improvement in condom use could be attributed to the positive impact of the intervention phase. Learners had a session where they were shown what condoms look like and a demonstration was given of how to use male and female condoms.

Analysis of the findings of this study, in the context of gender, helps to demonstrate the vulnerability of boys and girls to HIV infection. Gender analysis could also improve our understanding of the epidemiology of HIV and AIDS and in turn could help to design further research studies, policies and interventions for HIV and AIDS prevention. The findings of this study support the importance of gender-based HIV prevention interventions.

Some people may question the need for a gender-based analysis, in terms of research findings generated by this study. This gendered analysis serves as an important tool for policy makers and questions female and male roles and the expectations concerning 'being a man' in Zulu culture. The lack of gender sensitivity or implementation of gender-equality tends to get stronger especially in heterosexual decision-making in Zulu culture.

Mainstreaming a gendered analysis of research findings is the process of assessing the implications for women and men of any planned actions, including HIV prevention intervention programmes, and sensitising policy makers. It includes implementation, monitoring and evaluation of policies (Breines, Connell and Eide, 2000:11) and HIV prevention programmes in all societal spheres, so that women and men benefit equally and gender-power inequalities are not perpetuated but are eradicated.

This study is in line with the Millennium Development Goals (MDG), in particular MDG Number 6 that focuses on preventing and reversing the spread of HIV/AIDS and other diseases by the year 2015 (de Bruyn, 2005:1). The gender

perspective analysis of this study concur with MDG Number 3, specifically about gender, calling for an end to gender power-disparities and focusing on the promotion of gender equality and empowerment of women. The relevance of gender is not confined to the educational sphere but affects men and women in every aspect of their lives. The sexual transmission of HIV infection and HIV infection rates are distinctly higher among young women than among young men in sub-Saharan Africa, where heterosexual sex is the primary mode of transmission. This reflects the underlying realities of sex and gender that HIV prevention researchers, programme planners and policy makers should target (MDG Number 6). This clause calls for HIV halting and a start to reversing new HIV infections by 2015 (Gender and Women's Health and World Health Organisation, 2003:5).

Although young women are still at an overall disadvantage in society, all men and women must change their behaviour if the HIV and AIDS epidemic is to be controlled. The solution seems to lie not just in empowering women but in targeting young men and women with the aim of creating a mindshift in the meanings of masculinity and femininity (Gupta, 2003:15).

According to Gupta (2003:15), "The knowledge of gender issues is central to understanding and controlling the epidemic and why gender needs to be fully integrated in all future research." While I agree with Gupta's view of integrating gender into future research, the findings of my study seem to suggest that knowledge on its own is not enough and we need to know more about the people who are at risk: how they think and act and what pressures they live under, in order to develop an intervention that actually helps them to live less risky sexual lives.

CHAPTER SEVEN: SUMMARY OF MAJOR FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

In this chapter I shall review the most important findings of the evaluation phase of this project. I will start by reminding the reader about the following:

Goals of the intervention programme

The purpose of designing and conducting a gender-based life skills intervention programme was to help reduce sexual risk taking amongst the sample population, on the assumption that gender stereotypes and inequalities are factors that contribute to such risk taking. The approach taken was to educate and sensitise girls and boys to a number of complex and culture-related issues such as gender and sexuality issues, sexual and reproductive rights, negotiation and decision-making skills. The main goal was to promote mutual gender respect and responsibility in sexual decision-making among young boys and girls in their sexual relations. Another goal was to increase youth's knowledge of HIV and AIDS, encourage the reduction of HIV risk-related behaviour which could expose them to HIV infection.

SUMMARY OF MAJOR FINDINGS

MEASURES OF SUCCESS OR FAILURE OF THE INTERVENTION PROGRAMME

The success of any intervention is gauged by whether it achieved its goals. In this section I review the extent to which this gender intervention was successful by examining its impact on knowledge, attitudes and practices.

7.1 Gender values

Gender issues

The workshops, a central feature of the intervention, were intended to change the gender values of participants by making them aware of the importance of gender equality. This intervention was successful insofar as the girls were concerned. Their levels of understanding gender issues were higher than the boys'. Boys continued to think they had more sexual rights than girls. Girls developed a new appreciation of their rights to negotiate intimacy, to refrain from sexual intercourse if they so desired and generally to express their needs. This conclusion is derived from the results of the third phase, which determined the impact of focus group discussions in the intervention phase.

Sexual rights

The workshops shifted the views and understandings of boys and girls but overall, girls and boys had different understandings of the meaning of 'sexual rights'. Girls related the meaning of sexual rights to the right to choose to have safer sex. This is surprising, because the social context is conservative and expects that men should determine the conditions of sexual intercourse. The girls who participated in the intervention saw that traditional gender values were being challenged and they began to assert stronger agency.

The meaning given to sexual rights by girls is similar to that given by the WHO (2004:3) where sexual rights are explained as a facet of human rights, already recognised in national laws, and international human rights documents. These include the right to decide to be sexually active or not, the right to consensual and safe sexual relations, the right to decide whether or not, and when, to have children. By contrast, boys seemed to relate the meaning of 'sexual rights' to their traditional right to initiate and dominate decisions on sexual matters. Male learners seemed to believe they had a right to initiate relations and make sexual decisions.

Boys and girls in 'Zulu culture' are brought up differently and develop different understandings. Boys are oriented by society and are encouraged to be active, strong, independent, dominant and aggressive; masculinity signifies control of decision-making and the initiation of sexual relations. In contrast, girls are associated with the private

sphere and are seen as passive, dependent, powerless and nurturing (Kimmel, Hearn and Connell, 2005:232).

Whereas there were areas of significant divergence in gender understanding between boys and girls, there were areas of common understanding. Boys and girls perceived the meaning of the terms 'gender' and 'gender-equality' in a similar manner, associating the term 'gender' with socially constructed roles associated with females or males. Gender equality was understood as 'women and men are equal' and 'men and women are the same'. However, while their understandings were similar, the meanings they attached to gender equality were different. For girls, gender equality represented the promise of improvement in their lives whereas boys understood it as a threat, a diminution of their status. These findings demonstrate nevertheless that female and male learners even in rural areas have picked up discourses of gender equality that permeate the media.

There is a contradiction between what boys say about gender equality and sexual rights. While boys acknowledge that 'gender-equality' means that "men and women are the same", this does not prevent them from believing in their superiority over girls and their rights to initiate sexual activity. They see the dominance of men as 'natural' and just. In traditional Zulu culture, as part of socialization and the development of traditional masculinities, young men are encouraged to be aggressive, sexually knowledgeable and to initiate and dominate sexual relationships to prove their manhood.

It is not clear whether parents are agents of changing gendered perceptions but it is clear that learners value their involvement. Most learners, 85.2% girls and 80.6% boys, felt that parents should play a role in advising them about gender issues such as shared gender equality and respect, sexuality and HIV prevention. However, parents still seem to be facing difficulties in playing this role. This was verbalised by South African celebrities, such as talk show host Felicia Mabuza-Suttle, who reported that as a parent, she was still unable to speak to her two daughters about sex (Jacobson and Levin, 2000:8). In support of this view, former Miss South Africa, Kerishnie Naicker, reported that she had to wait until University to discover the facts about sex (Jacobson and Levin, 2000:8).

Nearly all learners trust their parents enough to talk to them about sex and HIV and AIDS, though more females (92.6%) than males (76.1%) have this trusting relationship. However, 11.9 % of males and 2.8% of females reported that parents do not have time to talk to them at home.

The findings of this study suggest that parents have a responsibility to provide information about sexuality, gender issues and HIV prevention that is appropriate to the age of the child. This will help to build informed decision-making skills and encourage our children to develop their values. One of the wise decisions our children could make would be to delay sexual debut until they are older and able to use safer sex methods, like condoms, if they decide to be sexually active, to protect themselves and their partners.

7.2 Sexual behaviour and goals of the study

One of the goals of this study was to reduce sexual risk-taking. One measure of sexual risk-taking is how many people are having sex. It was a logical goal of this intervention that levels of abstinence would rise and the number of people having sex would drop. Under the circumstances, however, this was not a realistic goal. Even in a context where abstinence is often the major message of HIV prevention, the reality is that sexuality is an important arena of gender identity construction and teenagers are likely to be tempted to become sexually active. Table 7.1 shows that over the duration of the intervention, there was an increase in the number of participants who were sexually active. The rise amongst girls was dramatic (from 37% at the time of the first phase to nearly 60% at phase three). For boys, there was a rise also, but from a higher base. 70.1% of boys had had sex at Phase one and this rose to 77.6% at Phase three.

Table 7.1 Comparison of sexual activity in Phases 1 and 3 by gender (n = 175)

Have you ever had sex?						
	Phase 1			Phase 3		
	Two groups/categories of sexual activity in phase 1			Two groups/categories of sexual activity in phase 3		
	Yes	No	Total	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	40 37%	68 63%	108 100%	55 59.9%	53 49.1%	108 100%
Male	47 70.1%	20 29.9%	67 100%	52 77.6%	15 22.4%	67 100%
Total/ Percentage	87 49.7%	88 50.3%	175 100%	107 61.1%	68 38.9%	175 100%

Table 7.1 shows the global figure of sexual activity of 87 (49.7%) learners when they were asked the question ‘Have you ever had sex?’ in phase 1, compared to 88 (50.3%) learners who reported that they were abstaining from sexual activity. In phase 3, the figure had risen to 107 (61.1%). This figure includes 51 (29.1%) learners who reported being sexually active in phases 1 and 3. Thirty-eight learners (21.7%) who had been abstinent at Phase 1 had, by the third phase, become sexually active, while 18 learners (10.3%) appear to have embraced abstinence.

On the basis of these figures it appears that the intervention enjoyed mixed fortunes. It seems to have convinced some learners to cease sexual activity but the more significant trend was for them to become sexually active despite the workshops. Yet this is only one measure of success. For those who became sexually active, it is important to see under what conditions sexual relations were engaged in, and I return to this question below.

Early sexual debut increases risk of HIV infection and it was one of the goals of this intervention to delay sexual debut. In Table 7.2 I review the data on patterns of sexual debut amongst participants. I compare the age of sexual debut of participants who reported sexual activity in phase 1 and those learners who reported having become sexually active for the first time in phase 3.

Table 7.2

Comparison of sexual debut in Phases 1 and 3 by gender

	Age of sexual debut in Phase 1 (n=87)				Age of sexual debut of Newly sexually active in Phase 3 (n= 38)			
	Child ≤ 12 years	Young teen 13-16 years	Late teen 17 to 19 years	Total	Child ≤ 12 years	Young teen 13-16 years	Late teen 17 to 19 years	Total
Gender	Frequency / Percentage	Frequency/ Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage	Frequency / Percentage
Female	5 12.5%	26 65.0%	9 22.5%	40 100.0%	0 0%	16 59.3%%	11 40.7%	27 100.0%
Male	6 12,8%	30 63.8%	11 23.4%	47 100.0%	0 0%	5 45.5%	6 54.5%	11 100.0%
Total	11 12.6%	56 64.4%	20 23.0%	87 100%	0 0%	21 55.3%	17 44.7%	38 100%

One of the goals of the intervention was to delay sexual debut. This is obviously impossible for learners who were already sexually active in phase 1, so my focus here is only on those who were abstaining in phase 1 and subsequently reported sexual activity in Phase 3, referred to as ‘newly sexually active’ in Table 7.2.

The age of sexual debut will be divided into the same three types of age category depending on learners’ reports of sexual debut. The question was asked, “How old were you when you first had sex?” There was the ‘Children’ category, if a learner sexual debut at 12 or below, ‘Early or Young Teenage’ category if it was at 13-16 and ‘Late Teenage’ category for those who reported their sexual debut at 17 - 19 years. The aim of this categorisation is to determine the relative patterns of sexual debut among learners.

There are notable differences between sexual debut trends in phase 1 and phase 3. No learners in phase 3 reported becoming sexually active at 12 years or younger. This is because all learners were over 12. In Phase 1, six boys (12.8%) and five girls (12.5 %) stated that their sexual debut had been at 12 or younger.

Thirty eight (42.7%) learners reported in the third phase that they had become sexually active for the first time. Of these, 21 (55.3%) were between the ages of 13 and 16 years. This group was made up of 16 (59.3%) females and 5 (45.5%) boys. This shows that one unanticipated effect of the intervention may have been to make girls aware of their sexual rights in such a way as to encourage them to be sexually experimental. An alternative explanation is that the pattern evident in phase 1 was repeated in phase 3. In the first phase, the majority of learners, 56 (64.4%) reported that they had become sexually active when they were 13 to 16 years old. This pattern was largely replicated in Phase 3.

A third feature of sexual debut was that a substantial number of participants appear to have delayed sexual activity until the late teen phase. Seventeen (44.7%) learners, 11 (40.7%) girls and 6 (54.5%) boys, reported that they became sexually active between 17 and 19. This suggests that more participants were delaying sexual activity than before since, in phase 1, only 20 (23.0%) learners, 11 (23.4%) boys and 9 (22.5%) girls, reported becoming sexually active between the ages of 17 and 19 years. The delay in sexual debut was more pronounced among boys: in phase 1, 23.4% of boys became sexually active in the late teen period, whereas in phase 3 this increased to 54.5%. Delaying the age of sexual debut is a positive factor in the prevention of STIs and could assist people to make responsible sexual decisions.

The findings in Table 7.2, especially in the third phase, show that the age of sexual debut amongst boys is getting later and amongst girls it is getting earlier. These findings contradict the findings of Harrison's study conducted in rural KwaZulu-Natal, which indicated that 12.1% males reported sexual debut at age 14 or below, whereas only 7.6% females reported their age of sexual debut to have been during this period (Harrison, 2003:200).

In a Nigerian study conducted amongst adolescents it was found that most of the sexually active adolescents reported that they started between ages 13 - 20 years (Summola, Depeolu, Babalola and Adebayo 2003:41). Although the findings of the third phase of this study and the Nigerian one are similar, they need to be interpreted with

caution because these are self-reported sexual activities and the type of sexual activity is not differentiated as penetrative or non-penetrative, anal or vaginal sex. However, seeing that the reality is that youth are getting sexually active at a relatively young age, it is vital to sensitise them to the idea that boys and girls have the right to abstain from sex or to engage in other forms of safer sexual relations until they are ready to make responsible decisions to prevent HIV infection before HIV infection occurs (Mkhize, cited in the *Sunday Tribune*, 2001:6)

I now move to consider levels of sexual abstinence. In the first phase, 87 (49.7%) learners reported they were sexually active compared to half of the learners, (88 - 50.3%), who reported that they were abstinent. More than half of the learners (89 - 50.9%) reported in the third phase that they were sexually active, compared to less than half of the learners (86 - 49.1%) who reported that they were abstinent.

How do we explain this rise? One possibility could be that learners became sexually emboldened as a result of the intervention. While this may have reduced the abstinence levels, it needs to be read in conjunction with levels of condom use. Another possibility is that learners may have become more willing to talk about sex and reported their sexual activity after the intervention phase, whereas they may have withheld this information in phase 1.

The findings of this study concur with the the findings of previous research studies (LoveLife report, 2001; Harrison, 2003) which indicated that sexual activity in this age group is common. For young people in the age group of 13 - 19 years, sexual experimentation (including sexual activity) is a high priority (Kaaya, et al. 2002; Reddy, et al. 2003; Selikow, Zulu and Cedras, 2002). It is not surprising, therefore, that abstinence levels did not rise; in fact they dropped slightly.

Table 7.3 Comparison of sexual activity at the time of data collection in Phases 1 and 3 by gender (n = 175)

Summary of sexual activity at the time of data collection: Are you sexually active at present?						
	Two groups/categories of sexual activity in phase 1			Two groups/categories of sexual activity in phase 3		
	Yes	No	Total	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	40 37%	68 63%	108 100%	46 42.6%	62 57.4%	108 100%
Male	47 70.1%	20 29.9%	67 100%	43 64.2%	24 35.8%	67 100%
Total/ Percentage	87 49.7%	88 50.3%	175 100%	89 50.9%	86 49.1%	175 100%

In the first phase, as indicated in Table 7.3, half of the learners (88 - 50.3%), reported that they were abstinent compared to 87 (49.7%) learners who reported they were sexually active. Less than half of the learners (86 - 49.1%) reported that they were abstinent in the third phase. In summary, we find a slight increase in levels of sexual activity and a slight decline in levels of abstinence. As a first statement about the success of the intervention, we would thus have to conclude that it had failed to promote abstinence. Against this sombre conclusion, we note that 68 (38.9%) learners, 53 of 108 girls and 15 boys of 67, who reported they were abstinent in phase 1 remained abstinent in phase 3. The intervention could be credited with helping some participants to remain abstinent.

Of the 89 (50.9%) participants who were sexually active in phase 3, we find that 38 learners (27 girls of 108 and 11 boys of 67) were newly sexually active. Fifty one learners (19 girls of 108 and 32 boys of 67) were sexually active in phases 1 and 3. More girls became sexually active than did boys, a surprising finding.

A gendered breakdown of the abstinence figures shows that more males (9 - 13.43%) than females (9 - 8.33%) reported a cessation of sexual activity from phase 1 to phase 3. This was a surprising finding as boys generally reported that they were more sexually active than girls in the first phase. Although abstinence rates tell us something about the

impact of the intervention, on their own they do not establish success or failure, since it is not just sexual activity that indicates risk. The conditions in which sexual activity occurs are also important, and most significant among these is the use of condoms.

The following section will present and compare the findings of negotiation for condom use as reported by participants in Phases 3 and 1.

NEGOTIATION FOR CONDOM USE

Negotiation for condom use was one of the foci of the workshops and it was expected that this would improve the ability of participants to reduce risky behaviour. It was encouraging therefore to find that the number of learners who negotiated condom use with their sexual partners rose dramatically after the intervention. There was also a marked increase in the number of girls (36 - 94.7%) compared to boys (19 - 70.4%) who stated in the third phase that they had suggested the use of a condom to their partners (see Table 6.12 in Chapter 6). All the boys (19 - 100.0%) and 32 girls (88.9%) reported that their partners agreed. This can be compared to only one girl and seven (50.0%) boys in the first phase who reported that they suggested the use of condom to their partners. A similarly low percentage of boys 5 (35.7%) boys compared to none of the girls reported that their partners agreed. There was a gender-related variation among those learners who reported that they suggested the use of condoms, as more males suggested condoms and a high percentage of their partners agreed. Only a few girls who suggested condoms to their partners and a low percentage agreed to use condoms in the first phase as opposed to the third phase.

The following section will examine condom use in relation to newly sexually active learners in the third phase, to further determine the success or failure of the intervention.

CONDOM USE

While there may be a close relationship between negotiating condom use and actual condom use, this study took the view that it was important to distinguish these two aspects. It was heartening to find that the rate of condom use increased markedly.

Seventy-three percent of learners (65) in the third phase, compared to 14 (16.1%) learners in Phase 1 reported that they were using condoms. A global figure of 65 (73%) learners reported condom use in the third phase, which includes 35 (39.3%) learners sexually active for the first time. This includes 30 (33.7%) learners who were sexually active in phases 1 and 3.³⁵

Another important finding is that over 90% of the newly sexually active learners reporting condom use during sexual activity in the third phase. In other words, the intervention was most successful with participants who had not been sexually active during phase 1. It equipped them with knowledge and attitudes which allowed them to engage in safe sex.

Table 7.4 Comparison of condom use in Phases 1 and 3 by gender

Do you use a condom during sexual activity?						
	Phase 1 (N = 87)			Phase 3 (n= 89)		
	Two groups/categories of sexual activity in phase 1			Two groups/categories of sexual activity in phase 3		
	Yes	No	Total	Yes	No	Total
Gender	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage	Frequency/ Percentage
Female	5 12.5%	35 87.5%	40 100.0%	38 82.6%	8 17.4%	46 100%
Male	9 19.1%	38 80.9%	47 100.0%	27 62.8%	16 37.2%	43 100%
Total/ Percentage	14 16.1%	73 83.9%	87 100.0%	65 73%	24 27%	89 100%

Table 7.4 shows that more females (82.6%) than boys (62.8%) reported using condoms. Thirty-eight girls out of 46 and 27 boys out of 43 said that they were using condoms in phase 3. More (82.6) of sexually active females in phase 3 were using condoms than 62.8% of males who indicated that they were condom users at Phase 3. This includes 17

³⁵ As shown in Table 6.12, Chapter 6: Evaluation Phase results

boys who had been sexually active in Phase 1 and ten boys who were sexually active for the first time.

The most significant development was the increase in the number of girls using condoms, from 12.5% to 82.6% of those who were sexually active. There was also an increase in condom use amongst boys but not to such a marked degree. This shows that the intervention was particularly successful in giving girls the life skills and the confidence to conduct sexual relations safely.

While condom usage amongst boys did increase, there were in phase 3 still over a third of the boys who were not using condoms. This echoes the findings of other studies conducted amongst the youth which reveal that despite knowledge of the benefits of condoms, many males still resist using them (Jegede and Odumosu, 2002:68; Selikow, Zulu and Cedras, 2002: 27; Adler and Qulo, 2000: 30; Ndiaye, 2000: 31; Campell, 2001:280). This kind of behaviour is associated with constructions of masculinity and identities that encourage sexual violence against women and promote youth's vulnerability to STIs, HIV transmission.

The following section will present recommendations from the findings of my study and from other research studies.

RECOMMENDATIONS

In South Africa and other parts of sub-Saharan Africa, HIV is largely spread through heterosexual contact, and infects females more than males. Gender inequality is one of the several factors that have been identified as contributing to the transmission of HIV. The findings of this study indicate that prevention of HIV infections, especially amongst the youth, is a multidimensional challenge and requires collaborative effort based on the eight integrated Millennium Development Goals (MDGs). Gender equality, mutual respect and responsibility in HIV prevention must be given high priority.

The recommendations derived from the findings of this study will be divided into four sections: recommendations to stakeholders, for programmes and workshops, for curriculum issues and for further research.

RECOMMENDATIONS TO FOR MULTI-SECTORAL COLLABORATION APPROACH, PARENTS AND COMMUNITY INVOLVEMENT

This study does not deal with political leaders or municipal officials; my focus is rather on learners at the high school stage, that is to say, adolescents who are for the most part at, or past puberty. I am also concerned with the role which their parents need to play, though no direct intervention was made in my study which directly affected parents. The findings of the study will, I hope, be valuable to teachers and policy-makers including political leaders, community leaders and members, health personnel and other stakeholders who have a role to play in combating HIV and AIDS as well as in promoting gender equality and mutual respect and responsibility in reducing HIV epidemic. For these recommendations to succeed in achieving the purposes of MDG 6, that is, combating HIV and AIDS, the aims of MDG 3, of promoting gender equality and the empowerment of women should be understood and promoted by HIV prevention programme planners and policy-makers. For these recommendations to be successfully implemented political support, adequate funding and community involvement will be necessary.

It must be recognized that sexual activity is common amongst learners at high school and that instruction in safe sex, sexual rights, respect for partners and gender equality must be made available to help adolescents develop into healthy, productive adults by providing them with a safe and supportive environment, accurate information and counseling.

RECOMMENDATIONS FOR INTERSECTORAL /COLLABORATION PROGRAMMES AND WORKSHOPS

HIV prevention intervention programmes are needed. Males as well females must be given access to life skills building programmes, including sex education, and there needs to be open discussion of the responsibility of men and boys for their own sexual

behaviour and for their partners' sexual and reproductive health and rights. Emphasis must be placed on conflict resolution and gender sensitization. Accessible, good quality health services are vital.

There is a need for programmes that rely on skills building to achieve a broader community reach, using existing structures to reach both females and males. It became clear during my programme that parents and the extended families were not playing a sufficiently active role in the lives of their adolescent children. Future interventions should be designed to change social and cultural norms within the community. Thus some intervention strategies at least should be designed to aim at individuals and communities, and should deal with social norms.

There is a need to implement HIV prevention programmes that go beyond awareness and that target female and male learners. Action research that targets behaviour change in young people must encourage later sexual debut, safer sexual practices and reduction of the number of sexual partners. Such programmes should expose learners to gender-based life skill building workshops, focusing on assertiveness, negotiation and decision-making.

Sexual reproductive health and HIV programmes must move out of their isolation in the health sector and become integrated with other educational programmes. Other studies indicate that in addition to gender, structural factors such as unemployment and poverty impact on both gender relations and sexual reproductive and HIV; my own research not dealt with these matters, but has revealed the need for gender-based interventions at high school level, where attitudes are to an extent already formed, but are not unchangeable.

RECOMMENDATION FOR CURRICULUM CONTENT AND STRATEGIES FOR TEACHING

There is a need to include gender and sexual issues in the life orientation skills taught to learners at all levels. Learners who participated in this study reported that they had not previously received formal teaching in sexuality and gender issues at school. Rather than merely offering formal instruction, strategies should include role-plays, drama and games

to teach life skills. These will reinforce and enhance female and male learners' understanding of sex and gender issues. Negotiation skills for abstinence, condom use and other safer sexual practices should also be taught. The appendices delineating the strategies used by myself in the course of my research may well be of considerable help to teachers who are giving Life Skills Orientation at High School level.

RECOMMENDATIONS FOR FURTHER RESEARCH AND FUNDING

Funding will be required to ensure that more research-based interventions are undertaken. I regret, for example, that the funding available to me was granted after data collection and therefore did not include money for recording apparatus. Further HIV prevention intervention research projects should focus on informing parents, teachers, community leaders and members, religious leaders, health personnel, researchers concerning skills they require to empower children, from infancy, and especially when they embark upon their sexual and reproductive lives. All young people need to be empowered on gender and sexuality issues and life skills such as assertiveness and negotiation and decision-making.

More research projects are required at community level to focus attention on parents, community leaders and members, who should be helped to talk to children about sex. They should be advised as to why, what, how and when to start talking to children about sexual activity, HIV and AIDS and HIV prevention. This will make it easier for adolescents to question their parents, whose responsibility is to offer correct information appropriate to their age. Parents must be able to educate, challenge misunderstandings and correct information, so as to empower children with gender-based life building skills, in the hope that they will make informed decisions about sex.

Further HIV prevention intervention research projects are required at community level to focus attention on the community and its cultural context, as gender-inequality is intertwined with culture. These research projects are essential and will contribute to community level risky behaviour change that requires joint involvement of youth, all those affected by HIV and AIDS and their community. These research Interventions should aim to break the silence around HIV and AIDS, as well as to eliminate stigma and discrimination, develop partnerships between society and government. These research

projects are vital to successfully achieve the HIV risk behaviour change and attain MDGs 3 and 6, by 2015.

Further research projects are required to monitor and evaluate the achievement of gender equality and its importance in combating HIV and AIDS. These projects should include female-controlled methods of HIV Prevention, such as free and accessible female condoms and microbicides.

CONCLUSION

Many of the conclusions which proceed from my project have been anticipated in Chapter 7, in which my findings have already been summarised and discussed. In addition, I have appended a conclusion to each separate chapter. My final conclusion below will therefore be relatively brief.

This study has shown that the intervention had some positive effects, particularly insofar as strengthening the agency of girls. More girls were empowered and aware of their rights and equality in phase 3 than in phase 1. Their self esteem was also increased, as they became more assertive, negotiated condom use with their sexual partners and engaged in less risky sexual behaviour. But not all the news was 'good'. The intervention did not noticeably delay sexual debut or encourage abstinence amongst girls. Changes in the attitudes and practices of boys were less marked. Some boys were prepared to acknowledge that girls have rights too but their knowledge did not always change their dominance in sexual decision-making. These findings seem to tell us that young Zulu boys like to demonstrate their manhood by becoming more sexually experienced at an earlier age, by having a number of sexual partners and by avoiding the use of condoms. These sexual behaviours increase the likelihood of sexually transmitted diseases.

Judging by these findings, it seems that more time is required to create a mindshift among boys. Embedded notions of patriarchy are difficult to shift, and it is likely that they should be challenged by parents and authority figures at an early stage of a child's life.

However, Zulu culture is dynamic, as shown by girls and boys expressing themselves openly regarding sex, particularly during the intervention and third phase. My presence and my talking to them about sexual issues did not intimidate them, despite taboos in Zulu culture attached to talking about sexual issues. I decided to take a learner-centred approach before starting and throughout the intervention. I conducted icebreaking exercises, explained the purpose of the study and the role of researchers in order to reach the participants. I also reached out to them by drawing on my own Zulu culture.

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APPENDIX 1: QUESTIONNAIRE FOR FIRST AND THIRD PHASES OF THE STUDY

TITLE: SCHOOL-GOING YOUTH, SEXUALITY AND HIV PREVENTION IN NORTHERN KWAZULU-NATAL: A GENDER PERSPECTIVE.

Dear Learner

Thank you for participating in this three-phase study. You are kindly requested to complete this questionnaire in the first / orientation phase of this research study, which will be followed by the second /intervention phase and the third / evaluation phase, as already explained to you during recruitment and on your informed consent form.

This questionnaire is to be used as a self self-administered tool to obtain accurate information from you during the first and third phases of the study to determine your perceptions of a number of issues, such as gender issues, relationships, sexual decision-making, HIV/AIDS and prevention of HIV infection. All your answers (responses) will be treated as anonymous and confidential.

Provide us with honest information to the best of your ability. If you do not understand the question/s or you need clarification, please feel free to ask by putting your hand up. The research assistant/s and I will be available to provide clarification to you.

PLEASE: DO NOT WRITE YOUR NAME AND SURNAME ANYWHERE ON THE QUESTIONNAIRE. WRITE THE STUDY NUMBER YOU HAVE BEEN GIVEN IN THE SPACE PROVIDED TO KEEP THIS INFORMATION ANONYMOUS AND CONFIDENTIAL.

You are kindly requested to indicate your answer/response by making a tick (✓) in the appropriate block or by writing your answer or response in the space provided.

Thank you

S. Majeke
Researcher

APPENDIX 1

QUESTIONNAIRE FOR FIRST AND THIRD PHASES OF THE STUDY

TITLE: SCHOOL-GOING YOUTH, SEXUALITY AND HIV PREVENTION IN NORTHERN KWAZULU-NATAL: A GENDER PERSPECTIVE.

Q 1 First / orientation phase € Or **Third / evaluation phase €**

Learner's Study Number: **Questionnaire completed by learner: Day** **Date:**

Time of day completion of questionnaire by learner started /began:

Time of day completion of questionnaire by learner finished or ended:

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

1. Age in years

2. Sex

Female	Male
--------	------

3. Race

African	Coloured	Indian	White
---------	----------	--------	-------

4. Main home language

Zulu	Xhosa	English	Afrikaans	Other (specify) ----- -----
------	-------	---------	-----------	--------------------------------

5. Religion (Religious Affiliation) _____

6. Present Grade in school

8	9	10	11	12
---	---	----	----	----

7. Area where your school is located

Rural (Homeland)	Peri-urban (Township)	Urban (Town)
------------------	-----------------------	--------------

8. Where do you live?

Home	School residence	Renting	Other ((specify) ----- -----
------	------------------	---------	---------------------------------

9. Who lives with you? (Please tick the number of boxes that apply to you):

Both parents	Only your mother	Only your father	Alone	Only your sister
Only your brother	Both grandparents	Your grandmother	Your grandfather	Other (specify).....

10 Your home: 10.1 Name of the area in which your home is situated _____

10.2 Type of area where your home is located

Rural (Homeland)	Peri-urban (Township)	Urban (Town)
-------------------	-----------------------	--------------

10.3 Type of housing of your home

Mud	Blocks	Bricks	Shacks	Traditional houses	Other (specify).....
-----	--------	--------	--------	--------------------	----------------------

10.4 How many rooms are there in your home?

1	2	3	4	5	6 or more
---	---	---	---	---	-----------

10.5 How many people live in your home? (Including yourself)

1	2	3	4	5	6 or more
---	---	---	---	---	-----------

10.5 How many people are adults (20 years and older)?

1	2	3	4	5	6 or more
---	---	---	---	---	-----------

10.6 How many people are children? (Under 20 years, including yourself)

1	2	3	4	5	6 or more
---	---	---	---	---	-----------

11. Do you have parent(s)?

Yes	No
-----	----

NB 1: If the answer to question 11 is yes, answer question 11.1.

NB 2: If the answer to question 11 is no, answer question 11.2 and other following questions

11.1 Do you have both parents?

Yes	No
-----	----

11.1.1 Is your mother?

Employed (full-time)	Employed (part-time)	Self-employed	Unemployed	Pensioner
----------------------	----------------------	---------------	------------	-----------

11.1.2 If employed what work does she do?

Clerk	Driver	Teacher	Nurse	Builder	Other (specify) -----
-------	--------	---------	-------	---------	-----------------------

11.1.3 Is your father?

Employed (full-time)	Employed (part-time)	Self-employed	Unemployed	Pensioner
----------------------	----------------------	---------------	------------	-----------

11.1.4 If employed what work does he do?

Clerk	Driver	Teacher	Nurse	Builder	Other (specify) -----
-------	--------	---------	-------	---------	-----------------------

11.1.5 In your home, how many people are employed in full-time positions?

0	1	2	3	4	5 or more
---	---	---	---	---	-----------

11.1.6 Who is the main breadwinner or main provider or financial supporter in the household?

Mother	Father	Sister	Brother	Grand-mother	Grand-father	Other (specify) -----
--------	--------	--------	---------	--------------	--------------	-----------------------

11.2 If you do not have parents, or your parents are not employed, who is supporting you financially?

Sister	Brother	Aunt	Uncle	Grandmother	Grandfather	Other (specify) -----
--------	---------	------	-------	-------------	-------------	-----------------------

11.2.1 Is your financial provider/supporter?

Employed (full-time)	Employed (part-time)	Self-employed	Unemployed	Pensioner
----------------------	----------------------	---------------	------------	-----------

11.2.2 If employed, what work does your financial provider do?

Clerk	Driver	Teacher	Nurse	Builder	Other (specify) -----
-------	--------	---------	-------	---------	-----------------------

SECTION B: GENDER ISSUES INFORMATION

12. Indicate your response/answer with a tick (✓) in the following statements	Agree	Disagree
12.1 Gender and sex mean the same thing	-----	-----
12.2 Gender refers to the socially defined roles and responsibilities of women and men	-----	-----
12.3 Sex refers to whether people are males or females according to the type of genital organs they have	-----	-----
12.4 Gender equality means equal respect and treatment of girls/women and boys/men	-----	-----
12.5 Boys and girls should get the same opportunities e.g. education, career, salaries	-----	-----
12.6 Young girls and boys should get the same sexuality education	-----	-----
12.7 Young women and men have the same rights, including the same sexual rights	-----	-----
12.8 Girls/women and boys/men should know and respect each other's sexual rights	-----	-----
12.9 The South African constitution says that all people should be free from discrimination, including on the grounds of gender; is this in line with your beliefs?	-----	-----
12.10 Patriarchy is a system of practices in which men dominate, control, oppress, exploit and violate women's rights	-----	-----
12.11 Girls/women are more sensitive than boys/men and it is normal for them to cry	-----	-----
12.12 Boys/men are strong and are not supposed to cry, even at funerals	-----	-----
12.13 It is right for a boy/man to demonstrate his manhood by beating his girlfriend	-----	-----
12.14 A girl has a right to say "No" to sex and decide when, with whom and how to have sex	---	-----
12.15 Men need to be more sexually experienced than women	-----	-----
12.16 Women should be virgins until they get married	-----	-----
12.17 It is right for a boy/man to have more than one sexual partner	-----	-----
12.18 It is wrong for a girl/woman to have more than one sexual partner	-----	-----
12.19 A man is supposed to work and support his wife and children	-----	-----
12.20 A woman is not supposed to work and her place is in the kitchen	-----	-----
12.21 Young women should be passive, submissive and dependent on men for money	-----	-----
12.22 Men and women should help each other to cook and take care of their children	-----	-----
12.23 Men are the ones who make decisions at home since they are superior to women	-----	-----
12.24 Girls/women and boys/men should negotiate issues, respect each other's views and make decisions together	-----	-----

SECTION C: RELATIONSHIPS AND SEXUAL DECISION-MAKING

The following questions are about your relationships, sexual decision-making, sexual activities and partners. You are requested to please answer the questions as honestly as possible so that we can obtain accurate information for the research study. Your answers to these questions will be confidential.

13. Do you have a partner? (Partner refers to a girl/ boy friend that you are in love with)?

Yes	No
-----	----

13.1. If the answer is no to question 13, give your reason for not having a partner -----

13.2. If the answer is yes to question 13, give your reason for having a partner -----

14. Who should initiate (start) a relationship between partners?

Female	Male	Both (male and Female)	Other (specify).....
--------	------	------------------------	----------------------

14.1 Explain your choice in question 14:

15. How would you react if your partner breaks off your relationship?

(Indicate your answer by making a tick (✓) in one box /answer)

Respect her or his decision	Angry	Depressed	Ask for a reason	Hit him/her	Other(specify) -----
-----------------------------	-------	-----------	------------------	-------------	----------------------

16 Indicate by making a tick (✓), whether you agree or disagree with the following statements:

Agree Disagree

16.1 Making decisions about sex:-

16.1.1 Is linked to knowing "Who you are"

16.1.2 Is linked to knowing "What you believe in"

16.1.3 Influences "How you behave"

-----	-----
-----	-----
-----	-----

16.2 Suppose the following statements were said to you by your partner to pressurize you to have sex (sexual intercourse), how would you respond? Would you agree or disagree?

Agree Disagree

16.2.1 I love you so much. If you love me too you will have sex with me

16.2.2 Every one is having sexual intercourse, why are we waiting?

16.2.3 I spent a lot of money on you tonight, I think you owe it to me

16.2.4 Well, if you do not have sex with me, I am going to leave you

-----	-----
-----	-----
-----	-----
-----	-----

17. Have you ever had any information about sex?

Yes € No €

17.1 If the answer is yes, who told you about sex for the first time?

17.2 Where else did you continue to learn about sex?

17.3 Has one or both parents spoken to you about sex?

Yes € No €

17.4 If the answer is yes to question 17.3, who was it?

Mother€, Father € or Both €

17.5 Have you ever had a lesson on sex in your school? Yes € No €

17.5.1 If the answer is yes in question 17.5, who was giving the lesson on sex in your school?

(Indicate your answer by making a tick (✓) in one box / answer)

Teacher	Health officer	Principal	Department of Education officer	Other (specify).....
---------	----------------	-----------	---------------------------------	----------------------

18. Have you ever had sex? Yes € No €

18.1 If no, what is your reason for abstaining from sex?

.....

NB: If the answer is no to question 18, after giving your reason in 18.1, skip the next seven (7) questions and answer question 21

18.2 If the answer is yes to question 18, how old were you when you first had sex?

Younger than 9 years	9 - 10	11 -12	13 -14	15 - 16	17 - 18	19	More than 19 years
----------------------	--------	--------	--------	---------	---------	----	--------------------

18.3 How old was your sexual partner?

Younger than 9 years	9 - 10	11 -12	13 -14	15 - 16	17 - 18	19	More than 19 years
----------------------	--------	--------	--------	---------	---------	----	--------------------

18.4 Where was your partner from?

The community	The same school	Another school	A teacher from school	A stranger	Other (specify)
---------------	-----------------	----------------	-----------------------	------------	-----------------------

19. Who initiated (started) sexual activity? Me € Partner €

20. Was it your choice or decision to have sex? Yes € No €

20.1. If the answer is no to question 20, were you forced? Yes € No €

20.2 If the answer is yes to question 20, what was your reason for becoming sexually active?

(Please indicate your answer by making a tick (✓) in one box):

Pressure from friends	To prove love to my partner	Pressure from my partner	Other (specify)
-----------------------	-----------------------------	--------------------------	-----------------------

21. Is it acceptable for women in your community to have more than one sexual partner? Yes € No €

21.1 Give a reason for your answer

.....

22. Why do some women have more than one sexual partner?

NB: Please indicate your answer by making a tick (✓) in one box /answer):

Money	Satisfaction	Accommodation	Other (specify).....
-------	--------------	---------------	----------------------

23. Is it acceptable for men in your community to have more than one sexual partner? Yes € No €

23.1.If no, give a reason for your answer

.....

23.2 If yes to question 23, give a reason why men in your community have more than one sexual partner

.....

24. Have you ever had more than one sexual partner Yes No

25. How many sexual partners do you have at present?

26. How many sexual partners did you have sex with in the last 4 (four) months?

None	One	Two	Three	Four	Five or more
------	-----	-----	-------	------	--------------

27. Have you ever seen a condom? Yes € No €

27.1 If yes, where did you see a condom for the first time?

27.2 If no, would you like to see what a condom looks like? Yes € No €

27.2.1 If no, state your reason for not wanting to see a condom

27.3 Do you use a condom when having sex? Yes € No €

27.3.1If the answer is no to question 27.3, give your reason for not using condoms

.....

NB 1: If your answer is no to 27.3, after giving reason, answer question 27.4 to the end of the questionnaire

NB 2: If the answer is yes to question 27.3, please answer question 27.3.2. to the end of the questionnaire:

27.3.2 Do you know how to use a condom properly? Yes € No €

27.3.3 How often do you use a condom when having sex?

Not applicable	Never	Always	Sometimes
----------------	-------	--------	-----------

27.3.4 Did you suggest the use of a condom to your partner? Yes € No €

27.3.4.1 If yes, how did your partner react or what did your partner say?

.....

27.3.4.2 If no to question 27.3.4 did your partner suggest the use of a condom? Yes € No €

27.3.4.2.1 If yes how did you react or what did you say to your partner?

.....

27 4 Is it easy to get condoms? Yes € No €

27.4,1 If no, what problems have you experienced in getting condoms?.....

27.4.2 Where would you like condoms to be placed for you to get them easily?

All over the place at home	Classrooms at school	Toilets at school	Public places like parks, discos, toilets	Youth centres	Health clinics	Other (specify).....
----------------------------	----------------------	-------------------	---	---------------	----------------	-------------------------------

27.5 Indicate what you regard as your main reason for using a condom.

(Tick (✓) one box with a reason /answer that you regard as most important for using condom).

Prevent pregnancy	Protect self from STI/HIV/AIDS	Protect partner from STI/HIV/AIDS	Other (specify).....
-------------------	--------------------------------	-----------------------------------	-------------------------------

SECTION D: HIV/AIDS AND PREVENTION OF HIV INFECTION

28. Have you ever heard about HIV and AIDS? Yes €
No €

28.1 If yes, where did you get information about HIV and AIDS for the first time

29. What does AIDS mean?.....

30. What does HIV mean?.....

31. Is there a difference between HIV and AIDS? Yes € No €

NB: If yes, indicate what the difference is between HIV and AIDS by making a tick (✓) in 31.1 and 31.2

31.1. A person with HIV carries a virus that will later cause AIDS Yes € No €

31.2 A person with AIDS is sick with signs of illness Yes € No €

32. Is there a vaccine to protect people from getting HIV infection? Yes € No €

32.1 If yes, what is the HIV vaccine called?.....

33. Is AIDS curable? Yes € No €

33.1 If your answer to 33 is yes, explain what it is that cures AIDS?
.....

33.2 If your answer to 35 is No, explain why you say AIDS is not curable:
.....

34. Indicate whether the following people are at risk or most likely to get HIV infection, and become HIV positive. Tick (✓) either agree or disagree Agree Disagree

34.1. Those having sex with multiple partners or with someone having other sexual partners ....	.....
34.2. Those having sex before, during and immediately after a woman's menstrual period .....	.....
34.3. Boys and girls under 19 years of age, who have sex without using a condom .....	.....
34.4. Those having anal or vaginal sex with an infected partner without using a condom .....	.....
34.5. Heterosexuals (those having sex with the partners of the opposite sex) .....	.....
34.6. Homosexuals (those having sex with the partners of the same sex) .....	.....
34.7. Drug users including alcohol and dagga users .....	.....
34.8. Prostitutes (commercial sex workers or those having sex to get money) .....	.....

34.9. Pricked or injured by sharps such as needles/razor blades contaminated with blood

35. Can the following methods protect you or your partner from getting HIV infection?

35.1. Using contraceptives Yes € No €

35.2. Using a condom when having sexual intercourse Yes € No €

35.3. Consulting traditional healers Yes € No €

35.4. Consulting faith healers Yes € No €

35.5. Speaking to ancestors Yes € No €

36. HIV infection can spread from one person who is HIV positive to another by:
(Indicate by making a tick (✓), whether you agree or disagree):

	Agree	Disagree
36.1 Hugging an HIV positive person	.....	.....
36.2 Being in the same room with a person who is HIV positive	.....	.....
36.3 Having sex with a person who is HIV positive without using a condom	.....	.....
36.4 Shaking hands with a person who is HIV positive	.....	.....
36.5 Sharing sharp instruments with blood, e.g. razor blades or needles	.....	.....
37. Can an HIV positive mother spread HIV infection to her baby	Yes € No €	
37.1 If the answer to question 37 is yes, answer questions 37.1 to 37.3		
37.1.1 Can an HIV positive pregnant mother spread HIV infection to her unborn baby?	Yes € No €	
37.1.2 Can an HIV positive mother spread HIV infection to her baby during delivery?	Yes € No €	
37.1.3 Can an HIV positive mother spread HIV infection to her baby during breastfeeding?	Yes € No €	
38. Does a person who is HIV positive have any signs to identify him/her as HIV positive? Yes € No €		
38.1 If yes, what are the signs that can help to identify a person who is HIV positive?		
38. 2 If no, how can a person find out that he/she is HIV positive? (Answer 38.2.1 below) Agree Disagree		
38.2.1. Having his or her blood tested for HIV	.....	.....
39. Do you think that your partner has other sexual partners?	Yes € No €	
40. Suppose you happen happened to know that your partner had other sexual partners, how would you react?		
.....		
40.1. Give a reason for your reaction.....		
.....		
41. Suppose you have heard that your partner has other sexual partners and you think that your sexual partner puts you at risk of getting HIV infection, would you:		
41.1. Continue having sex with him/her, without protection?	Yes € No €	
41.1.1 Give a reason for your answer.....		
41.2. Negotiate for the use of a condom?	Yes € No €	
41.2.1 Give a reason for your answer.....		
41.3 Refuse to have sex with him/her?	Yes € No €	
41.3.1 Give a reason for your answer.....		
41.4 End your relationship?	Yes € No €	

41.4. 1 Give a reason for your answer.....

42 The signs of sexually transmitted infections include burning urine, drop, or open sores? Yes € No €

43. Did you know that having sex with somebody who has a sexually transmitted infection (STI) increases the risk of becoming HIV positive? Yes € No €

43.1. If yes, did that lead to any change in you sexual behavior? Yes € No €

43.1.1 Give a reason for your answer to 43.1.....

43.1.2 If yes to 43.1, explain how it changed your behaviour?.....

44. Do you regard yourself as being at risk of becoming HIV positive? Yes € No €

44.1 Give a reason for your answer

45. What age group, do you think, is at the highest risk of being infected with HIV?

0 – 6 years	7 - 13 years	14 – 20 years	21 - 27 years	28 - 34 years	35 - 41 years	42 – 48 Years	49 – 55 years	56 years or more
----------------	-----------------	------------------	------------------	------------------	------------------	------------------	------------------	---------------------

46. What would your reaction be if your closest friend told you s/he was HIV positive or had AIDS?

46.1 Give a reason for your reaction.....

47. If your partner becomes HIV positive, before you had sex with him/her, how would you react?

47.1. Continue having sex with him/her without using a condom? Yes € No €

47.1.1. Give a reason for your answer

47.2. Negotiate for the use of a condom when having sex? Yes € No €

47.2.1. Give a reason for your answer.....

47.3. Refuse to have sex with him/her? Yes € No €

47.3.1. Give a reason for your answer.....

47.4. End your relationship? Yes € No €

47.4.1. Give a reason for your answer.....

48. If you find out that your partner is HIV positive, after you had unprotected sex with him/her, how would you react?

48.1 Give a reason for your reaction.....

49. Have you ever refused to have sex with your partner until s/he agrees with you to use a condom correctly/properly? Yes € No €

49.1. Give a reason for your answer.....

50. Do you know anybody who is HIV positive? Yes € No €

50.1. If yes, did that lead to a change in your sexual behavior Yes € No €

50.1.1. Give a reason for your answer

51. Do you know anybody who has died of AIDS? Yes € No €

51.1. If yes, did that lead to a change in your sexual behavior Yes € No €

51.1.1. Give a reason for your answer

51.1.2. If yes to 51.1, explain how it changed your behavior?

52. What do you think you can do to protect/prevent yourself from becoming HIV positive?

(Indicate your answer by making a tick (✓) in one box with the most appropriate answer to you)

Abstain from having sex	Be faithful to one partner	Eat well	Use a condom	Sleep with A virgin	Go for virginity testing	Make responsible sexual decisions
-------------------------	----------------------------	----------	--------------	---------------------	--------------------------	-----------------------------------

53. Should parents play an active role in making their children aware or educating them about sexuality, sex, gender issues, assertiveness as well as HIVprevention? Yes € No €

53.1. Give reasons for your answer.....

53.1.1 If yes to 53, at what age should parents start making their children aware of the above?years

53.1.2 If yes what should parents do to make their children aware of the issues stated in 53?

(Indicate your most appropriate answer by making a tick (✓) in one box)

Talk to them as parents at home	Send them to health staff eg. in youth centres for ounselling	Send them to the mountains for "ukusokwa"	Send them to elder people eg "amaqhikiza" for advise	Send them for virginity testing	Other (specify)...
---------------------------------	---	---	--	---------------------------------	--------------------

53.2 In order to change attitudes, perceptions and behaviour/practices, one must start at home?Yes € No €

54. Should traditional healers play a role in the prevention of HIV infection? Yes € No €

54.1 Give reason for your answer.....

55. Do you get life- skills education in your school? Yes €No €

55.1 If yes to 55, does it include the following:

55.1.1 Sexuality and sex education? Yes €No €

55.1.2 Gender issues, reproductive and sexual rights? Yes €No €

55.1.3 Prevention of sexually transmitted infections/diseases (STDs), including HIV/AIDS? Yes €No €

55.2 Who is responsible for teaching life skills in your school?

55.3 Who is responsible for teaching health matters, including STIs and HIVAIDS in your school?

Guidance teacher	All teachers	Deputy Principal	Nurse	Doctor	Other (specify).....
------------------	--------------	------------------	-------	--------	----------------------

55.4 Does the school health nurse visit your school to give health education talks to you? Yes € No €

55.5 Do you think the use of child-to-child or peer group education and counselling in sexuality, sex education, HIV and AIDS and its prevention could help to reduce the spread of HIV infection? Yes €No €

55.5.1 Give reasons for your answer (whether it was yes or no)

56. Should the following form part of the formal school curriculum?

56.1 Sexuality and sex education for youth? Yes €No €

56.2 Gender issues, patriarchy, assertiveness and negotiation skills? Yes €No €

56.3 Reproductive Health and sexual rights? Yes €No €

56.4 Sexually transmitted infections/diseases, HIV and AIDS and its prevention? Yes €No €

57 To change attitudes, perceptions and behaviour / practices, one should start at school? Yes €No €

APPENDIX 2: INTERVENTION PROGRAMME GUIDE

RESEARCH PROJECT TITLE:

SCHOOL-GOING YOUTH, SEXUALITY AND HIV PREVENTION IN NORTHERN KWAZULU-NATAL: A GENDER PERSPECTIVE

AN INTERVENTION PROGRAMME GUIDE DESIGNED AND IMPLEMENTED DURING
THE INTERVENTION PHASE OF THE THREE-PHASED STUDY
CONDUCTED IN FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY IN THE CENTRE FOR GENDER STUDIES
FACULTY OF HUMANITIES AND SOCIAL SCIENCE, UNIVERSITY OF NATAL

By Sisana Janet Majeke

August 2001

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INTRODUCTION

In the first phase of this three-phase project I undertook a baseline assessment with the aim of determining girls 'and boys' perceptions regarding complex, culture-related gender and sexuality issues, HIV and AIDS. This was done to assess the impact of the intervention by contrasting the baseline data obtained before the intervention, in the first phase, with data obtained after the intervention, in the evaluation or third phase. By comparing the data, I would be able to establish what shifts, if any, had occurred.

This appendix contains the programme of eleven (11) sessions, including the introductory session that was conducted on the first day, nine sessions of the intervention programme and the thanksgiving ceremony that was conducted on the last day³⁶. Objectives of the intervention phase were outlined, together with other objectives of the study

The intervention programme was conducted in the second phase and it was the major motivation for conducting this research study³⁷. An action research, with a qualitative approach, within a phenomenological design was used for this intervention phase, which forms the main focus of this study.

Purpose of the intervention phase of the study

The purpose of the intervention phase of the study was to design, conduct and integrate a gender-based life skills building intervention programme. The intervention programme was designed and conducted to expose and sensitise learners to the themes that underpin the study, including a number of complex and culture-related issues such as gender and sexuality issues, sexual and reproductive rights, negotiation and decision-making skills. The main goal was to promote a model of shared gender respect and equal responsibility in sexual decision-making and HIV prevention among young boys and girls in their heterosexual relations.

These themes were further explored within the framework of theories related to Connell's theory of gender and power, feminist theories, masculinity and theories related to vulnerability. Many of these themes informed the intervention that was conducted in

³⁶ As outlined in Table 3.3 in the Methodology Chapter of this study

³⁷ As outlined in Chapter 1 of this study

the second phase of this study. Subsequently, an intervention programme was conducted to equip boys and girls with gender-based life building skills to promote HIV prevention within the context of gender and mutual respect.

Why focus on boys and girls?

HIV/AIDS is a pandemic that tends to be more prevalent in certain age and gender groups. Both boys and girls are vulnerable to HIV infection. Cultural beliefs and society's expectations about 'manhood' encourage men to be the initiators of risky sexual behavior, which places boys and their partners, girls, at great risk of HIV infection (Roche, 2000: 2). Gender issues are increasingly being recognised as having a critical influence on the HIV epidemic in Southern Africa (UNAIDS, 2000:5).

The goal of the intervention was to target young men and women and create a mind-shift away from traditionally constructed masculinities and femininities and assist them to deconstruct some of the values that legitimate male domination and the subordination of females and demand their unquestioning obedience. In addition, the aim of the intervention was to encourage boys and girls to modify and adopt notions of gender equality, respect and healthier sexual behaviour. The goal at all times was to promote the reduction of HIV risk-related behaviour which could protect them against HIV infection in a gender perspective.

The following section outlines the intervention programme guide that was designed and conducted during the intervention programme of the second phase of the study:

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

INTERVENTION PROGRAMME GUIDE

Pseudonym of School:.....

DAY: **DATE:**..... **TIME:** Fromto.....

METHODOLOGY / STRATEGY: Group discussion: Flip charts, marker pens, transparencies, overhead projector or power point slides plus laptop and projector

FIRST DAY: INTRODUCTION SESSION (45 minutes)

Objectives for first day or introduction session (NB: Will vary according to different sessions)

- To orientate learners as participants to the intervention programme
- To prepare learners as participants of the gender-based intervention programme for the intervention phase of the study
- To organise a warm up or ice breaking exercise
- To introduce the format and sessions of gender-based HIV intervention programme to the participants

Materials (NB: These will be the same for each session of the intervention programme)

- Room (big room for sessions)
- Flip charts, markers, Prestik



- Alarm clock or watch for time keeping
- Overhead projector and transparencies or laptop and projector for power point presentation (for facilitator's end-of-session summary)

- Bigger font size should be used to type the facilitator's end of each session summary that will be presented either on transparency using the overhead projector or in power point slides using laptop and projector
- Instructions or directions to participants and objective/s for each exercise
- Evaluation forms for each session

Agenda

- ❖ Orientation of participants to the gender-based life skills intervention programme
 - Introduction, purpose and objectives of the intervention programme (5 minutes)
 - Brainstorming of ground rules for the intervention programme (7 minutes)
 - Researcher's summary of ground rules (3 minutes)
 - Formation of groups (5 minutes)
 - Warm up or ice breaking exercise to create a relaxed atmosphere (10 minutes)
 - Introduction of the format and sessions of gender-based intervention programme and invitation of questions from participants and facilitation of discussion to clarify critical issues (10 minutes).
 - Serving of refreshments to all participants at the end of the session (5 minutes)

Personnel (NB: These will be the same for each session of the intervention programme)

Female Learners acting as participants

Male Learners acting as participants

Researcher acting as facilitator

Research Assistants acting as co-facilitators

Pre-requisite for researcher and research assistants:

Ideally the researcher and research assistants should participate in the training of facilitators and co-facilitators at least once, as participants need to have experience with facilitation and co-facilitation of group work and the techniques and strategies used during sessions such as focus group discussions, games and role-plays.

Estimated time: 45 minutes

ORIENTATION OF PARTICIPANTS

AIM: To help participants feel both relaxed and actively involved throughout the gender-based HIV prevention intervention programme

1. INTRODUCTION AND WELCOME

Researcher as facilitator opens the first day introduction session with a brief message such as the following message:

I would like to start this session by sincerely thanking you for participating in this three-phased study. I welcome all of you to the introduction session of the second phase of the study as you have already participated in the first phase of this study.

I know each one of you is expecting to learn something from this intervention programme. I would like you to share and tell me “what do you expect to learn from this intervention programme?” Your answers to this question will enable me to determine your expectations from the intervention programme before it even starts and also to clarify those that will be covered or achieved and reasons why others, if any, will not be achieved. As a preliminary activity, I shall provide learners with an opportunity to outline their expectations from the intervention programme. The sessions of this gender-based intervention programme are planned as interactions, so that participants can freely express their opinions. I hoping that you will be frank and truthful to one another, prepared to learn and freely share your experiences as you participate in these sessions.

I also hope that you are going to benefit and gain gender-based life building skills that will safeguard you in HIV prevention and all aspects of your sexual health throughout your lives.

1.1 PURPOSE OF THE GENDER-BASED INTERVENTION PROGRAMME

To expose school- going young boys and girls to a gender-based life building skills programme through active participation of participants in all sessions of the programme. A combination of innovative strategies to be used will include focus groups discussion, games and role plays.

1.2 OBJECTIVES OF THE GENDER-BASED³⁸ INTERVENTION PROGRAMME

- To brainstorm and arrive at a shared meaning of the terms sex, gender, gender-equality, sexuality, reproductive rights and sexual rights and patriarchy through focus group discussions.
- To allow participants, through gender games, to examine how they learn about gender (or about men and women), including gender-based stereotypes and patriarchy;
- To provide participants, through gender games, with an opportunity to share their gender-based experiences (or their experiences of being female or male);
- To identify through focus group discussions how gender, or being female or male, can affect their lives in the area of sexual and reproductive health;
- To provide learners with an opportunity to be exposed to and to practice life skills such as assertiveness skills, negotiations and sexual decision-making skills for HIV prevention in relation to gender through games and role-plays;
- To provide learners with an opportunity to re-inforce their knowledge and understanding of sexually transmitted infections (STIs) – HIV and AIDS and prevention of HIV infection, through focus group discussions, games, role-plays;
- To provide a summary at the end of each session through discussion.

2. GROUND RULES FOR THE GENDER-BASED INTERVENTION PROGRAMME

First let the learners, who are participants, brainstorm ground rules and invite one of them to write these on the flip chart.

➤ GROUND RULES FORMULATED BY LEARNERS FOR THE SESSIONS OF THIS GENDER-BASED INTERVENTION PROGRAMME

- Respect each other and avoid hating another
- Time management
- One person talking at a time
- Report future absence
- Sign attendance register if present
- Raise your hand if you want to talk
- Try to speak English

³⁸ (De Bruyn and France, 2000:2)



SUMMARY OF GROUND RULES EXPLAINED BY RESEARCHER

- Listen with respect to everyone's opinion even if you do not agree with them
- Welcome different views with respect and do not laugh at or discourage others
- Speak in "I" not "you" statements (I think..., I believe..., I like/dislike..., etc.).
- Respect confidentiality – if someone shares something personal, do not repeat it outside the room in a way that can identify them.
- Seek agreement from all participants that personal things said in the group will remain confidential.
- Put aside fears about expressing what we really think and feel about a subject.
- Agree to allow the use of "sensitive" or "taboo" words and terms during the workshop.
- Come back from the break or group exercises on time³⁹

The facilitator acknowledges the focus on sensitive issues:

The facilitator seeks permission from the group to focus on sensitive issues. Over the next sessions of the gender-based intervention programme, we will be doing a lot of talking about sex, sexual and gender issues, HIV and AIDS, life skills such as assertiveness, negotiations and sexual decision-making skills. Some of what will be discussed may seem very personal, and sometimes we might feel a little uncomfortable. It is natural to feel shy and scared, at the start or beginning, especially when talking about some of these issues and when learning something new, but that means it is important to come to all the sessions regularly. If we can all keep up together as a team, adhere to our ground rules and develop a relationship of trust, it will make it easier to be comfortable talking about these issues

Explanation of roles of researcher and research assistants:

Explain researcher's role of acting as a facilitator and her professional counselling skills as well as the referral provision to other professional counsellors for further assistance, with the permission of learners who participate in the gender-based HIV prevention intervention programme

³⁹ (De Bruyn and France, 2000:3)

- Explain the two research assistants' role of acting as co-facilitators during focus group discussions, games and role-plays.

3. FORMATION OF GROUPS OF PARTICIPANTS

I requested participants to form four groups of about six to 13 (two groups of male learners and two groups of female learners) in the schools attended by both boys and girls or four groups of girls in a girls-only school. An example of how these focus groups could be formed is outlined in the Methodology chapter of this study.

4. INTRODUCTION OF A WARM-UP EXERCISE⁴⁰

Aim: To organise an ice breaking exercise to create a relaxed atmosphere

Theme: When we were young (10 minutes)⁴¹:

Methodology: Pair work followed by group sharing of experiences

Instructions: Ask the participants to pair with someone and sit or stand with their backs to one another. Next give them instructions to close their eyes and think of themselves in a beautiful place, perhaps with soft music playing in the background. Then they must think back to their early years of life and try to remember when they first realized that they were male or female; what events that made it obvious to them that boys and girls were different? Did a person they admired teach them about being male or female?

Reflect on whether this experience had only to do with something physical or with comments or reactions from other people. Was it a negative, positive or neutral experience?" (Allow participants to think in silence for about three minutes)

Thereafter, sit down and share early memories with the partner. After a couple of minutes, ask the volunteers to share their experiences with the entire group, mentioning whether they were positive, negative or neutral. If no one mentions a story involving gendered characteristics, give an example of what might be expected. Explain that the experiences are discussed to identify which experiences had to do with characteristics that differentiate girls from boys e.g. having a first menstrual period, or wet dream; and which were related to gender e.g. activities forbidden to boys or girls. If no-one in the

⁴⁰ Refer to other examples of warm-up or ice breaking exercises attached as appendix 2.1

⁴¹ (de Bruyn and France, 2000:13)

group wants to share right away, give some examples from your own life; this often prompt participants to share their views or experiences.

Summary of ice-breaking exercise:

I conclude the exercise by highlighting the importance of early experiences in recognising one's own gender. Experiences are mentioned that, even when they were related to biological differences, are often influenced by gender factors. The group can also discuss what the advantages and disadvantages are of being born female or male⁴²

5. INTRODUCTION OF THE FORMAT AND SESSIONS OF THE INTERVENTION PROGRAMME

5.1 Format for sections of each session of the intervention programme

Conduct each session of the intervention programme for about two hours. Divide the time of each session into sections that should be explained during the introductory day and prior to the commencement of each session⁴³.

I explain that each session will begin with an introductory section which will take not longer than 10 minutes. I shall give instructions to participants in the plenary introductory section, before they divide into their respective groups. This will be followed by other sections, as outlined below:



Introduction of the session

The introduction of the session should be done during the plenary introduction prior to the start of the group work of each session; it should take about ten minutes. The topic and objective of each session will be explained and instructions given to participants concerning group work, prior to their separation into groups.

Group exercise (30 minutes)

I shall ensure that participants receive the same topic and instructions for the session, if they are to do the same exercise, by combining them for instructions that guide participants on the exercise to be done before they separate for the group exercise or to

⁴² (de Bruyn and France, 2000:14).

⁴³ Each session to follow the format outlined in Table 3.2 of the Methodology Chapter of this study.

work in smaller, established groups. Each group will be given a copy with the topic, objective or purpose of the session and instructions for each session.

Each small group will be asked to elect a time controller, a scribe and to have a volunteer or designate one of their members to be the leader, to present their views in the plenary feedback session. These three roles should be rotated in each session to give various group members a chance to play these roles.

If using focus group discussions, I shall give a copy of the topic and instructions for each session to guide the group exercise, and provide each group with a flip chart and a marking pen to be used to write their views for the plenary feedback session.

If using games and role-plays, give the topic of the session and instructions that guide participants to act out their responses in the form of games or role-plays. Ask participants to practice their games and role-plays in their established groups for a period of 30 minutes in preparation for the plenary feedback.

I shall announce the length of time to be spent during an exercise during the introductory day and before the commencement of the session. Each group will be expected to discuss, play the game or role-play the session topic for about thirty minutes, and thereafter, to give feedback to the combined group.

Together with my assistants, I shall monitor the group exercises to stimulate constructive discussions amongst the participants. Each facilitator should stay with each small group assigned to her, to listen and respond to questions and doubts raised by learners. Facilitators should not participate in the actual exercise itself, but can clarify issues. They should then leave and visit the groups again after five to eight minutes to ensure that the participants do not spend too much time on one part of an exercise. They should also warn the participants when the exercise session is about to finish, before the plenary feedback session, to ensure that participants finalise their exercise and have a summary to present (De Bruyn and France, 2000:9).

Plenary / combined group feedback session (10 minutes per group x4 groups=40minutes)

The total duration of presenting /reporting or role-playing should be forty minutes for four groups, ten minutes per group. Prior to the exercise, the facilitator should explain that when groups have done the same exercise, one group will present their conclusions

and the other groups will be asked to add any new insights or comments, to avoid repeating the same views as stated by previous groups.

Refreshments (10minutes)

The facilitators should also state that a short break of about ten minutes will be taken during which refreshments will be served to participants. Participants are to be reminded to come back from the refreshment break on time.

Facilitator's end of session summary (30 minutes)

I shall conclude each session after the group presentation with a summary, and clarify important points. For example, after the short break, I shall allow about thirty minutes to give participants an opportunity to ask questions and have an open discussion to clarify issues raised. This will allow me to clarify points and summarise each topic of the session in relation to what emerges from the presentations of the four groups. I shall identify shared similar or different meanings and give references from literature to support and validate meanings and other topics of sessions during my summary at the end of each session. My summary for end of each session will be written on a transparency and will not be given to participants, but attached to the separate page/s of the Appendix of each session, together with the topic and instructions given to participants prior to the exercise.

EVALUATION FORM FOR EACH SESSION

I shall distribute the evaluation form⁴⁴ to each group either at the start of the session or when participants return from the refreshment break, so that they have sufficient time to complete them (De Bruyn and France, 2000:10). I shall ask participants to give this feedback to the facilitator. They should indicate what they found most interesting and useful, what they liked least, what they would like to be explored further and to suggest ways of improving each activity (De Bruyn and France, 2000:10). I shall thank them for their participation at the end of each session.

⁴⁴ Refer evaluation form attached as Appendix 2.2

COLLECTION OF FLIP CHARTS AND EVALATION FORMS FOR EACH SESSION

The facilitators must ensure that they have collected the flip charts, on which each group write their responses, and the evaluation forms, since these can be useful in improving following sessions.

I shall announce what the next session will be focussing on and remind participants of the next date for the session of the intervention programme.

5.2 Sessions of the gender-based skills building intervention programme

I shall write an outline of sessions of the intervention programme (see Chapter 3), including the first introduction session and the final session for thanksgiving⁴⁵. Materials such as the room, alarm clock and personnel, participants, myself as researcher and my research assistants will be the same for each session.

I shall conduct the sessions of the intervention programme using relevant guides or those developed by me which should serve as session material guides and attached as part of Appendix 2 (sub-numbers of Appendix 2 e.g. Appendix 2.19).

Various methods of gathering data will be utilised⁴⁶ by the facilitator to collect data during sessions of the intervention programme. The methods and strategies used should be in line with the purposes of the intervention programme.

I shall identify topics⁴⁷ for the sessions of the intervention programme and address each topic once a week during the period agreed upon with the school authorities and participants.

Session One Topic: Terminology, such as the meaning of the terms ‘sex’ and ‘gender,’ gender equality, sexuality. Methodology / Strategy: Focus group discussions⁴⁸.

Session Two Topic: Sexual and reproductive rights. Methodology / Strategy: Focus group discussions⁴⁹.

Session Three Topic: Patriarchy. Methodology / Strategy. Focus group discussions⁵⁰.

Session Four Topic: Gender-based stereotypes. Methodology / Strategy: Game⁵¹.

⁴⁵ As outlined in Table 3.3 of the Methodology Chapter of this study

⁴⁶ As outlined in Table 3.3 of the Methodology Chapter of this study

⁴⁷ As outlined in Table 3.3 of the Methodology Chapter of this study and below in this intervention guide.

⁴⁸ Refer Appendix 2.3: Session one topic, instructions and facilitator’s summary for end of session

⁴⁹ Refer Appendix 2.4: Session two topic, instructions and facilitator’s summary for end of session

⁵⁰ Refer Appendix 2.5: Session three topic, instructions and facilitator’s summary for end of session

Session Five Topic: Issues of sex. Methodology / Strategy: Focus group discussions⁵².

Session five will be divided into two sections. The first section will deal with the terms used for the language of sex and its related issues. The second section will deal with sources from which participants, learnt about sex.

Session Six Topic: STIs –HIV and AIDS. Methodology / Strategy: Focus group discussions, role-play and game⁵³. Session six will be divided into three sections. The first section, HIV/AIDS and factors which increased youths' vulnerability to sexually transmitted infections (STIs) including HIV, using focus group discussions. The second and third sections deal with basic issues of HIV and AIDS using role-play with learners acting as peer educators, and a board game to address the basic issues of HIV and AIDS such as meaning of and difference between HIV and AIDS, HIV transmission and ways of preventing it and risky behavior.

Sessions Seven, Eight and Nine: Topics: Life skills, especially assertiveness skills will be dealt with in session seven and negotiation skills in sessions eight and nine.

Methodology / Strategy: Role-play⁵⁴.

Session Ten Topic: Thanksgiving ceremony. Methodology/ strategy:

Discussion. Facilitator should thank learners for participating in the sessions of the intervention programme of this study and give each learner a certificate of appreciation and attendance⁵⁵ and the English version of Living Positively with HIV and AIDS and the isiZulu version of '*Phila ngokuzethemba ne-HIV ne-AIDS*' (supplements of Sunday Times 2001)⁵⁶. They will also be encouraged to share what they have learned in these sessions with their friends and to attend the evaluation phase which is the last phase of this three-phased study. Participants should be informed that the last phase of this study will take place in nine months time, after the completion of the intervention programme, and the date must be announced.

⁵¹ Refer Appendix 2.6: Session four topic, instructions and facilitator's summary for end of session

⁵² Refer Appendix 2.7: Session five topic, instructions and facilitator's summary for end of session

⁵³ Refer Appendix 2.8: Session six topic, instructions and facilitator's summary for end of session

⁵⁴ Refer Appendices 2.9, 2.10, 2.11: Sessions 7, 8 & 9 topics, instructions and facilitator's summary for end of sessions

⁵⁵ Refer to Appendix 2.12 for certificate of appreciation and attendance given to learners as participants

⁵⁶ Appendix 2.13 & 2.14 English & IsiZulu version: Cover and table of contents of living positively.

Facilitator's summary of end of introductory day

I shall invite questions from participants and encourage discussion to clarify their expectations: those that will be achieved and the rationale for those that will not be achieved, such as drama sessions, as expected by learners from one school, reflection on perceived meaning of issues covered in the completed questionnaires in the first phase relating to gender and sexuality issues, rights, HIV and AIDS

The participants will be given evaluation forms and asked to complete them for a few minutes before leaving. I shall collect the flip charts on which each group of participants wrote their views and the evaluation forms; these will be useful to improve the following session's exercises.

I shall remind participants of the agreed day and time for conducting the sessions of the intervention programme and the topic of the next session and thank them for their participation.

Attached Appendix 2 sub-Appendices: Intervention Programme Guide:	Page
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APPENDIX 2.1 WARM-UP EXERCISES⁵⁷

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke **Institution:** University of Natal

The following are examples of ice-breaking exercises that were used in other sessions:-

✚ What are your expectations of the following exercise?

- Ask participants to talk about their expectations of the activity, prior to the exercise you will be doing.
- What do they most want to gain from participating?
- How far were their expectations met?

Paired introductions: Instructions to participants:-

- Ask participants to pair up with someone and sit or stand with their backs to one another.
- Ask each participant to talk for a few minutes with the partner, about what s/he wants to be called and what s/he expects to discover in today's session and why.
- Then each must introduce their partner to the group and talk about expectations for today's session and her/his reason.

✚ Formation of circle and throwing of a ball: Instructions to participants:-

- Ask participants to form a circle and have people throw a ball (or other object) to each other, calling out their name as they do so.

⁵⁷ Developed by Sisana Majeke 2001 (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 1).

- When everyone has called their name two or three times, ask them to throw the ball to each other naming the person to whom they are throwing it.
- Ask each participant to write one word that describes how s/he feels at the moment.
- Ask each participant to write one word on her/his feelings at the end of the group session and see how her/his feelings have changed.

APPENDIX 2.2 EVALUATION FORM⁵⁸

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:

Intervention phase group number:

Day: Date: Time: From To.....

INSTRUCTIONS TO PARTICIPANTS

Use a tick (✓) to indicate type of group in the box provided: Females € Males €

Please do not write your name but write the group number in the space provided above.

You are kindly requested to write down few short comments summing up your feelings about the session/activity conducted today:

⁵⁸ Developed by Sisana Majeke 2001: Facilitators should give this form to participants towards the end of each session to evaluate the session (de Bruyn and France, 2000:39; De Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998:52).

1. What did you find most useful/interesting?

.....
.....
.....

2. What did you like least?

.....
.....
.....

3. What would you like to be continued/explore further and why?

.....
.....
.....

4. Make comments or suggest ways to improve the activity/session

.....
.....
.....
.....
.....

Thank you for your participation in today's session of the intervention programme!

APPENDIX 2.3 SESSSION ONE: PERCEIVED MEANING OF TERMINOLOGY⁵⁹

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gendered perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

⁵⁹ Developed by Sisana Majeke 2001: Appendix 2.3 to be given to participants with instructions for exercise

Intervention session number: Day..... Date..... Time: From...to....

SESSION ONE: TOPIC: Perceived meaning of terminology, such as the meaning of the terms sex and gender, gender-equality, sexuality.

METHODOLOGY/STRATEGY: Focus group discussions. Flip charts and marker pens

OBJECTIVE OF SESSION ONE

To brainstorm and debate the meaning of the terms sex, gender, gender-equality, sexuality and arrive at a shared definition of them.

INSTRUCTION TO PARTICIPANTS

Ask learners, as participants, to divide into their established groups of girls and boys in schools attended by girls and boys, or into groups of girls in a single-sex school⁶⁰ and reunite the groups for plenary feedback section to share their views.

Ask the groups to say what comes to their minds when they hear or think of the following terms or words: sex, gender, equality, gender-equality, sexuality.

Give flip charts and marker pens to be used to write their views on the flip charts, in preparation for the plenary feedback or presentation section. In the plenary section four representatives will give feedback and debate for 40 minutes on the meaning of the above stated terms, based on the group views. Duration: 30 minutes

APPENDIX 2.3.1 FACILITATOR'S SUMMARY FOR END OF SESSION ONE⁶¹

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

⁶⁰ As formation of separate groups according to sex is explained in the Methodology Chapter of this study

⁶¹ Developed by Sisana Majeke 2001: Appendix 2.3.1: Facilitator's summary for end of session one.

Intervention session number:Day.....Date.....Time: From...to.....

SESSION ONE TOPIC: Perceived meaning of terminology, such as meaning of the terms sex, gender, gender-equality, sexuality.

METHODOLOGY / STRATEGY:

Group discussions and facilitator's summary⁶² for session one: Transparency and overhead projector or power point slides plus laptop and projector⁶³.

SESSION ONE: SHARED MEANING OF TERMINOLOGY

I shall summarise the session one exercise by explaining the meaning of the relevant terms used in literature and by organisations. I shall begin by indicating that most people will say that they associate sex with gender or vice-versa or will list the same meanings under sex and gender. I shall point out the confusion that exists between these terms⁶⁴. I shall clarify by referring to literature to arrive at the shared meaning of the terms:

1. Sex:

Sex refers to the physiological attributes that identify a person as male or female⁶⁵:

- type of genital organs (penis, testicles, vagina, womb, breasts)
- type of predominant hormones circulating in the body (oestrogen, testosterone)
- ability to produce sperm or ova (eggs)
- ability to give birth to and breastfeed children.

2. Gender:

Gender refers to widely shared ideas and expectations (norms) concerning women and men. These include ideas about typically feminine and masculine characteristics and abilities and shared expectations about how women and men should behave.⁶⁶ Gender refers to the socially constructed and defined roles and responsibilities of women and men or girls and boys. These ideas, expectations and roles determine the status and power

⁶² Bigger font size should be used to type the facilitator's end of session summary.

⁶³ Refer to Appendix 2.3 for objective of session one and instructions to participants for exercise

⁶⁴ (De Bruyn and France, 2000:13)

⁶⁵ (De Bruyn and France, 2000:16)

⁶⁶ (De Bruyn and France, 2000:16)

of men and women in society.⁶⁷ These are learned from family, friends, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles, sexual decision-making, social status, economic and political power of women and men in particular societies.⁶⁸

2.1. Difference between ‘sex’ and ‘gender’

I shall point out that the meaning attached by most people to the terms ‘sex’ and ‘gender’ tend to be similar. I shall clarify that there is a difference between these terms ‘sex’ and ‘gender’ when we are talking about the social-science use of the term ‘gender’. I shall indicate during the discussion that that gender refers to the social and cultural constructions of ideas and norms of roles for women and men. Because of this the content of gender can vary across cultures and societies⁶⁹. Sex has to do with biological and physiological characteristics.⁷⁰

3. Gender-equality

Gender equality means equal treatment and respect of women’s and men’s dignity and views/opinions in all aspects including

- sexual decision-making
 - laws and policies
 - access to information
 - access to education
- access to resources and services within families, communities and society.⁷¹

3.1 Gender equity

Gender equity means justice in the distribution of benefits and responsibilities between women and men. It often requires specific programmes related to women and girls to empower them to control their own lives and fertility to end gender-based inequalities⁷².

⁶⁷ (De Bruyn, 2000: 1 (Ipas: Family Care International S&R H Briefing Cards , 2000:1))

⁶⁸ (De Bruyn and France, 2000:16)

⁶⁹ De Bruyn and France, 2000:13)

⁷⁰ (as indicated above in the mean of sex according to de Bruyn and France (2000:16))

⁷¹ (De Bruyn, 2000: 1 (Ipas: Family Care International S&R H Briefing Cards , 2000:1))

⁷² (De Bruyn, 2000: 1 (Ipas: Family Care International S&R H Briefing Cards , 2000:1))

3.2 Gender-based inequality

Gender-based inequality refers to situations in which women and men do not have the same access to information, education, decision-making power, household and community resources because of their sex. The following are examples⁷³ of gender inequality.

“No matter who and how a woman is, her intellect is very small” said one man.

“I told my boyfriend that it is better to use condoms, the doctor said so. The doctor has also given me some to use. My boyfriend became very angry and asked who gave me permission to bring those condoms to him” said one girl.

4. Sexuality:

Facilitator ends the exercise on sexuality by re-emphasising the following:

- 4.1 Aim:**
1. To facilitate an understanding of the concept of “sexuality”
 2. To highlight the difference between “sex” and “sexuality”
 3. To facilitate an understanding of sex stereotypes and their implications.

Sex was traditionally singled out as a sacred area of life was taken ‘taboo’ and not a subject for discussion, especially for girls in Zulu culture. Sexuality is a relatively new concept. Today, however, the importance of understanding human sexuality is appreciated and accepted as a part of everyday life.

4.1.1 Sexuality

Sexuality is the sum of a person’s inherited make-up, knowledge, attitudes, experience and behaviour as they relate to being a man or woman⁷⁴. It involves more than the reproductive organs; it includes the perceptions human beings have of being male or female. It includes those ways of behaving which enrich the personality and increase the

⁷³ Dde Bruyn, 2000: 9)

⁷⁴ (Devenish, Funnell and Greathead, 1992:106)

love between people⁷⁵. According to Devenish, Funnell and Greathead, (1992:107) sexuality affects all areas of our lives, including the following:

- the physical body
- feelings and attitudes
- the way people walk, dress, behave
- the decisions we make
- our beliefs and values
- sexual intercourse
- inherited characteristics
- relationships between people
- social aspects of people's lives
- spiritual aspects of people's lives

4.1.2 Difference between sex and sexuality Sex and sexuality are often confused. This is incorrect as sex is the physical act of intercourse and sexuality is the way people relate to those of the same or opposite sex.⁷⁶

4.1.3. Sex-role Stereotypes

Stereotyping is⁷⁷:

- To prejudge a person to fit them into a particular category, e. g. effeminate men are homosexual, fat people are funny, all girls are emotional.
- Adopting a mental picture of the appearance and character of a person to fit them into a group.
- Discussion should include the effects of such stereotyping on the individual and society.
- The basis on which people are stereotyped are:
 - height

⁷⁵ (Devenish, Funnell and Greathead, 1992:107)

⁷⁶ (Devenish, Funnell and Greathead, 1992:104)

⁷⁷ (Devenish, Funnell and Greathead, 1992:109)

- weight
- skin colour
- hair colour
- nationality
- religion disability
- language
- gender and sex

At birth, the first statement is usually “it’s a boy” or “it’s a girl”⁷⁸. The physical sex of an individual is determined at conception.

I shall end Session One by stating that one of the goals of this exercise is to demonstrate that people assign different meanings to most terms that are related to gender and sexuality issues, and will re-emphasise that we learn about sex and gender issues as children; the meaning we attach to them can influence us for the rest of our lives⁷⁹.

I can further emphasise that it is important, especially for young people, to understand the concept of gender and its difference from sex. We must all know that we ourselves are influenced by the concept of gender through our cultures, traditions and prejudices, sometimes without knowing it. My role as the facilitator of this research project is to help young people who are participating in the gender-based life skills building intervention programme of this study, to know that they can change norms and stereotypes that put you in situations that can lead to risks of contracting sexually transmitted infections including HIV⁸⁰

All researchers must ensure that they have served refreshments to participants and collected the response sheets and evaluation forms from the groups of participants.

5. Important points to remember are:⁸¹

1. Technology affects how we view gender: men and women can feed infants with baby bottles; machines make it possible for both sexes to do heavy labour; medical

⁷⁸ (Devenish, Funnell and Greathead, 1992:109)

⁷⁹ (de Bruyn and France, 2000:26)

⁸⁰ (De Bruyn and France, 2000:16)

⁸¹ (De Bruyn and France, 2000:17)

technologies make it possible for sex characteristics to be changed. The content of “gender” can change with time; individuals can change their sexuality.

2. Gender influences relationships, not only between men and women but also among women and among men.

3. Gender does not only apply to people who are heterosexual: It affects people who are heterosexual, bisexual, homosexual or lesbian and people who choose to abstain from sex.

4. Men and women can manipulate gender-based ideas and behaviours for their own benefit, at the same time reinforcing stereotypes (e.g., women crying or flirting to get something done).

5. It is difficult to be 100% gender-sensitive; we are almost all influenced by gender in our ideas and actions.

6. Gender sensitivity does not mean that we no longer recognise differences between men and women. Some differences remain because of physiological differences; others may remain because we choose to retain them even in equal relationships (e.g., conventions of politeness).

7. To incorporate a gender-sensitive perspective in our work, we don’t need to talk about gender itself but can refer to male and female roles or men’s and women’s work, for example.

APPENDIX 2.4 SESSSION TWO: PERCEIVED MEANING OF TERMINOLOGY⁸²

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females** € **Males** €

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION TWO TOPIC: Perceived meaning of terminology, such as meaning of sexual and reproductive rights.

METHODOLOGY / STRATEGY: Focus group discussions. Flip charts and marker pens

OBJECTIVE OF SESSION ONE

To brainstorm and debate the meaning and arrive at a shared definition of sexual and reproductive rights.

INSTRUCTION TO PARTICIPANTS

I shall ask participants to divide into their separate groups of girls and boys, in schools attended by girls and boys, or into groups of girls in the single-sex school⁸³ and re-unite for the plenary feedback section to share their views.

Ask the groups of learners, as participants, to say what comes to their minds when they hear or think of the following terms or words: sexual and reproductive rights

- Give flip charts and permanent marker pens for them to use to write their views on the flip charts, in preparation for the plenary feedback or presentation section. In the plenary section four group representatives will give feedback and debate the meaning of the above stated terms based on the group views for 40 minutes. Duration of each exercise: 30 minutes

To have a scribe to write their views, a leader and a time controller

⁸² Developed by Sisana Majeke 2001: Appendix 2.4 to be given to participants with instructions for exercise

⁸³ As formation of separate groups according to sex is explained in the Methodology Chapter of this study

APPENDIX 2.4.1 FACILITATOR'S SUMMARY FOR END OF SESSION TWO⁸⁴

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day**.....**Date**.....**Time:** From...to.....

SESSION TWO TOPIC: Perceived meaning of terminology, such as meaning of sexual and reproductive rights.

METHODOLOGY / STRATEGY:

Group discussions and facilitator's summary for Session Two: Transparency and overhead projector or Power point slides, laptop and projector.

SESSION TWO: SHARED MEANING OF TERMINOLOGY

I shall summarise the Session Two exercise by explaining the meaning of the following terms that are used and shared in various literature and organisations. I shall use bigger font size to type the facilitator's summary that will be presented on transparency and overhead projector.

⁸⁴ Appendix 2.4.1. Facilitator's summary for end of session two summary.

Sexual and Reproductive Rights:

2.1 Sexual Rights

Sexual rights include the rights of all people to⁸⁵:

- decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health.
- be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions; to expect and demand equality, full consent, mutual respect, and have shared responsibility in sexual relationships.

Sexual rights are part of the human rights of all people, including their rights to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, freedom from coercion, discrimination and violence.⁸⁶

According to the 'sexual rights campaign for equality and mutual respect in sexual decision-making', sexual rights mean you have the right to choose⁸⁷:

- when
- with whom
- and how to have sex
- to have a respectful sexual relationship
- to enjoy pleasurable and safer sex.

2.2 Reproductive Rights Includes the rights of individuals to:⁸⁸

- decide freely and responsibly about the number, spacing and timing of children have the information, education and means to do so attain the highest standard of sexual and reproductive health make decisions about reproduction free of discrimination, coercion (force) and violence.

2.3 Sexual and reproductive health care includes⁸⁹:

- youth centres, counselling services

⁸⁵ (de Bruyn, 2000: 1; *Ipas*: Family Care International S&R H Briefing Cards , 2000:1)

⁸⁶ FWCW PLATFORM FOR ACTION, 95

⁸⁷ (Women's Health Project, 2000:1)

⁸⁸ De Bruyn, 2000: 1 (*Ipas*: Family Care International S&R H Briefing Cards , 2000:1))

⁸⁹ (De Bruyn, 2000: 1 (*Ipas*: Family Care International S&R H Briefing Cards , 2000:1))

- family planning information and services
- preconceptual services
- premarital services
- prenatal, delivery care and post-natal care
- health care for infants

I shall conclude by explaining that this Session Two exercise can help us to remember that sexual rights are part of human rights for all and to consider what rights a girl/woman has over her body, the circumstances in which sex is really voluntary as well as the possibility of choosing virginity. In addition, I shall emphasise the importance of woman's honour and that it should not depend solely on her sexual actions. Boys and men need to be empowered on the gender-equal respect responsibility and rights-based approach to sexual and reproductive decision-making, so that they know that they do not have the right to control girls or women.⁹⁰ This will reduce vulnerability to STIs including HIV infection and unplanned or unwanted pregnancies.

I and my assistants will ensure that we serve refreshments to participants and collect the response sheets and evaluation forms from the groups, since these can be useful in planning follow-up activities⁹¹ and improving later sessions.

APPENDIX 2.5 SESSION THREE: PERCEIVED MEANING OF PATRIARCHY⁹²

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

⁹⁰ (De Bruyn and France, 2000: 17)

⁹¹ (De Bruyn and France, 2000:26)

⁹² Developed by Sisana Majeke 2001: Appendix 2.5 to be given to participants with instructions for exercise

SESSION THREE TOPIC: Perceived meaning of terminology, such as the meaning of the term patriarchy.

METHODOLOGY / STRATEGY: Focus group discussions. Flip charts and marker pens

OBJECTIVE OF SESSION THREE

- To brainstorm and debate the meaning and arrive at a shared definition of the term patriarchy, give examples and recommendations of their role in relation to patriarchy.

INSTRUCTIONS TO PARTICIPANTS

I shall ask learners, as participants, to divide into their established groups and then reunite for the plenary feedback section to share their views. Members of the groups will be asked to say what comes to their minds when they hear or think of the term patriarchy. In addition, learners will be asked to state other examples of patriarch and further, to make suggestions of what they regard as their role in relation to patriarchy, based on the following question: what should young men and women (youth) do regarding the influence of patriarchy in sexual decision-making and in the spread of HIV infection?

- I shall give flip charts and marker pens for them to use to record their views in preparation for plenary feedback. In the plenary section, four group representatives will give feedback and debate the meaning of the above stated terms for 40 minutes, based on the group views.
- Duration of the exercise: 30 minutes
- To have a scribe to write their views, a leader and a time controller

APPENDIX 2.5.1 FACILITATOR'S SUMMARY FOR END OF SESSION THREE⁹³

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day**.....**Date**.....**Time:** From...to.....

SESSION THREE TOPIC: Perceived meaning of terminology, such as meaning of the term 'patriarchy'.

METHODOLOGY / STRATEGY:

Group discussion and facilitator's summary⁹⁴ for Session Three: Transparency and overhead projector or Power point slides plus laptop and projector⁹⁵.

SESSION THREE: SHARED MEANING OF TERMINOLOGY

I shall summarise the Session Three exercise to arrive at a shared meaning of patriarchy as the term is used in literature and organisations. I shall use a bigger font size to type the facilitator's summary, presented on transparency and overhead projector.

Patriarchy

In a patriarchal system, society is ruled by men, who control women at every level: legally, socially, economically and sexually. This domination takes different forms in different societies: exclusion from power-holding offices, disregard, insult, exploitation or violence. Linked to the system of patriarchy is the notion that men are superior to women. In this way of thinking women are seen as men's property.⁹⁶ I shall clarify the

⁹³ Developed by Sisana Majeke 2001: Appendix 2.5.1. Facilitator's summary for end of session three

⁹⁴ Bigger font size should be used to type the facilitator's end of session summary.

⁹⁵ Refer Appendix 2.5 for objective of session three and instructions to participants for exercise

⁹⁶ (DramAide, 2000: 74)

meaning and give examples of patriarchy and summarise recommendations of the various groups of their roles in relation to patriarchy and HIV prevention. I shall conclude by explaining that this Session Three exercise can help us to remember that it is important for all of us, thoroughly to understand the concept of patriarchy and know that we ourselves are influenced by gender-based inequalities such as patriarchy. We are socialised about such factors from during birth, infancy and throughout our lives. The gender-based skills programme is planned to make young people aware of such gender-based inequalities so that they know that they can change such inequalities that put them at risk of contracting HIV. I shall point out how these terms related to gender issues influence expectations of women's and men's behaviour⁹⁷.

In the next session of the exercise, we will examine how to apply the concepts of 'gender' and 'sex' and how these concepts, norms and role stereotypes influence our heterosexual relations, sexual decision-making and HIV prevention practices. Again, we shall serve refreshments to participants and collect the flip charts and the evaluation forms from the groups.

APPENDIX 2.6: SESSION FOUR: GENDER-BASED STEREOTYPES⁹⁸

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:..... **Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

⁹⁷ (de Bruyn and France, 2000:26)

⁹⁸ Developed by Sisana Majeke 2001: Appendix 2.6 to be given to participants with instructions for exercise

SESSION FOUR TOPIC: Gender-based stereotypes

METHODOLOGY / STRATEGY: Gender game. Small group exercise and debate

OBJECTIVE OF SESSION FOUR

To give female and male learners an opportunity to play the gender game with the aim of exploring how they learn how to apply the concepts of 'gender' and 'sex' and to identify gender-based stereotypes.

INSTRUCTIONS TO PARTICIPANTS

Learners should divide into their established group. They must be reminded that their groups will be re-united, after playing the gender game, for the plenary feedback section to debate their views. A sheet of paper will be handed out, describing the gender game, with the numbered list of statements⁹⁹ to each group and one member will read out each statement. The group should try to come to a consensus by writing "G" beside those statements they think refer to gender, "S" beside those they think refer to sex and "G and S" beside those they which think contain elements of both gender and sex. These statements can be adapted to the local situations. Or one sheet of paper with a numbered list of the same statements may be given to each group member, if sufficient copies are available. They may mark them individually, and compare their answers.

- Each group of learners will be asked to discuss and answer the gender game questions after they have marked their list.

Ask each group to have a time controller and a volunteer who will report to the plenary session on their behalf.

I shall remind participants that in the plenary section, four group representatives will give feedback and debate the marking they made based on the group's understanding of the list of statements and answers they gave to gender game questions for 10 per group minutes.

- Duration of the exercise as a whole: 30 minutes

⁹⁹ Attached as Appendix 2.6 A: GENDER GAME

APPENDIX 2.6.A SESSSION FOUR: GENDER GAME¹⁰⁰

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION FOUR TOPIC: Gender-based stereotypes

METHODOLOGY / STRATEGY: Gender game. Small group exercise and debate¹⁰¹

APPENDIX 2.6.A GENDER GAME¹⁰²

1. Women give birth to children, men don't.
2. Girls are delicate or gentle, boys are tough.
3. Among agricultural workers in India, women receive 40-60% of the wages that men do.
4. Women in sub-Saharan Africa contribute an average of 70% of the labour for household and market food production, yet rural women are poorer than men and have lower levels of literacy, education, health and nutrition.
5. Many women do not make decisions with autonomy, especially regarding sexuality and couple relationships.
6. Men's voices change with puberty, women's voices do not.
7. Women's risk for HIV infection is determined by their partners' sexual behaviour.
8. Women can breastfeed babies, men can bottle-feed babies.
9. In ancient Egypt, men stayed at home and did weaving. Women managed household affairs. Women inherited property and the men didn't.
10. In Great Britain, the majority of people working in construction are men.
11. Women should breastfeed babies because the mother-child bond will be less strong if they do not.
12. Men must have male children to carry on the family line.
13. In 1999, adolescent males in Uganda thought that having a child could enhance their status and prove their manhood: "We are fond of impregnating the girls." "It is normal to have a child."
14. 1 in 4 girls and 1 in 8 boys in South Africa will have their "sexual debut" through force, coercion or abuse before they reach the age of 14 years.
15. Of the estimated 6-7 million persons around the world who inject drugs, four-fifths are men.

¹⁰⁰ Developed by Sisana Majeke 2001: Appendix 2.6 A to be given to participants with instructions in Appendix 2.6

¹⁰¹ Refer Appendix 2.6 for objective of session four and instructions to participants for exercise

¹⁰² (de Bruyn and France, 2000:19) NB: These statements can be modified and adapted to the local situations by the facilitators.

APPENDIX 2.6.B SESSSION FOUR: GENDER GAME QUESTIONS¹⁰³

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION FOUR TOPIC: Gender-based stereotypes

METHODOLOGY / STRATEGY: Gender game. Small group exercise and debate¹⁰⁴

APPENDIX 2.6.B: GENDER GAME QUESTIONS TO ANSWER¹⁰⁵

- Did the statements surprise you? If so, why, and if not, why not?
- How do you think that gender contributes to the differences seen in various statements?
- Why do you think that gender roles vary among societies, cultures and historical periods?
- How do age, race and class interact with gender to determine our social roles? Do any other factors have an influence?
- Who benefits from the gender divisions between men and women and what are some of the disadvantages for both women and men?

¹⁰³ Developed by Sisana Majeke 2001: Appendix 2.6. B. : To be given to participants with instructions in Appendix 2.6

¹⁰⁴ Refer Appendix 2.6 for objective of session four and instructions to participants for exercise

¹⁰⁵ (de Bruyn and France, 2000:19) NB: These questions can be modified and adapted to the local situations by the facilitator

APPENDIX 2.6.1 FACILITATOR'S SUMMARY FOR END OF SESSION FOUR¹⁰⁶

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day:**.....**Date:**.....**Time:** From...to.....

SESSION FOUR TOPIC: Gender-based stereotypes

METHODOLOGY / STRATEGY:

Group discussion and facilitator's summary¹⁰⁷ for Session Four: Transparency and overhead projector or Power point slides plus laptop and projector¹⁰⁸.

SESSION FOUR: SHARED MEANING, APPLICATION OF CONCEPTS OF 'GENDER' AND 'SEX' AND IDENTIFICATION OF GENDER-BASED STEREOTYPES

I shall summarise the exercise on gender-based stereotypes by re-emphasising the aim of Session Four as follows:

- AIM:**
1. To facilitate an understanding and application of the concepts 'gender' and 'sex'
 2. To sensitise learners on gender and sexual identities
 3. To facilitate an understanding and identification of gender-based stereotypes and their implications.

I shall begin my summary of the Session Four exercise by clarifying the meaning of gender and sexual identities and the concepts 'stereotype' and 'gender-based stereotypes'

¹⁰⁶ Developed by Sisana Majeke 2001: Appendix 2.6.1. Facilitator's summary for end of session four

¹⁰⁷ Bigger font size should be used to type the facilitator's end of session summary.

¹⁰⁸ Refer to Appendix 2.6 for objective of session four and instructions to participants for exercise

as they are used in literature and organisations, as outlined below. I shall emphasise that this exercise was conducted with to increase understanding of and ability to be sensitive to gender-based stereotypes. I shall re-emphasise that the summary I shall be presenting at the end of this session will assist participants to arrive at shared meanings of these concepts and to identify gender-based stereotypes.

✚ **Gender and sexual Identity¹⁰⁹:**

Gender identity refers to the socially constructed roles adopted by men and women. The existence and perpetuation of sexual and gender identities are culturally and historically defined. Gender roles influence the clothing, behaviour, thoughts, feelings and relationships, considered appropriate or inappropriate for members of each gender.

Gender identity refers to how one thinks of one's own gender – whether one thinks of oneself as a man (masculine) or as a women (feminine). Society often prescribes arbitrary rules (how one is supposed to dress, act, think, feel, relate to others, think of oneself) based on one's sex (whether one has a vagina or a penis). These gender roles are called 'feminine' and 'masculine'. People who do not abide by these rules may be targeted for mistreatment, ranging from being excluded from a circle of friends, being ignored, snide comments, verbal harassment, assault, rape and even murder.

Sexual identity means the physical differences and the expression of these differences between men and women. Sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes. Sexual identity refers to the way we think of ourselves and others in terms of those we are sexually attracted to, specifically members of the same sex or members of the opposite sex.

Stereotype and gender-based role stereotypes

1. Stereotype

A stereotype is an idea not necessarily based on fact. It reflects subjective opinion about things and people and it is often associated with bad characteristics of a category of people.¹¹⁰

¹⁰⁹ (DramAide, 2000:74)

2. Gender-based role stereotypes

Gender- based role stereotypes refer to beliefs that are so ingrained or accepted in our consciousness that many of us think that they are ‘natural’ and do not question them, such as:

- A person’s masculinity or femininity
- Socially defined behaviour that people are expected to conform to. These are qualities that are nurtured in one gender based on the different activities men and women usually carry out as a result of social norms. For example, women are usually shown in the media as housewives, child minders or secretaries. Men are shown as doctors, household heads, managers, newspaper readers.

3. Stereotypes used to describe men and women¹¹¹

Women are stereotype as being	Men are stereotype as being
Emotional	Unemotional
Illogical	Logical and rational
Temperamental	Controlled and stable
Physical weak	Strong
Unassertive	Assertive, aggressive
Caring	Witty
Timid	Independent
Creative	Conformist
Gentle	Brave
Sympathetic	Rough
Verbally gifted	Silence

I shall re-emphasise that these characteristics of women and men are not fixed, and are changing, and this serves as evidence that the stereotypes are also changing.¹¹² Thereafter, I shall conclude the Session Four exercise by giving students feedback on whether

¹¹⁰ (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998:Card 2)

¹¹¹ (Devenish, Funnell and Greathead, 1992:111)

¹¹² (De Bruyn and France, 2000:4)

statements have been marked appropriately or inappropriately. I shall do this after the groups have presented and debated their answers to questions in the plenary session. I shall refer to the numbered list of statements with the most likely answers given in brackets beside each statement¹¹³ and explain reasons for the answers suggested in brackets and based on my understanding of the theories on which this study is based.¹¹⁴ I c These exercises will show us the importance of examining with a critical eye/ear our own experience and influences such as gender and sexual identities and gender-based stereotypes in our behaviour or in the media.¹¹⁵ We should be aware of the impact of gender-based stereotypes in our sexual decision-making process to reduce our vulnerability to STIs including HIV infection. In addition I shall re-emphasise that gender influences vary and interact with other factors. This means that they can be changed.¹¹⁶ I shall indicate that in the next sessions of exercises, the groups will examine issues of sex, STIs, including HIV and AIDS, and how these ideas, norms and gender-based role stereotypes influence heterosexual relations, sexual decision-making and HIV prevention.

APPENDIX 2.6.1.A. SESSSION FOUR: GENDER GAME FACILITATOR'S LIST¹¹⁷

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION FOUR TOPIC: Gender-based stereotypes

METHODOLOGY / STRATEGY: Gender game. Small group exercise and debate¹¹⁸

¹¹³ Attached as Appendix 2.6.1. A: GENDER GAME FACILITATOR'S LIST

¹¹⁴ See principal theories forming the framework of this study, as outlined in Chapter Two: Theoretical framework

¹¹⁵ (De Bruyn and France, 2000:26)

¹¹⁶ (De Bruyn and France, 2000:21)

¹¹⁷ Developed by Sisana Majeke 2001: Appendix 2.6.1. A.: GENDER GAME FACILITATOR'S LIST.

¹¹⁸ Refer Appendix 2.6 for objective of session four and instructions to participants for exercise

APPENDIX 2.6.1.A. GENDER GAME¹¹⁹ FACILITATOR'S LIST (with suggested answers)

1. Women give birth to children, men don't. (S)
2. Girls are delicate or gentle, boys are tough. (G)
3. Among agricultural workers in India, women receive 40–60% of the wages that men do. (G)
4. Women in sub-Saharan Africa contribute an average of 70% of the labour for household and market food production, yet rural women are poorer than men and have lower levels of literacy, education, health and nutrition. (G)
5. Many women do not make decisions with autonomy and freedom, especially regarding sexuality and couple relationships. (G)
6. Men's voices change with puberty, women's voices do not. (S)
7. Women's risk for HIV infection is determined by their partners' sexual behaviour. (G&S)
8. Women can breastfeed babies, men can bottle-feed babies. (S & G)
9. In ancient Egypt, men stayed at home and did weaving. Women managed household affairs. Women inherited property and the men didn't. (G)
10. In Great Britain, the majority of people working in construction are men. (G)
11. Women should breastfeed babies because the mother-child bond will be less strong if they do not. (S& G)

12. Men must have male children to carry on the family line. (G)
13. In 1999, adolescent males in Uganda thought that having child could enhance their status and prove their manhood: "We are fond of impregnating the girls." "It is normal to have a child." (G)
14. 1 in 4 girls and 1 in 8 boys in South Africa will have their "sexual debut" through force, coercion and abuse before they reach the age of 14 years. (G)

15. Of the estimated 6-7 million persons around the world who inject drugs, four-fifths are men. (G)

APPENDIX 2.7: SESSSION FIVE: ISSUES OF SEX¹²⁰

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females** € **Males** €

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

¹¹⁹ (de Bruyn and France, 2000:19) NB: These statements can be modified and adapted to the local situations by the facilitator.

¹²⁰ Developed by Sisana Majeke 2001: Appendix 2.7 to be given to participants with instructions for exercise

SESSION FIVE TOPIC: Issues of sex

METHODOLOGY / STRATEGY: Focus group discussions. Flip charts and marker pens

OBJECTIVES OF SESSION FIVE

To encourage learners to discuss issues around sex and sexuality and to share common synonyms of terms used in relation to issues of sex and sexuality.

- To allow participants to explore, outline and share information that they learnt from various channels or sources of sex education and what they learnt from those sources.

INSTRUCTIONS TO PARTICIPANTS

I shall ask participants to divide into their established groups and remind them that their groups will be re-united after conducting this exercise on issues of sex for the plenary feedback section to share and debate their views.

I shall hand out a sheet of paper with the list of terms used for the language of sex and related issues¹²¹ to each group. The groups of learners will provide the list of synonyms used in their community for each term and answer the questions.¹²² Or I may hand out one sheet of paper with the same list of terms used in the language of sex to each group member, if sufficient copies are available, and allow them to answer them individually and to compare their answers with others in their group. Each group of participants, will discuss sources of information on sex and what they learnt from their sources of information, after they have listed synonyms of terms used. Each group nominates a leader who will or report back to the plenary session on their behalf and also a time controller. Participants will be reminded that in the plenary section, four group representatives will give feedback based on the group views and debate for 40 minutes.

- Duration of the exercise: 30 minutes

¹²¹ Attached as Appendix 2.7 A: List of terms used for the language of sex and sex-related issues

¹²² Attached as Appendix 2.7.B: Questions to answer for the terms used for the language of sex and related issues

APPENDIX 2.7.A SESSSION FIVE: TERMS USED FOR THE LANGUAGE OF SEX AND RELATED ISSUES¹²³

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION FIVE TOPIC: Issues of sex

METHODOLOGY/ STRATEGY: Focus group discussions. Flip charts and marker pens¹²⁴

APPENDIX 2.7.A. TERMS USED FOR THE LANGUAGE OF SEX AND RELATED ISSUES¹²⁵

- male genital organs
- female genital organs
- breasts
- sexual activity
- condoms
- STIs
- HIV/AIDS

¹²³ Developed by Sisana Majeke 2001: Appendix 2.7. A. to be given to participants with instructions in Appendix 10.7

¹²⁴ Refer Appendix 2.7 for objectives of session five and instructions to participants for exercise

¹²⁵ (de Bruyn and France, 2000:21) NB: These terms can be modified, added, reduced and adapted to the local situations.

APPENDIX 2.7.B SESSSION FIVE: QUESTIONS TO ANSWER ¹²⁶

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females** € **Males** €

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION FIVE TOPIC: Issues of sex

METHODOLOGY/ STRATEGY: Focus group discussions. Flip charts and marker pen¹²⁷

APPENDIX 2.7.B.: QUESTIONS TO ANSWER FOR EACH TERM USED FOR THE LANGUAGE OF SEX AND RELATED ISSUES¹²⁸:

1. Which synonyms are most acceptable for use in your community?
2. Which synonyms are most acceptable for use by young people?
3. What barriers keep young people from using, in the presence of adults, terms used for issues of sex that are acceptable in communicating with adolescents?

APPENDIX 2.7.1 FACILITATOR'S SUMMARY FOR END OF SESSION FIVE¹²⁹

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

¹²⁶ Developed by Sisana Majeke 2001: Appendix 2.6. B. : To be given to participants with instructions in Appendix 2.7

¹²⁷ Refer Appendix 2.7 for objective of session five and instructions to participants for exercise

¹²⁸ (de Bruyn and France, 2000:22) NB: These questions can be modified and adapted to the local situations by the facilitator

¹²⁹ Developed by Sisana Majeke 2001: Appendix 2.6.1. Facilitator's summary for end of session five.

Intervention session number:Day.....Date.....Time: From...to.....

SESSION FIVE TOPIC: Issues of sex

METHODOLOGY/ STRATEGY:

Group discussion and facilitator's summary¹³⁰ for Session Five: Transparency and overhead projector or Power point slides plus laptop and projector¹³¹.

I shall / can summarise this exercise on issues of sex by re-emphasising the aim of Session Five as follows:

- AIM:** 1. To determine common terms and encourage female and male learners, as participants to become comfortable discussing terms used for different sexual organs, sexual acts and consequences of issues around sex and sexuality.¹³²
2. To determine what the best source (s) of information will be for female and male adolescents to learn about issues around sex and sexuality and to sensitise them on the importance of identifying reliable resources.¹³³

I shall begin the summary at the end of Session Five exercise by writing the different words on a flip chart and inviting participants to write additional terms¹³⁴ used in issues of sex and sex-related issues to create a glossary of these terms. In addition, I shall discuss with participants what they reported having learned in order to verify what has been reported during the feedback session and to encourage them to talk openly about their doubts and ask questions. I shall answer questions and clarify ambiguities, referring to suitable authorities. I shall emphasise that this exercise is important and will contribute to learners's understanding of terms used in issues of sex and sex-related issues and the ability of participants and facilitators to talk to young people in their own language. This exercise will encourage young people to use the words that they feel most comfortable with and learn about those that are acceptable in their communities and which do not

¹³⁰ Bigger font size should be used to type the facilitator's end of session summary.

¹³¹ Refer to Appendix 2.7 for objectives of session five and instructions to participants for exercise.

¹³² Refer to Chapter 5: Session five results for what transpired during session five

¹³³ Refer to Chapter 5: Session five results for what transpired during session five

¹³⁴ (de Bruyn and France, 2000:23)

contribute to negative images of women and men¹³⁵. Thereafter, I shall focus on what participants learned about sex from different sources by discussing differences between individual experiences, as well as how sources of information on sexual issues can have positive or negative aspects. I shall emphasise the importance of finding reliable sources. People can possess basic information related to sexual issues and still believe in myths.¹³⁶ For example they know that unsafe sexual activity can lead to pregnancy and sexually transmitted infections (STIs) including HIV but believe it is impossible for a girl to become pregnant or for a boy or girl to contract STIs, including HIV, the first time s/he has a sexual encounter.

I shall conclude the Session Five by re-emphasising that girls and boys often receive conflicting messages during their socialisation process. For example, in Zulu culture, it is forbidden for girls to have sex before or outside marriage, while nothing is said if boys gain sexual experience before and outside marriage. Such differences contribute to inequalities in sexual decision-making between girls and boys.¹³⁷ I shall thank learners for their input, ensure that they are served refreshments and the response sheets and evaluation forms are collected.

APPENDIX 2.8: SESSSION SIX: SEXUALLY TRANSMITTED INFECTIONS (STIS), HIV AND AIDS¹³⁸

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....Group number:..... Females € Males €

Intervention session number: Day:..... Date:..... Time: From...to....

¹³⁵ (de Bruyn and France, 2000:23)

¹³⁶ (de Bruyn and France, 2000:24)

¹³⁷ (de Bruyn and France, 2000:24)

¹³⁸ Developed by Sisana Majeke 2001: Appendix 2.8 to be given to participants with instructions for exercises

SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

METHODOLOGY / STRATEGY: Focus group discussions. Flip charts and marker pens
Role-play and games

OBJECTIVES OF SESSION SIX

- To provide female and male learners with an opportunity to express their perceptions about factors that they think put them at risk of contracting STIs, including HIV.
- To encourage female and male learners to re-inforce and demonstrate their understanding of STIs, HIV, AIDS and HIV prevention.

Material: Session six

- Same material as outlined in Appendix 10 plus the following additional material for Session Six:
 - Boxes of female and male condoms
 - STIs, HIV and AIDS Cards
 - HIV and AIDS Board Game

INSTRUCTIONS TO PARTICIPANTS

I shall ask learners to divide into their groups, and remind learners that their groups will be re-united after conducting exercises on STIs, HIV and AIDS for the plenary feedback section. Each group will be asked to present a volunteer or nominate a leader who will be a scribe and who will debate or report to the plenary session on their behalf for 2 minutes, on the first section of Session Six and also to have a time controller for the group. The group will be required to nominate or have volunteers who will be their representatives to demonstrate how they conducted peer education in the second section for 8 minutes and how they played the games for 10 minutes in the third section of Session Six during the plenary feedback section.

Sheets of paper will be handed out indicating that Session Six is divided into three sections, with instructions guiding learners on how to conduct each exercise during this session within a specific time-frame. Participants will be informed that the first and second sections of Session Six will be conducted on one day while the third section will be conducted on the following day.

First section of Session Six: Discuss what puts you, as young people at risk of getting STIs and HIV and AIDS. Strategy: Focus group discussion. Duration: Ten minutes.

Second section of Session Six: Conduct role-play as an exercise to show how to conduct peer education to your age-group friends about STIs, HIV/AIDS basic facts.¹³⁹ Duration: 20 minutes = 30 minutes in all.

Third section (on the following day): Play the two games¹⁴⁰ on STIs, HIV risk, transmission and prevention and AIDS. Duration: 30 minutes. Group representatives to report to plenary.

APPENDIX 2.8.A SESSSION SIX: STIs, HIV AND AIDS: SOME BASIC FACTS¹⁴¹

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

¹³⁹ Attached as Appendix 2.8. A. STIs, HIV and AIDS: Some basic facts

¹⁴⁰ Attached as Appendix 2.8.B.1 HIV/AIDS, STDs Card game and Appendix 2.8.B.2 HIV/AIDS Board game

¹⁴¹ Developed by Sisana Majeke 2001: Appendix 2.8. A. to be given to participants with instructions in Appendix 2.8

METHODOLOGY / STRATEGY: Role-play on Peer education of age-group friends
about some basic facts of STIs, HIV and AIDS ¹⁴²

APPENDIX 2.8.A. STIS, HIV/AIDS: SOME BASIC FACTS¹⁴³

1. HIV and AIDS

- What does HIV mean?
- What happens when HIV enters the body?
- What does AIDS mean?
- What is the difference between HIV and AIDS?
- How does a person know that s/he has HIV and AIDS?
- How does HIV spread?
- How can young people protect themselves from HIV?
- **2. Sexually transmitted diseases / infections (STDs or STIs)**
- What does STD or STI mean?
- What are the common types of STIs that you know of?
- What causes STDs or STIs?
- How does a person become at risk of getting HIV if having STIs?
- How does a person know if s/he has a STI?
- How can a person protect herself/himself from STIs and HIV?

¹⁴² Refer Appendix 2.8 for objectives of session six and instructions to participants for exercises

¹⁴³ Developed by Sisana Majeke 2001 from various sources of literature that will be cited in facilitator's summary

3. Care and support of people living with HIV and AIDS

- How can a person give care and support to people who are living with HIV and AIDS?
- How can a person prevent the spread of HIV infection while taking care of people who are living with HIV and AIDS at home?
- How should a person deal with dying people and death at home?

APPENDIX 2.8.B.1. SESSSION SIX: STIs, HIV AND AIDS CARD GAME ¹⁴⁴

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....Group number..... Females € Males €

Intervention session number: Day..... Date..... Time: From...to....

SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

METHODOLOGY / STRATEGY: STIs, HIV AND AIDS CARD GAME¹⁴⁵

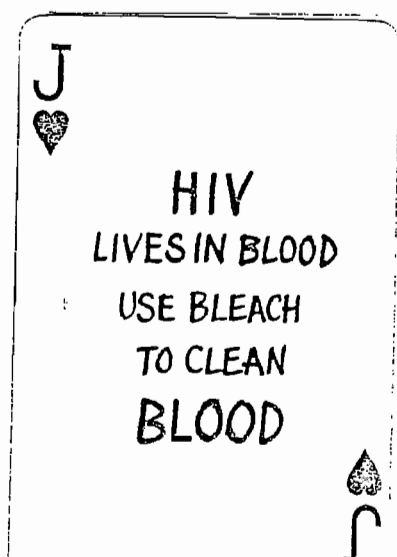
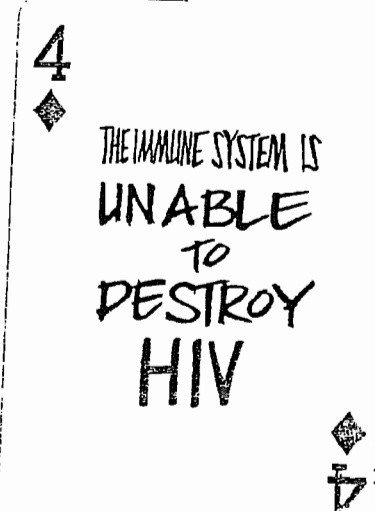
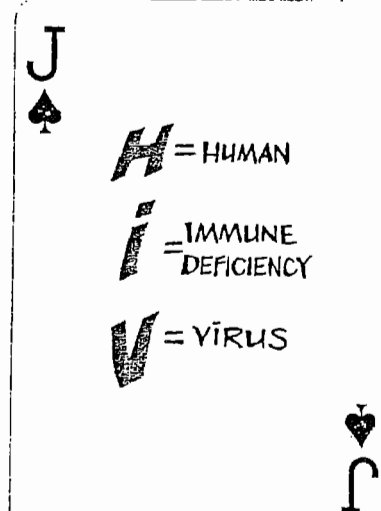
APPENDIX 2.8.B.1. STIS, HIV and AIDS CARD GAME¹⁴⁶

See pages 368 to 377 for STIS, HIV and AIDS CARD GAME

¹⁴⁴ Developed by Sisana Majeke 2001: Appendix 2.8.B.1. To be given to participants with instructions in Appendix 2.8

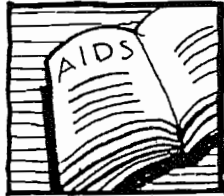
¹⁴⁵ Refer Appendix 2.8 for objectives of session six and instructions to participants for exercise

¹⁴⁶ Appendix 10.8.B.1 STIs, HIV and AIDS Card Game (Department of Health KwaZulu-Natal Province)



4
♠

DONT BE
AFRAID

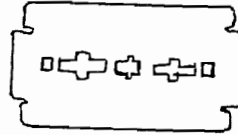


FIND OUT
ABOUT AIDS!

♥
7

2
♥

HIV LIVES IN
THE BLOOD OF
PEOPLE WITH HIV



DONT SHARE
BLADES

♥
2

3
♥

MEN, WOMEN &
CHILDREN OF ALL
RACES

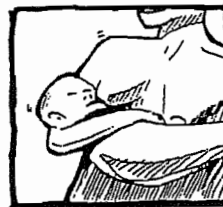


CAN GET AIDS

♥
3

Q
♠

BREASTFEEDING



CAN PASS THE
HIV FROM A
MOTHER TO CHILD

♥
Q

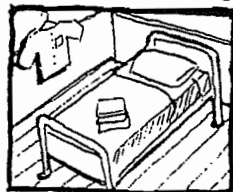
5
♠

YOU CAN'T
GET HIV
FROM HUGGING
& TOUCHING OR
FROM WORKING
WITH A PERSON
WITH AIDS

♥
5

K
♠

YOU CAN'T
GET AIDS




FROM DRY BED LINEN
CLOTHES OR TOWELS

♥
K

8
♦ TOGETHER
WE CAN


AIDS
♦ 8

4
♥ YOU CAN'T
GET AIDS

FROM SHARING
FOOD, PLATES,
FORKS & KNIVES
♠ 7

8
♣ AFTER YEARS
LIVING WITH
HIV
A PERSON DIES OF
AIDS
♣ 8

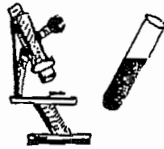
9
♣ TREAT BOTH
PARTNERS FOR
STD
OR WE'LL KEEP
INFECTING
EACH OTHER
♣ 6

8
♥ A LOT OF
TEENAGERS
WON'T REACH
AGE OF 30
BECAUSE OF
AIDS
♠ 8

10
♣ LETS UNITE
FIGHT AIDS
& BUILD A
STRONG NATION

♣ 01

K
♣

WE CAN'T SEE
HIV



ONLY WITH A
SPECIAL
BLOOD TEST

♣
K

7
♦

IN AFRICA



THE HIV VIRUS
IS HIGHEST IN
25-35 YEAR OLD
MALES &
15-25 YEAR OLD
FEMALES

♦
7

JOKER

TB
IS NO
JOKE

JOKER

6
♠

PROLONGED FEVER,
SWOLLEN GLANDS,
DIARRHOEA,
LOSS OF WEIGHT
& EXTREME NIGHT
- SWEATS -
ARE COMMON
SIGNS OF HIV
INFECTION

♥
6

7
♥

EVERYONE
HAS THE RIGHT
TO SAY
NO
TO UNSAFE
SEX

♠
7

7
♠

IMMUNE
DEFICIENCY

- MEANS THE -
BODY CANNOT FIGHT
GERMS & VIRUSES

♥
7

9
♠



SEX
WITH NO
CONDOM
IS RISKY

♥
6

8
♠

ANY SEXUALLY
TRANSMITTED
DISEASE
CAN HELP SPREAD
HIV

♥
8

A
♠

A = ACQUIRED

I = IMMUNE

D = DEFICIENCY

S = SYNDROME

♥
A

6
♥

RASH,
DROP & SORES
CAN BE SIGNS
OF AN
STD

♠
9

9
♥

A PERSON WITH
AIDS



NEEDS OUR DAILY
HELP & LOVE

♠
6

A
♦

THERE IS
NO CURE



**FOR
AIDS**

♦
A

Q
♣

CONDOMS

PROTECT US



AGAINST
SEX DISEASE

♣
0

10
♥

HIV

CAN NOT BE
SPREAD BY
MOSQUITOES

♥
01

Q
♦



SOME STD'S
SHOW NO
SIGNS OR PAIN
GET CHECKED

♦
0

10
♠

BSERVE
AND CARE FOR
ONE ANOTHERS
HEALTH

♠
01

K
♦

AIDS DOES NOT
DISCRIMINATE



ITS A WORLDWIDE
CONCERN

♦
X

**AIDS
HELP
LINE**

0800 012 322
TOLL FREE

5
♣

HIV
IS FOUND IN
MEN'S & WOMEN'S
SEXUAL FLUIDS
& BLOOD

♣
5

JOKER

AIDS
IS NO
JOKE

JOKER

4
♣

AN UNBORN
CHILD



CAN GET HIV
FROM ITS MOTHER

♣
4

7
♣

A PERSON WITH
HIV



LOOKS LIKE
YOU OR ME

♣
7

3
♣

A BALANCED
DIET IN HIV
INFECTED PERSONS
IMPROVES HEALTH

♣
3

6
♣

MOST BABIES
BORN WITH
HIV



DIE AT A VERY
YOUNG AGE

♣
9

5
♥

MOST
PEOPLE WITH
HIV
HAVE HAD A
STD

5
♠

J
♣

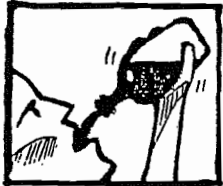


TB
IS CURABLE



2
♣

TOO MUCH
ALCOHOL



CAN LEAD TO
UNPROTECTED SEX

2
♣

2
♠

STOP THE SPREAD
OF AIDS



USE A CONDOM
FOR EACH ROUND



A
♣

FAITH HEALERS
& SPECIAL DIETS



CANNOT CURE AIDS

A
♣

9
♦

DO YOU BURN
WHEN URINATING?



SEE YOUR
CLINIC

6
♦

6
♦

IF YOU THINK
YOU HAVE AIDS
CONSULT
YOUR
DOCTOR

♦
9

Q
♥

HIV/AIDS AVOIDS
PEOPLE WHO PRACTICE
SAFER SEX
WHAT DO YOU
PRACTICE?

♥
8

3
♠

BE OPEN



TALK ABOUT SEX &
SEXUAL DISEASES

♥
2

K
♥

MORE
SEX PARTNERS



INCREASES YOUR
CHANCES OF GETTING
HIV

♠
X

5
♦

ONE LIFE LONG
FAITHFUL PARTNER



COULD SAVE
YOUR LIFE

♦
5

A
♥

DON'T BE IN
THE DARK



KNOW YOUR
PARTNER'S
SEXUAL
HISTORY

♠
A

10



MANY
NEW-BORN BABIES



ARE BLIND FROM
THEIR MOTHER'S
STD



01

APPENDIX 2. 8. B. 2. SESSSION SIX: HIV AND AIDS BOARD GAME¹⁴⁷

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....


SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

METHODOLOGY / STRATEGY: HIV AND AIDS BOARD GAME¹⁴⁸

APPENDIX 2.8.B.2. HIV AND AIDS BOARD GAME plus INSTRUCTIONS ON HOW TO PLAY¹⁴⁹

INSTRUCTIONS ON HOW TO PLAY HIV AND AIDS BOARD GAME

respond negatively towards sick swap them with a friend. poster and revise how the immune



How to play the board game

The board game on pages 4 and 5 of this week's ReadRight is based on Snakes and Ladders. A minimum of two and a maximum of four players can play. Each player throws the dice. The player with the highest score starts. The player moves forward the number thrown. Each player has a turn to throw and move his or her token. Players move up ladders and down snakes. The first player to reach the Finish square wins.

A supplement from Sunday Times,
ReadRight, 01 September 2001, page 6

¹⁴⁷ Developed by Sisana Majeke 2001: Appendix 2.8.B.2. To be given to participants with instructions in Appendix 2.8

¹⁴⁸ Refer Appendix 2.8 for objectives of session six and instructions to participants for exercise

¹⁴⁹ Appendix 2.8.B.2 HIV and AIDS Board Game and instructions on on how to play the board game (ReadRight, a supplement to the Sunday Times, 2001:5)

Finish

WINNER

25 Never touch
somebody
else's
blood.

24 **FALSE:**
You can get
AIDS from
knives and forks.

23 Miss a turn.

22 **FACT:**
Anyone can
get AIDS.

15 It's okay to
hug somebody
with AIDS.

16 A friend has a
bloody nose.
You call an adult.
Throw again.

17 You can get AIDS
from infected blood
entering your
bloodstream.

18 **FALSE:**
You can get AIDS
from sneezing or
coughing.

19 **FACT:**
You can get
AIDS from
unprotected sex.

20 You find
used syri
and call
adult. Thi
again.

13 Kiss
somebody
you love.
Move
onward one
space.

12 **FALSE:**
You can get AIDS
from kissing.

10 The AIDS
virus attacks your
T-cells. Your T-cells
fight germs.

9 The HIV virus is
very small.
You cannot
see it.

8 **FALSE:**
You can get AIDS
from mosquitoes.

7 **FACT:**
There
no cure
for AIDS

2 Miss a turn.

3 **FALSE:**
You can get AIDS
from swimming in
pools. Move back
one space.

4 **HIV** is a virus.
It causes **AIDS**.

5 Make a
GET WELL
card for a friend.
Move forward one
space.

Start

**BOARD
GAME**

APPENDIX 2.8.1 FACILITATOR'S SUMMARY FOR END OF SESSION SIX¹⁵⁰

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day**.....**Date**.....**Time:** From...to.....

SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

METHODOLOGY/ STRATEGY

Group discussion and facilitator's summary¹⁵¹ for Session Six: Transparency and overhead projector or Power point slides plus laptop and projector.¹⁵² I shall summarise this exercise on STIs, HIV and AIDS by re-emphasising the aim and strategies used in Session Six as follows:

- AIM: 1.** To determine the factors contributing to youth's vulnerability to STIs, HIV and AIDS, using focus group discussions.
- 2.** To assess learners' knowledge and re-inforce their understanding of STIs, HIV and AIDS, including HIV risk, transmission and prevention, using role-play and games.

I shall begin my summary of the end of Session Six exercises by discussing with participants what they reported in the first section of Session Six as factors that increase their risk to STIs, including HIV and AIDS. This discussion should verify what has been reported during plenary feedback. This will encourage learners to talk openly about these

¹⁵⁰ Developed by Sisana Majeke 2001: Appendix 2.8.1. Facilitator's summary for end of session six.

¹⁵¹ Bigger font size should be used to type the facilitator's end of session summary.

¹⁵² Refer to Appendix 2.8 for objectives of session six and instructions to participants for exercise.

factors, including their fears, experimentation¹⁵³ and will encourage them to ask questions. I shall answer participants' questions and clarify their ambiguities in an honest manner and also refer to other factors raised in relevant literature.

I shall further summarise the first section of Session Six by asking learners to respond verbally to the following exercise on other factors that increase risk behaviour:

First section of Session Six summary: Oral exercise on other factors promoting STIs/HIV risk behaviour.

	Young people are at risk of STIs/HIV because of:	In the Community	Among my friends	Me
1	Sexual interest, strong curiosity and desire			
2	Sex drive strong and demanding			
3	Ill informed about sexual matters			
4	Don't talk to adults about sexual activity			
5	Sexual experimentation with more than one partner is common			
6	Many teens experiment with drugs			
7	Teen sexual encounters are unplanned and therefore unprotected			
8	Embarrassment, inexperience and lack of knowledge make it difficult for teenagers to talk about safer sex with a partner			
9	Teenagers are reluctant to buy, carry and use condoms			
10	Teenagers seldom use protection against pregnancy and STDs			
11	When teenagers are in love they do what a partner wants in order to keep him/her			

Adapted from *The Complete Guide to Safer Sex* by Ted McIlvenna, Exodus Trust 1987¹⁵⁴

I shall conclude session six by encouraging participants to write down and find out the meaning of any new words, because learning about HIV will involve learning lots of new

¹⁵³ As will be outlined in Chapter Five: Results of session six of this study.

¹⁵⁴ (Devenish, Funnell and Greathead, 1992:243)

terms, some of which they do not know yet. After a while they will find that they have learnt things they would never have expected. For many people who are living with HIV and AIDS, the meaning of the words associated with HIV and AIDS do not mean very much until they are explained.¹⁵⁵ Thereafter, I shall summarise the basic facts about STIs, HIV and AIDS to re-emphasise what participants demonstrated during the plenary feedback section through role-play, on peer education of age-group friends about some basic facts of STIs, HIV and AIDS. Card and board games will be used in the second and third sections of Session Six.

1. HIV and AIDS: Some basic facts



Meaning of HIV:

- HIV stands for Human Immunodeficiency Virus.
- HIV is a virus that attacks the body's immune system which protects the body against illness
- Immunodeficiency means 'reduced immunity'.
- A virus is a genetic organism that can only reproduce inside cells of another living organism. Antiviral drugs are used to reduce multiplication of viral infections.
- Examples of viral infections that affect people with HIV include Hepatitis A, B and C; cytomegalovirus (CMV); herpes (HSV)¹⁵⁶

Viral load: Levels of HIV are measured using viral load, the risk of catching HIV is high when HIV comes in contact with broken skin or through cells close to the surface of the skin. The risk is highest when the viral load levels are high.

CD4 cell refers to cell (lymphocyte) in the body's immune system. CD4 cells are also used by HIV as factories to reproduce in.¹⁵⁷

¹⁵⁵ (Treatment training for advocacy, 2001:2)

¹⁵⁶ (Treatment training for advocacy, 2001:2; PPASA. 2000:67)

¹⁵⁷ (Treatment training for advocacy, 2001:13)

✚ **What happens when the HIV virus enters the body?**

When the HIV virus enters the body, it attacks millions of cells. The body is normally protected from disease by an immune system. The HIV virus invades this immune system and destroys it by killing the white blood cells that safeguard the body against illness. As a result, it is no longer able to fight off life-threatening infections and diseases such as pneumonia and tuberculosis¹⁵⁸.

✚ **Meaning of AIDS:**

- AIDS stands for Acquired Immune Deficiency Syndrome
- Acquired — because it is largely an infection that people catch
- Immune — because it relates to your body's immune system
- Deficiency — because it reduces your body's immune system
- Syndrome — because it describes a collection of different infections and illness caused by HIV¹⁵⁹.

- A syndrome is a group of symptoms or illnesses originating from one cause. AIDS is therefore a collection of diseases resulting from the breakdown of the immune system after it has been invaded and weakened by HIV¹⁶⁰.

✚ **The difference between HIV and AIDS:**

- HIV is a virus which invades the immune system and destroys it by killing the white blood cells
- AIDS is a disease caused by HIV, which is therefore a collection of diseases resulting from the breakdown of the immune system after it has been invaded and weakened by the HIV

¹⁵⁸ (Treatment training for advocacy, 2001:2; PPASA, 2000:67)

¹⁵⁹ (Treatment training for advocacy, 2001:2; PPASA, 2000:67))

¹⁶⁰ (Visagie, 2000:23)

✚ **Can you identify a person who is HIV positive by looking at her or him?**

- HIV cannot be identified by looking at someone who is infected. It can be identified when the result of HIV blood test is HIV positive.

➤ **How does a person know that s/he has AIDS?**

Refer to the World Health Organisation (WHO) staging system of HIV infection and Disease that outlines the clinical stages and associated conditions or illnesses including AIDS defining conditions¹⁶¹.

How does HIV spread and how can a person protect herself or himself from HIV?

I shall re-emphasise ways of preventing HIV infection that young people should be aware by referring to literature.¹⁶² I shall summarise HIV transmission and prevention in the following tabular format:

1.1. Way / mode of HIV spread /transmission	1.2. Way / means/ methods of HIV prevention
1. Sexual intercourse	Abstaining, using a good condom, being faithful to one partner after both partners have tested HIV negative excluding window period, testing for HIV
2. Needle-sharing or sharing of contaminated sharp objects such as needles, razors	Do not use contaminated instruments or sharp objects to pierce the skin. Always use a new needle or razor or syringe, proper sterilization of the re-usable objects, taking medicine by mouth rather than injections
3. Blood transfusions	Thorough screening of blood at medical institutions and hospitals
4. During pregnancy, labour, breast feeding (mother to child transmission of HIV infection)	Use of condoms, ARVs during pregnancy, Nevirapine during labour, exclusive breastfeeding for 6 months to prevent mother-to-child-transmission of HIV (PMTCT) to the baby.

¹⁶¹ Attached as Appendix 2.8.1 .1 WHO Staging system of HIV infection and Disease

¹⁶² Such as (HIV transmission, 2001; PPASA, 2000, Visagie, 2000:20; Treatment training for advocacy, 2001; PPASA. 2000)

✚ **The spread of the HIV virus is prevented by¹⁶³**

- Abstaining from sex until both of you are HIV tested and the results are negative, after excluding the window period. Thereafter remaining faithful to one partner. .
- Being faithful to one partner for life
- Using a good quality condom, properly and always when involved in sexual activity
- Using a new needle and syringe for medical reasons and not for drug abuse
- Taking medicines or drugs by mouth rather than injections, whenever possible.
- Sharing food, plates, glasses or utensils
- Handling money
- Using someone's pen or pencil
- Shaking hands
- Sitting on a toilet seat
- Being bitten by a mosquito
- Being sneezed on
- Hugging
- Holding hands

2. Sexually transmitted diseases/infections (STDs or STIs)

- **What does STD or STI mean and what are examples of common STDs or STIs?**

Sexually transmitted disease (STD) or sexually transmitted infection (STI) refers to a disease or infection that is spread through unprotected sexual encounters; these include the drop, gonorrhea, syphilis and herpes.

- **What causes STDs or STIs and how does a person know if s/he is having STIs?**

Sexually transmitted infections are caused by micro-organisms such as bacteria. If you suspect that you have STIs, visit a health centre or doctor and encourage your partner to have a check-up because STIs can be easily cured with antibiotics. STI symptoms

¹⁶³ (HIV transmission, 2001:4; PPASA, 2000:69)

include abnormal discharge from the genitalia, burning on passing urine, rashes, blisters or sores on the genitalia. Women are less likely to have obvious symptoms of STIs¹⁶⁴.

- **How does a person become at risk of getting HIV if having STIs?**

People who have STIs are more at risk of getting the HIV virus because STIs can cause sores on the private parts making it easier for HIV to gain entry through broken skin or sores¹⁶⁵

- **How can a person protect herself/himself from STIs and HIV?**

HIV is a STI because you can get it from having unprotected sex. You can protect yourself and prevent the spread of STIs, including HIV, by always using a condom when engaging in sexual activity or by wearing protective materials such as gloves when handling body fluids such as blood from a person¹⁶⁶

3. Care and support of people living with HIV and AIDS¹⁶⁷

- **How can a person give care and support people who are living with HIV and AIDS?**

A person could give support to people with HIV and AIDS by being close to them, treating them like any other person who is not infected and putting on gloves if s/he comes into contact with body fluids, providing moral support and also keeping them active and involving them in numerous day to day activities. Giving them attention and love. Letting them know that they can live a positive life with HIV and AIDS.

¹⁶⁴ (HIV transmission, 2001; PPASA, 2000, Visagie: AIDS Policy, Treatment training for advocacy, 2001; PPASA. 2000) Soul City, 2001:8)

¹⁶⁵ (Soul City, 2001:8)

¹⁶⁶ (Soul City, 2001:8)

¹⁶⁷ (Soul City, 2001:26)

- **How can a person prevent the spread of HIV infection while taking care of people who are living with HIV and AIDS at home?**¹⁶⁸

One could prevent the spread of HIV infection while taking care of people with HIV at home by making sure that new sharp instruments are used and all sharp instruments such as needles and razors are discarded after use. It is also essential to keep all eating utensils, linen, clothing thoroughly washed and clean. In addition, make use of gloves when dressing infected people if they have sores or physical openings or if you come into contact with their body fluids.

- **How should a person deal with dying people and death at home?**¹⁶⁹

Death is not an easy matter as everybody handles death differently. One should be a friend to the one dying and reassure them to reduce anxiety and comfort the family members of the one who is terminally ill or who has passed away.

I shall conclude the summary of the second section of Session Six by advising participants to conclude their peer education on facts of STIs, HIV and AIDS by:

1. Inviting questions from their friends and providing answers to his/her questions!
2. Thanking your friend for her time and inviting your friends to come again if needing further clarification. Give her pamphlets to read about STIs, HIV and AIDS.

Thereafter, I shall conclude Session Six exercise by discussing with participants and giving them feedback on whether the games have been played appropriately or if not. I shall offer advice, after the groups have presented and debated and demonstrated their peer education role-play and played their STIs, HIV and AIDS card and board games. I shall encourage participants to ask questions and answer them. I shall also encourage participants to share what they have learned with their friends and to apply what they have learned in the sessions of intervention programme to protect themselves from contracting HIV infection.

¹⁶⁸ (Soul City, 2001:34)

¹⁶⁹ (Soul City, 2001:42)

I shall indicate that having examined how gender influences affect our ideas and expectations about women's and men's behaviour and how STIs including HIV can spread or can be prevented, in the next sessions of exercises, we will examine life skills in relation to issues of sex, assertiveness, negotiation and sexual decision-making skills to prevent STIs, including HIV and AIDS. These ideas, norms and gender-based role stereotypes influence our heterosexual relations, and HIV prevention practices.

I shall ensure that refreshments are served to participants and collected the response sheets and evaluation forms from the groups of participants.

APPENDIX 2.8.1.1 FACILITATOR'S SUMMARY FOR END OF SESSION SIX:

WHO Staging System for HIV Infection and Disease¹⁷⁰

Research Project Title: School - going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day:**.....**Date:**.....**Time:** From...to.....

SESSION SIX TOPIC: Sexually transmitted infections (STIs), HIV and AIDS

METHODOLOGY/ STRATEGY: Group discussion and facilitator's summary¹⁷¹ for Session Six: Transparency and overhead projector or Power point slides plus laptop and projector¹⁷².

¹⁷⁰ Developed by Sisana Majeke 2001: Appendix 2.8.1.1. Facilitator's summary for end of session six :

¹⁷¹ Bigger font size should be used to type the facilitator's end of session summary.

¹⁷² Refer to Appendix 2.8 for objectives of session six and instructions to participants for exercise.

APPENDIX 2.8.1.1 WHO STAGING SYSTEM FOR HIV INFECTION AND DISEASE

Clinical Stage	Associated conditions
1	Acute retroviral infection
2	2. Asymptomatic
	3. Persistent generalised lymphadenopathy
2	Weight loss <10% bodyweight
	Minor mucocutaneous manifestations
	Herpes zoster within last 5 years
	Recurrent upper respiratory tract infections
3	Weight loss >10% body weight
	Unexplained chronic diarrhoea >1 month
	Unexplained prolonged fever > 1 month (intermittent or constant)
	Oral candidiasis
	Vulvo-vaginal candidiasis > 1 month or not responsive to therapy
	Oral hairy leucoplakia
	Pulmonary TB within the last year
	Severe bacterial infection (e.g. pneumonia)
4 (AIDS defining conditions)	HIV wasting syndrome
	Pneumocystis carinii pneumonia
	Toxoplasmosis of the brain >1 month
	Cryptosporidiosis with diarrhoea
	Cryptosporidiosis, extrapulmonary
	Cytomegalovirus infection (other than spleen, liver or lymph nodes)
	Herpes simplex infection >1 month or visceral any duration
	Progressive multifocal leuco-encephalopathy
	Any disseminated endemic mycosis e.g. histoplasmosis
	Candidiasis of oesophagus, trachea, bronchi or lungs
	Atypical mycobacteriosis – disseminated
	Non-typhoidal salmonella septicaemia
	Extra-pulmonary TB
	Lymphoma
	Kaposi's sarcoma
	HIV encephalopathy

APPENDIX 2.9: SESSSION SEVEN: ASSERTIVENESS AND SEXUAL DECISION-MAKING SKILLS¹⁷³

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....Group number..... Females € Males €

Intervention session number: Day..... Date..... Time: From...to....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decision-making skills

METHODOLOGY / STRATEGY: Role-play

OBJECTIVE OF SESSION SEVEN

- To provide female and male learners with an opportunity to learn and demonstrate their understanding of life skills such as assertiveness and sexual decision-making skills

INSTRUCTIONS TO PARTICIPANTS

- Ask learners, to divide into their established groups and re-unite the groups for the plenary feedback section to share their views with one another.
- Hand out a sheet of paper with two exercises. One exercise has an example of practicing assertiveness¹⁷⁴ and second exercise has statements¹⁷⁵ to which learners must respond. Ask learners to pretend that they are in those situations given to them as examples and to conduct a role-play showing how they would respond in response to those situations and statements. Each group of learners is asked to conduct a role-play as

¹⁷³ Developed by Sisana Majeke 2001: Appendix 2.9 to be given to participants with instructions for exercises

¹⁷⁴ Attached as Appendix 2.9. A. Example of assertiveness scenario for practice

¹⁷⁵ Attached as Appendix 2.9.B. Examples of statements commonly said by partners for sexual decision-making skills

an exercise to show understanding of assertiveness and how to make sexual decisions.

Duration of this section: Thirty minutes.

- Remind participants that in the plenary section, four group representatives will give feedback for 40 minutes by conducting a role-play to demonstrate their understanding of life skills such as assertiveness and sexual decision-making.

APPENDIX 2.9.A SESSSION SEVEN: EXAMPLE OF ASSERTIVENESS SCENARIO FOR PRACTICE¹⁷⁶

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females** € **Males** €

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decision-making skills

METHODOLOGY / STRATEGY: Role-play¹⁷⁷

APPENDIX 2.9.A. Example of assertiveness scenario for practice

You are a girl of 15 and you have been dating a guy of 23 for six months. You really love one another. Today your partner gives you a gift when you are going out dancing. After having been dancing with your partner as usual, for the first time he asks you to have sex with him afterwards. You do not want to have sex with him but you are scared he will leave you. What will you do?¹⁷⁸

¹⁷⁶ Developed by Sisana Majeke 2001: Appendix 2.9. A. to be given to participants with instructions in Appendix 2.9

¹⁷⁷ Refer Appendix 2.9 for objective of session seven and instructions to participants for exercise

¹⁷⁸ Appendix 2.9 A. Scenario developed by Sisana Majeke (Devenish, Funnell and Greathead, 1992:133, PPASA, 2000: 128)

APPENDIX 2.9.B SESSSION SEVEN: STATEMENTS COMMONLY MADE BY PARTNERS FOR SEXUAL DECISION-MAKING SKILLS ¹⁷⁹

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females €** **Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decision-making skills

METHODOLOGY / STRATEGY: Role-play ¹⁸⁰

Appendix 2.9.B. Example of statements commonly used by partners for sexual decision-making skills ¹⁸¹

What would you say?

The following is a list of statements that are frequently used to pressurise someone to have sex. If these were said to you, how would you respond? Read the statements in the first column and then demonstrate how you will respond if you find yourself in such situations.

¹⁷⁹ Developed by Sisana Majeke 2001: Appendix 2.9. B. to be given to participants with instructions in Appendix 2.9

¹⁸⁰ Refer Appendix 2.9 for objective of session seven and instructions to participants for exercise

¹⁸¹ Developed by Sisana Majeke 2001 from various sources of literature that will be cited in facilitator's summary

Appendix 2.9.B. Example of statements commonly used by partners for sexual decision-making skills ¹⁸²

Statements commonly said by partners	Say and demonstrate your responses to these statements or situations
1. I love you so much. If you love me too you would have sex with me	1.
2. I want to show you how much I love you	2.
3. Everyone is doing it	3.
4. It's natural ,you would enjoy it	4.
5. You 're so beautiful	5.
6. You owe it to me – I spent so much on you tonight	6.
7. Don't be so old fashioned	7.
8. If you don't have sex with me, I'll leave you	8.
9. Don't be a tease, you get me all excited and then decide you do not want us to have sex. It's not easy for guys you know.	9.
10. Why are you so frigid? I thought you loved me.	10.

¹⁸² Developed by Sisana Majeke 2001 from various sources of literature that will be cited in facilitator's summary

APPENDIX 2.9.1 FACILITATOR'S SUMMARY FOR END OF SESSION SEVEN¹⁸³

Research Project Title: School - going youth, sexuality and HIV prevention in
Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:**Day:**.....**Date:**.....**Time:** From...to.....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decision-making skills

METHODOLOGY/ STRATEGY:

Group discussion and facilitator's summary¹⁸⁴ for Session Seven: Transparency and overhead projector or Power Point slides plus laptop and projector¹⁸⁵.

I shall begin my summary of the end of Session Seven exercise by clarifying the meaning of the terms 'Life skills' and 'assertiveness'. I shall re-emphasise that the summary I will be presenting at the end of this session will assist participants to arrive at a shared meaning and application of the terms 'life skills' and 'assertiveness' as they are used in literature and organizations. I shall emphasise that this exercise is being conducted with the purpose of increasing understanding and application of life skills on assertiveness and decision-making skills in sexual relationships, to protect themselves and their loved ones from HIV infection.

Meaning of 'Life skills' and 'Assertiveness'

Life Skills

Life skills should provide ways of developing a supportive network of positive relationships at home, school, and in the broader community. By life skills we mean the skills that are needed for the challenges that face young people as they mature. In the context of the HIV and AIDS epidemic, these skills could also be called survival skills. 'Life Skills' also refers to an educational approach: they may differ according to social

¹⁸³ Developed by Sisana Majeke 2001: Appendix 2.9.1. Facilitator's summary for end of session six.

¹⁸⁴ Bigger font size should be used to type the facilitator's end of session summary.

¹⁸⁵ Refer to Appendix 2.9 for objectives of session seven and instructions to participants for exercise.

and cultural circumstances. Educators need to avoid being prescriptive and should develop skills that are practical in the given circumstances¹⁸⁶.

What is assertiveness?

Assertiveness is based on personal responsibility and awareness of the rights of other people. It is used to describe behaviour that a person can use to 'stand up' for him/herself and his/her rights, without violating the rights of others. Being assertive means being honest with yourself and others. It means having the ability to say directly what it is you want, you need or you feel, but not at the expense of other people¹⁸⁷.

It means having confidence in your self and being positive, while at the same time understanding other people's points of view. Being assertive means being able to negotiate workable compromises. Above all, assertiveness means having self-respect and respect for other people.

Assertiveness skills complement other communication skills, such as effective listening and giving clear messages. Without assertion skills, negotiation in both private and professional life is impossible. Assertion resolves small problems before they grow. It is different from submissiveness or aggression.

I shall emphasise the importance of assertiveness skills by outlining different types of behaviour, that will assist girls and boys in their negotiations and sexual decision-making skills such as the three steps to assertiveness, rules that guide assertive behaviour and tips to keep young people safe:

¹⁸⁶ (DramAidE, 2000:74)

¹⁸⁷ (Sullivan and Decker, 1998:164)

1. DIFFERENT TYPES OF BEHAVIOUR

Assertive behaviour	Aggressive behaviour	Passive/submissive behaviour
STEP 1 <ul style="list-style-type: none"> * Actively listen to what is being said and then show the other person that you both hear and understand * Respect yourself as well as the other person's rights and view/s. * Expect the same from others. 	<ul style="list-style-type: none"> * Put yourself first at the expense of others * Bully others 	<ul style="list-style-type: none"> * Put others first at your own expense * Have trouble saying 'No' * Apologise a lot
STEP 2 <ul style="list-style-type: none"> * Stand up for your own rights without violating the rights of others * Talk calmly: say what you think or feel. * Express your positive and negative feelings. * Be honest about your feelings, needs or ideas. Use 'I' statements. 	<ul style="list-style-type: none"> * Stand up for your own rights but with no thought about the other person's rights * Get your way no matter what * Ignore other people's rights * Be bossy and pushy 	<ul style="list-style-type: none"> * Take no action to assert or stand for your rights* * Remain silent when something bothers you
STEP 3 <ul style="list-style-type: none"> * Do not follow others * Think and make decisions * Say what you want to happen. * Be confident. 	<ul style="list-style-type: none"> * Believe that winning is everything * Achieve your own goals at the expense of others 	<ul style="list-style-type: none"> * Do whatever others ask even if it is very inconvenient * Give in to what others want. * Do anything to avoid conflict.

Table 2.9.1.1 developed by Sisana Majeke, 2001¹⁸⁸

¹⁸⁸ (PPASA, 2000: 129; Sullivan and Decker, 1998:166; Kangan Batman institute of TAFE & Eastern Seaboard, 2000: 5)

2. EXAMPLES OF ASSERTIVENESS SKILLS

2.1. GIVE EXAMPLES OF RULES THAT GUIDE ASSERTIVE BEHAVIOUR

- Avoid excessive apologising
- Have self confidence and believe in yourself
- Avoid defensive adverse reactions such as aggression, temper tantrums, backbiting, revenge, sarcasm and threats.
- Use appropriate body language that matches verbal message (e.g. eye contact, body posture, gestures, facial expression).
Accept manipulative criticism while maintaining responsibility for your decision – don't blame others.
- Calmly repeat a (negative) reply without justifying it or giving a reason.
- Be honest about your feelings, needs and ideas. Remember: Honesty is the best policy
- Use "I" statements.
- Accept and/or acknowledge your faults calmly without apology¹⁸⁹

2.2. Teen Tips to keep you safe¹⁹⁰

2.2.1 Pray to God to help you set limits

- Set limits and goals for yourself in life and in your relationship
- Know how physically intimate you are prepared to be with your partner
- Think about your goals and limits before you begin a negotiation

2.2.2 Assertiveness communication

- This is the key to satisfying relationship
- Discuss your limits with your partner
- Find out what your partner's limits are
- Both of you are responsible for keeping the limits you have discussed
- Do not guess at what your partner wants, ask him /her. If s/he says "NO"s/he means "NO"
- Discuss where you will go on the date. Choose a mutually acceptable venue and activity.

2.3. Be assertive

- Once you have made your decision about your limits, stick to them
- Your values are important. Do not compromise them for another person
- Men often interpret passivity for permission, so be assertive about your limits
- Adhere to your set goals to achieve them and your set limits to be safe and succeed

¹⁸⁹ Part of Appendix 2.9.1. Facilitator's summary of end of session seven (Sullivan and Decker, 1998:166)

¹⁹⁰ Part of 2.9.1.Facilitator's summary of end of session seven (Devenish, Funnell and Greathead, 1992:133, PPASA, 2000: 129; Sullivan and Decker, 1998:166)

2.4. Where to go

- Avoid dark and isolated places
- Go to places where you can participate in an activity with other people, e.g. ice skating, ten-pin bowling and other such places.
- If you feel at all uncomfortable alone with your date, rather group date until you feel more comfortable as a couple
- If you are in a situation that becomes uncomfortable, leave
- Always know how you will get home if necessary
- Make sure someone you trust knows where you are going
- Do not get stranded without money

2.5. Respect your partner

You have the right to determine your limits, likes and dislikes, and the rights to have these respected. Respect your partner's values.

2.6. Non-verbal messages

Be aware that dress and nonverbal behaviours may not be wrong, but may be misunderstood and interpreted differently from what was intended. Be aware of them and how they are being understood.

2.7. Alcohol and drugs

Avoid the use of these substances as they alter your thinking, behaviour and effective communication and make you vulnerable to risky behaviour.

2.8. Get help. For example counselling.

2.9. Avoid date rape

I shall conclude the Session Seven exercise by focusing on the application of assertiveness skills. This is done by discussing with participants and giving them feedback on what issues to consider and or questions to ask themselves. I shall encourage participants to ask questions and will answer them and encourage participants to share what they have learned with their friends and to apply gender exercises and the application of lifeskills such as assertiveness to protect themselves against HIV.

Thereafter, I shall indicate that in the next session of exercises, the groups will continue examining and applying life skills in relation to negotiation for abstinence, condom use and HIV prevention practices.

I shall ensure that they have served refreshments to participants and collected the response sheets and evaluation forms from the groups of participants since these can be useful in planning follow-up activities¹⁹¹ and to improve following sessions.

¹⁹¹ (de Bruyn and France, 2000:26)

APPENDIX 2.9.1.A. SESSSION SEVEN: FACILITATOR'S RESPONSE TO APPENDIX 2.9.A¹⁹²

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**
Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decision-making skills

METHODOLOGY/ STRATEGY:

Group discussion and facilitator's summary¹⁹³ for Session Seven: Transparency and overhead projector or power point slides plus laptop and projector¹⁹⁴.

APPENDIX 2.9.1.A. Facilitator's response to Appendix 2.9.A

APPENDIX 2.9.A. Example of assertiveness situation to practice

You are a girl of 15 years old and you have been dating a guy of 23 years old for six months. You really love one another. Today your partner gives you a gift when you are going out dancing. After dancing, for the first time he expects you to have sex with him afterwards. You do not want to have sex with him but you are scared your boy friend will leave you. What will you do?¹⁹⁵

APPENDIX 2.9.1.A. Facilitator's response to Appendix 2.9.A Issues for discussion and questions to consider prior to sexual decision-making¹⁹⁶

1. Issues for discussion prior to sexual decision-making:

- Length of relationship
- What is love?
- Reasons for having sex
- What are the girl's values and beliefs?
- Have these been discussed with her boyfriend?
- What are the boy's feelings?
- Is true love conditional?
- Options available?

¹⁹² Developed by Sisana Majeke 2001: Appendix 2.9.1. A.: Facilitator's response to Appendix 2.9.A

¹⁹³ Bigger font size should be used to type the facilitator's end of session summary.

¹⁹⁴ Refer to Appendix 2.9 for objectives of session seven and instructions to participants for exercise.

¹⁹⁵ Appendix 2.9 A. Scenario developed by Sisana Majeke (Devenish, Funnell and Greathead, 1992:133, PPASA, 2000: 128)

¹⁹⁶ (Devenish, Funnell and Greathead, 1992:133, PPASA, 2000: 129)

2: Questions to ask yourself prior to sexual decision-making¹⁹⁷

- a) Why do I want to have sex now?
- b) Do I believe sex is right or wrong at this stage and why?
- c) How will I feel about myself the next day?
How do I feel about my parents knowing? How would my parents react if they knew, and how would I deal with this?
- d) How well do I know my partner?
- e) How long have we had our relationship?
- f) Have we discussed sexual histories in our relationship?
- g) Have we considered the use of contraception? Am I able to take full responsibility for the consequences if contraceptive methods fail?
- h) What are the possible consequences if we have sex now?
- i) Do I have accurate information about sex?
- j) Can I be certain that I will not be exposed to sexually transmitted infections, including HIV, from my partner?

I shall emphasise that responses to most of the above stated questions differ according to individuals. I may outline the following as some of the possible responses to the latter / last three questions:

j) What are the possible consequences if we have sex now?

* The following risks/consequences of unprotected / unplanned sex are usually denied.

- Consider all risks such as:
 - Loss of your virginity/ chastity
 - Pregnancy
 - Sexually transmitted diseases
 - HIV/AIDS
 - Emotional pain

k) Do I have accurate information about sex?

- Knowing the real facts about sex can prevent common misconceptions, fears and disastrous consequences;
Knowing about the male and female anatomy and sexual responses are essential for a mutually fulfilling relationship.

l) Can I be certain that I will not be exposed to a sexually transmitted disease from my partner?

- Know each other well enough to discuss sexual histories, including your limits/goals
- If either partner is sexually active, the risk of sexually transmitted infections including HIV cannot be ignored
- The more sex partners one has had, the greater the risk of becoming infected.

¹⁹⁷ (Devenish, Funnell and Greathead, 1992:133, PPASA, 2000: 129)

**APPENDIX 2.9.1.B. SESSSION SEVEN: FACILITATOR’S RESPONSE TO
APPENDIX 2.9.B¹⁹⁸**

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher’s name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION SEVEN TOPIC: Life skills on assertiveness and sexual decission-making skills

METHODOLOGY/ STRATEGY: Group discussion and facilitator’s summary¹⁹⁹ for session seven: Transparency and overhead projector or power point slides plus laptop and projector²⁰⁰.

APPENDIX 2.9.1.B. Facilitator’s response to Appendix 2.9.B

APPENDIX 2.9.B: Example of statements commonly said by partners for sexual decision-making skills

What would you say?

The following is a list of statements that are frequently used to pressurise someone to have sex. If these were said to you, how would you respond? Read the statements in the first column and then say and demonstrate how you will respond to these statements or if you find yourself in such situations.

¹⁹⁸ Developed by Sisana Majeke 2001: Appendix 2.9.1. A.: Facilitator’s response to Appendix 2.9.B

¹⁹⁹ Bigger font size should be used to type the facilitator’s end of session summary.

²⁰⁰ Refer to Appendix 2.9 for objectives of session seven and instructions to participants for exercise.

APPENDIX 2.9.1.B. Facilitator's response to Appendix 2.9.B²⁰¹

Statements commonly said by partners	Suggested responses to these statements
1. I love you so much. If you love me too you would have sex with me	1. If you loved me you would respect my decision and not pressurise me
2. I want to show you how much I love you	2. There are other way of showing love
3. Everyone is doing it	3. Everyone is not doing it and I'm not doing it and I 'm not everyone
4. It's natural,you would enjoy it	4. I might , but I 'm not ready for that kind of involvement
5. You're so beautiful	5. Thank you ,but that doesn't change my decision
6. You owe it to me-I spent so much on you tonight	6. I enjoyed our date – but I don't owe it to you or anyone to have sex
7. Don't be so old fashioned	7. Not wanting sex does not mean I' m old fashioned
8. If you don't have sex with me, I'll leave you	8. Sex should not be conditional. If that is your only interest in me ,then maybe we don't have much common
9. Don't be a tease, you get me all excited and then decide you do not want us to have sex. It's not easy for guys you know.	9. I'm not teasing you. I just don't want to go that far.
10. Why are you so frigid? I am very disappointed and I thought you loved me.	10. True love can wait and it is not conditional.

I shall ensure that they have served refreshments to participants and collected the response sheets and evaluation forms from the groups of participants since these can be useful in planning follow-up activities²⁰² and to improve following sessions.

²⁰¹ (Devenish, Funnell and Greathead, 1992:116, PPASA, 2000: 126)

APPENDIX 2.10: SESSSION EIGHT: ABSTINENCE NEGOTIATION ²⁰³

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION EIGHT TOPIC: Life skills on Abstinence negotiation

METHODOLOGY / STRATEGY: Role-play

OBJECTIVE OF SESSION EIGHT

- To provide female and male learners with an opportunity to demonstrate their understanding of life skills on abstinence negotiation through role-play in relation to HIV prevention.

INSTRUCTIONS TO PARTICIPANTS

- Ask learners to divide into their established groups and re-unite the groups for the plenary feedback section to share their views.
- Hand out a sheet of paper with two exercises: one exercise with an example of a negotiation scenario²⁰⁴ and the second exercise with abstinence negotiation scenario,²⁰⁵ both for role play practice. Ask learners to pretend that they are in the situations given to them as examples and conduct a role-play, acting out how they will respond to those questions or behave in those situations. Each group of learners is asked to conduct a role-play as an exercise to show their understanding of negotiation and applying assertiveness skills. Duration of this exercise: Thirty minutes.
- Remind participants that in the plenary section, four group representatives will give feedback by conducting a role-play to demonstrate their understanding of life skills on negotiation and abstinence negotiation role-play for 40 minutes.

²⁰² (de Bruyn and France, 2000:26)

²⁰³ Developed by Sisana Majeke 2001: Appendix 2.10 to be given to participants with instructions for exercises

²⁰⁴ Attached as Appendix 2.10.A. Negotiation scenario for role-play practice

²⁰⁵ Attached as Appendix 2.10.B. Abstinence negotiation scenario for role-play practice

APPENDIX 2.10.A SESSSION EIGHT: NEGOTIATION SCENARIO ²⁰⁶

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION EIGHT TOPIC: Life skills on Abstinence negotiation

METHODOLOGY / STRATEGY: Role-play ²⁰⁷

APPENDIX 2.10.A. Negotiation scenario for role-play practice ²⁰⁸

A girl goes to visit her boyfriend unexpectedly. She wants to talk, but the boyfriend has another plan in place: he tells her that he wants to play basketball. After discussion for few minutes, they plan plan to meet after his basketball to talk.

Questions for discussion

- What worked in the negotiation? Why?
- What would you do in the same situation?

²⁰⁶ Developed by Sisana Majeke 2001: Appendix 2.10. A. to be given to participants with instructions in Appendix 2.10

²⁰⁷ Refer Appendix 2.10 for objective of session eight and instructions to participants for exercise

²⁰⁸ Appendix 2.10. A. Negotiation scenario for role-play practice (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4)

APPENDIX 2.10.B SESSSION EIGHT: ABSTINENCE NEGOTIATION SCENARIO²⁰⁹

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number...**Females € Males €

Intervention session number: **Day**..... **Date**..... **Time:** From...to....

SESSION EIGHT TOPIC: Life skills on Abstinence negotiation

METHODOLOGY / STRATEGY: Role-play²¹⁰

Appendix 2.10.B. Abstinence negotiation scenario for role-play practice²¹¹

A girl and boy have been involved for a few months. They have not yet had sex. The boy would like to, but he is uncertain because the girlfriend keeps saying that she needs to wait until she is sure. After some discussion, he agrees to wait.

OPTION A

They get into other topics of conversation and leave to meet friends (Implying that they can still have a good time together as usual).

OPTION B

They leave to go have a drink. After a couple of beers, he tries to seduce her. Though feeling less confident, she says that beer should not make them change their minds and she suggests going to sit with friends.

QUESTIONS FOR DISCUSSION

- Is it right for a girl to refuse sex with her boyfriend?
- Why did the boy agree? (For boys:) Would you agree? Why or why not? What should the couple do if they cannot agree?
- Do boys sometimes feel pressured to have sex before they are ready?
- Do boys prefer to marry a girl who is a virgin? Why? If so, why do they pressure some girls to have sex?
- Do girls think boys are always after sex and how do they feel about it?

²⁰⁹ Developed by Sisana Majeke 2001: Appendix 2.10. B. to be given to participants with instructions in Appendix 2.10

²¹⁰ Refer Appendix 2.10 for objective of session eight and instructions to participants for exercise

²¹¹ Appendix 2.10.B. Abstinence negotiation scenario for role-play practice (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4) NB: To be given to participants.

- For option B: What should the couple do when, after alcohol or drug use, reasonable discussion becomes difficult?

APPENDIX 2.10.1 FACILITATOR'S SUMMARY FOR END OF SESSION EIGHT²¹²

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number:Day.....Date.....Time: From...to.....

SESSION EIGHT TOPIC: Life skills on Abstinence negotiation

METHODOLOGY/ STRATEGY: Group discussion and facilitator's summary²¹³ for session eight: Transparency and overhead projector or power point slides plus laptop and projector²¹⁴.

Facilitator's response to Appendix 2.10.A Negotiation scenario for role-play

I shall begin the summary of the end of Session Eight exercise by emphasising that the summary I shall be presenting for the end of this session will assist participants to arrive at a shared meaning and application of the term 'negotiation' as it is used in literature and organizations. I shall emphasise that this exercise will be conducted with the purpose of increasing their understanding and application of life skills on negotiation and decision-making skills in their sexual relationships. Exercises on negotiation and abstinence negotiation key points will be discussed below for sexual decision-making skills.

²¹² Developed by Sisana Majeke 2001: Appendix 2.10.1. Facilitator's summary for end of session eight.

²¹³ Bigger font size should be used to type the facilitator's end of session summary.

²¹⁴ Refer to Appendix 2.10 for objectives of session seven and instructions to participants for exercise.

↓ **Key points to address in the discussion by facilitator for the negotiation role-play**

▪ **Meaning of negotiation**

Negotiation involves going through a decision-making process together and making a joint decision. It also involves each person being able to express herself or himself and each person listening to the other's view point. Both people need to be respectful, caring and willing to compromise²¹⁵.

▪ **What worked out in the negotiation? Why?**

The couple considered their different opinions together without one dominating or deciding for both. Both partners were respectful, caring and willing to compromise²¹⁶.

Facilitator's response to Appendix 10.10.B Abstinence negotiation role-play

Thereafter, I shall conclude the Session Eight exercise by re-emphasising the importance of assertiveness skills and teen tips to keep young people safe. These were discussed in the previous session, in the negotiation process. I shall focus on discussing with participants and giving them feedback to consider for abstinence negotiation role-play. This can be done, after the groups have conducted their role-play

Key points for the facilitator to address in discussion for abstinence negotiation role-play²¹⁷

- In role-plays, people pretend they are in a certain situation and act as they think people in that situation would.
- Each couple needs to discuss and decide what is 'right' for their individual relationship, sexually or otherwise. There is no rule about when a sexual relationship

²¹⁵ (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4)

²¹⁶ (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4)

²¹⁷ (de Bruyn, Jackson, Wijermans, Knight and Berkwens, 1998, Card 4; PPASA, 2000:119).

should begin (you could ask: “What is the rule? Sex after one week? Or is it two months and three days?”).

- Bring up the fact that boys also can be pressured into sex, especially due to role expectations. A boy is often expected to lose his virginity as soon as he gets the chance, to want sex with a girl whenever he can get it, or to have sex with a willing girl even if he is committed in another relationship. People often think that boys do not have the same emotional attachment to their partners that girls have, when in fact many boys do, and they may prefer to wait for sex with a girl they care for and trust.
- Give time to girls and boys to discuss how it feels for them being pressured into sex.
- Discuss the influence of alcohol and drugs on previously made agreements. Remind young people to avoid the use of these substances as they alter people’s thinking, behaviour and effective communication and make one vulnerable to risky behaviour.
- Explain the difference between relationships based on love compared to those based on sex. The relationship built on love involves caring for each other’s feelings. It involves commitment and ensures that the continuity of the relationship is safeguarded regardless of decisions taken about sexual activity. A relationship with sex as a foundation will collapse. A relationship can survive without sex but not without love.

I shall conclude the Session Eight exercise by referring to what I said on issues of sex and what participants learned about sex by re-emphasising that girls and boys often receive conflicting messages during their socialisation process. For example, in Zulu culture it is disapproved of for girls to have sex before and outside of marriage while it is taken as normal if boys gain sexual experience before and outside of marriage. Such differences contribute to inequalities in sexual decision-making between girls and boys.

I shall encourage participants to ask questions and will answer them accordingly and also encourage participants to share what they have learned with their friends and to apply what they have learned in the sessions of the intervention. This will empower them,

influenced by the gender exercises, life skills on assertiveness, negotiation for abstinence, safer sex and sexual decision-making skills, to protect themselves from HIV.

Thereafter, the facilitator can indicate that in the following sessions of exercises, the group will continue examining and applying life skills in relation to negotiation for condom use and HIV prevention practices.

My assistants and I will ensure that we have served refreshments to participants and collected the response sheets and evaluation forms.

APPENDIX 2.11: SESSSION NINE: LIFE SKILLS ON CONDOM NEGOTIATION²¹⁸

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females** € **Males** €

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION NINE TOPIC: Life skills on condom negotiation

METHODOLOGY / STRATEGY: Role-play

OBJECTIVE OF SESSION NINE

To provide female and male learners with an opportunity to learn and demonstrate their understanding of life skills on condom negotiation through role-play in relation to HIV prevention.

²¹⁸ Developed by Sisana Majeke 2001: Appendix 2.11 to be given to participants with instructions for exercises

MATERIAL: SESSION NINE

- Same material as outlined in Appendix 2.10 plus the following additional material for Session Nine:

Boxes of female and male condoms (for demonstration on how to use condoms and for any learners who may wish to take condoms)

INSTRUCTIONS TO PARTICIPANTS

- Ask learners to divide into their established groups and re-unite the groups for the plenary feedback section.
- Hand out a sheet of paper with an exercise detailing questions for discussion and a condom negotiation scenario²¹⁹ for role-play practice. Ask learners to pretend that they are in that situation and to conduct a role-play showing how they would respond to the questions and behave in response to that situation. Each group of learners is asked to conduct a role-play to show their understanding of condom negotiation by applying assertiveness skills. Duration of this exercise: Thirty minutes.
- Remind participants that in the plenary section, four group representatives will give feedback by conducting a role-play.

²¹⁹ Attached as Appendix 2.11.A. Condom negotiation scenario for role-play practice

APPENDIX 2.11.A SESSSION NINE: NEGOTIATION SCENARIO²²⁰

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....**Group number:**..... **Females € Males €**

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION NINE TOPIC: Life skills on condom negotiation scenario

METHODOLOGY / STRATEGY: Role-play²²¹

APPENDIX 2.11.A. Negotiation scenario for role-play practice²²²

A boy and girl have been involved for few years and they want to have sex. The girl suggests the use of condoms, but the boy is against it. They discuss why it is not a matter of trust, but safety. The girl encourages her partner, saying that they can make it enjoyable through foreplay. The boy agrees to try it.

Questions for discussion

- Is faithfulness (or trust or honesty) enough to protect people?
- Was the girl right in suggesting condoms?
- What worked well in resolving the problem?
- If the boy respected the girl's choice this time, is it fair to say that next time she should do as he wants, if he doesn't want to use condoms?

²²⁰ Developed by Sisana Majeke 2001: Appendix 2.11. A. to be given to participants with instructions in Appendix 2.11

²²¹ Refer Appendix 2.11 for objective of session nine and instructions to participants for exercise

²²² Appendix 2.11. A. Condom negotiation scenario (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4)

APPENDIX 2.11.1 FACILITATOR'S SUMMARY FOR END OF SESSION NINE ²²³

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's name: Sisana Majeke

Institution: University of Natal

Pseudonym of School:.....

Intervention session number: **Day:**..... **Date:**..... **Time:** From...to....

SESSION NINE TOPIC: Life skills on condom negotiation

METHODOLOGY/ STRATEGY:

Group discussion and facilitator's summary²²⁴ for Session Eight: Transparency and overhead projector or Power Point slides plus laptop and projector²²⁵.

Facilitator's response to Appendix 2.11.A Condom negotiation scenario for role-play

I shall begin my summary of the end of the Session Eight exercise by emphasising that this exercise was conducted to increase understanding and application of life skills on condom negotiation and decision-making skills in our sexual relationships. The exercise on condom negotiation will be discussed below for sexual decision-making skills with reference to literature and organisations.

Key points to be addressed in the discussion of the condom negotiation role-play

- The couple took time to think about their opinions before having sex. They exchanged advice and considered the consequences of their different options. They listened to and respected one another: the boy agreed to the girl's wishes, but she also recognised his discomfort and suggested ways to make the option more appealing for both of them²²⁶.
- Fairness is not simply a matter of alternating options when the consequences of the options differ greatly. For example, the couple cannot say "This time we'll risk some discomfort and next time we'll risk disease and pregnancy."²²⁷.
- This time the boy and girl concluded that the consequences of sex without condoms such as pregnancy, STIs, including HIV, would be much worse than the consequences of sex with condoms that involves adjusting to discomfort. The next time they want to have

²²³ Developed by Sisana Majeke 2001: Appendix 2.11.1. Facilitator's summary for end of session nine.

²²⁴ Bigger font size should be used to type the facilitator's end of session summary.

²²⁵ Refer to Appendix 2.11 for objectives of session nine and instructions to participants for exercise.

²²⁶ (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4)

²²⁷ de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4) .

sex, they may go through the decision-making process again, but the differences between these sets of consequences will not change. If the potential consequences are so great, and two individuals cannot reconcile themselves to the same option, they may want to reconsider whether they want to be sexually involved²²⁸.

I shall summarise this exercise on condom negotiation role-play by re-emphasising the aim of Session Nine:

AIM: 1. To facilitate an understanding and awareness of “safer” sex and to provide an understanding of how to use condoms
2. To increase awareness of condoms and how to negotiate with your partner about condom use.

I shall write the concept ‘safer sex’ on the flip chart or transparency or Power Point slide and ask participants to say what the word means. I shall summarise the end of the Session Nine exercise by re-emphasising that my purpose is to increase learners’ understanding of ‘safe’ and ‘safer sex’ in the context of assertiveness and abstinence and/or condom negotiation skills. I may use my flip chart or transparencies and overhead projector or Power Point slides to outline feedback based on the aims of Session Nine, referring to literature to arrive at a shared meaning of ‘safe’ and ‘safer sex’ and how to use condoms.

- **What is safer sex?²²⁹**

Introduction:

‘Safe’ means having no negative consequences. ‘Safer’ means reducing negative consequences. In the sexual connotation, ‘safe’ means no negative consequences at all. In general, STIs (including HIV), pregnancy, cervical cancer and emotional hurt from exploitation are negative consequences. Condoms reduce the risk of transmission of STIs including HIV and also prevent pregnancy.

The concept of ‘safer sex’ was introduced with the advent of AIDS, and should be seen in the context of reducing the risks of sexual activity. Although AIDS is a deadly disease and cannot be cured, other problems associated with early sexual intercourse and multiple partners can also have devastating consequences. Many educators (and some parents) have seen the teaching of young people ways of reducing the risks associated with sex as the same as giving them permission to be sexually active. But the fear of pregnancy or of contracting STIs including HIV may not stop teenagers from becoming sexually involved. Reducing the risks and consequences can be seen in the same light as teaching safer driving techniques to prevent or reduce the incidence of car accidents.

²²⁸ (de Bruyn, Jackson, Wijermars, Knight and Berkvens, 1998: Card 4) NB: To be given to participants.

²²⁹ (Visagie, 2000:23; PPASA,2000:227)

Safer sex empowers people to take responsibility for themselves and not to rely on others. This is a new concept in many cultures where previously only one of the partners decided about the use of preventive methods. The clarification of the concept of 'safer sex' should be used in the context of assertiveness training for learners in this session:

Condoms were primarily used to prevent unwanted pregnancies but are now also used to prevent STIs, including HIV.

Safe sex means

- Abstinence from sexual activity, meaning not having sex at all. It is your choice to say 'NO' to a sexual encounter.

Safer sex means

- Having a long-term relationship with a faithful, uninfected partner.
- Only having sex while using a condom and using it correctly.
- Taking a sexual history, HIV test before having sexual intercourse
- Always using condoms properly during sexual encounters
- Masturbation is safe provided there is no exchange of blood or body fluids such as seminal and vaginal fluids.
- Hugging and cuddling is permissible.
- Acting out fantasies, dancing, sexy movements are also permissible.
- ❖ I shall conduct for participants the exercise of demonstrating how to use condoms properly in their respective groups:
 - Give each participant a male condom and a female condom
 - Ask them to check for the expiry date
 - Ask them to open the packet of a male condom first and handle it and lastly to open the packet of a female condom and handle it
 - Encourage them to open, smell and feel the texture of each condom
 - Once the group is feeling more comfortable about touching condoms, discuss how they felt about the exercise.

Some participants will not wish to participate and should not be made to feel awkward. If they are comfortable talking about their feelings it may be useful to discuss why they are unwilling to participate in the exercise.

- Using a Dildo, cucumber, banana or other appropriately shaped object, demonstrate how to put on a male condom
- Using a round object to simulate the female genital organ, demonstrate how to put on a female condom
- Discuss with the group of participants:

- removal and disposal of condoms

-prices of condoms

- storage of condoms

This exercise should be carried out in a relaxed environment where the educator is comfortable with demonstrating condoms. It is important to obtain permission from the headmaster, group leader or parents before carrying out this exercise.

Benefits of safer sex

- Opportunity to get to know each other better
- Opportunity to develop trust and affection
- A chance for each individual to do what he/she feels is right for him/her, rather than what is expected
- An opportunity for reducing the risk of STIs, pregnancy and other negative consequences of sexual activity.

Towards the end of Session Nine I shall give the following feedback to the whole group on how to negotiate with a partner about condoms:

Table 2.11.1 How to negotiate or talk to your partner about condoms²³⁰

If your partner says:	You can say:
I'm on the pill, you don't need a condom	We need to use one anyway because the Pill doesn't Kill germs. Only a condom will protect us both from infections we may not know we have
I know I'm clean, I am free of disease. I haven't had sex with anyone in months.	Thanks for telling me. As far as I know, I'm disease-free, too. But I still want to use a condom since either of us could have an infection and not know it
I'm a virgin	I'm not. This way we'll both be protected
I can't feel a thing; it's like wearing a raincoat	Even if you lose some feeling, you'll still have plenty left and the condom has enough lubricant, that will increase the feeling
I'll lose my erection if I stop to put it on	I'll help you put it on and that will help you keep it

²³⁰ (Modified from PPASA, 2000:239)

If your partner says:	You can say:
By the time you put it on, I'm out of the mood	Don't worry, I'll help you stay in the mood! OR Maybe so, but we feel strongly enough about each other to stay in the mood
It kills the romantic atmosphere	It doesn't have to be that. It's up to us to keep the romantic atmosphere going.
Condoms are unnatural, fake, a turn-off	Please, let's be sensible and remember that STIs such as HIV infection are not so great either. Let's try a condom, it will protect us from STIs/HIV.
What else can we do?	Maybe we'll just pet, and postpone sex for a while.
What an insult! Do you think I'm some kind of diseased slut or stud?	I didn't say that. I care for you, but in my opinion, it's best to use a condom and be safe.
None of my other boyfriends ever used a condom. A real man isn't afraid	Please don't compare me with them. A real man cares about the woman he dates, himself and their health.
I love you! Would I give you an infection?	Not on purpose! But most people don't know they're infected. That's why this is best for both of us right now.
Just this once	Once is all it takes
I don't have a condom with me	I do.
You carry a condom around with you? You were planning to have sex with me!	I always carry a condom with me because I care about myself. I have one with me tonight because I care about us both.
I won't have sex if you're going to use a condom	So, let's put it off until we can agree.

I shall encourage participants to ask questions and to share what they have learned with their friends. They should apply what they have learned in the sessions of intervention programme to protect themselves from contracting HIV.

Thereafter, I shall indicate that having examined life skills on assertiveness, sexual decision-making and abstinence and condom negotiation skills, we have come to the end of the nine sessions of the intervention programme. I shall thank the learners for their participation in the intervention programme and invite them to the next session, the thanksgiving ceremony as outlined in Session Ten of Appendix 2.

Refreshments will again be served to participants and the response sheets and evaluation forms collected.

APPENDIX 2.12: CERIFICATE OF APPRECIATION



**UNIVERSITY OF NATAL
GENDER STUDIES
FACULTY OF HUMAN SCIENCES**

CERIIFICATE OF APPRECIATION

PRESENTED TO

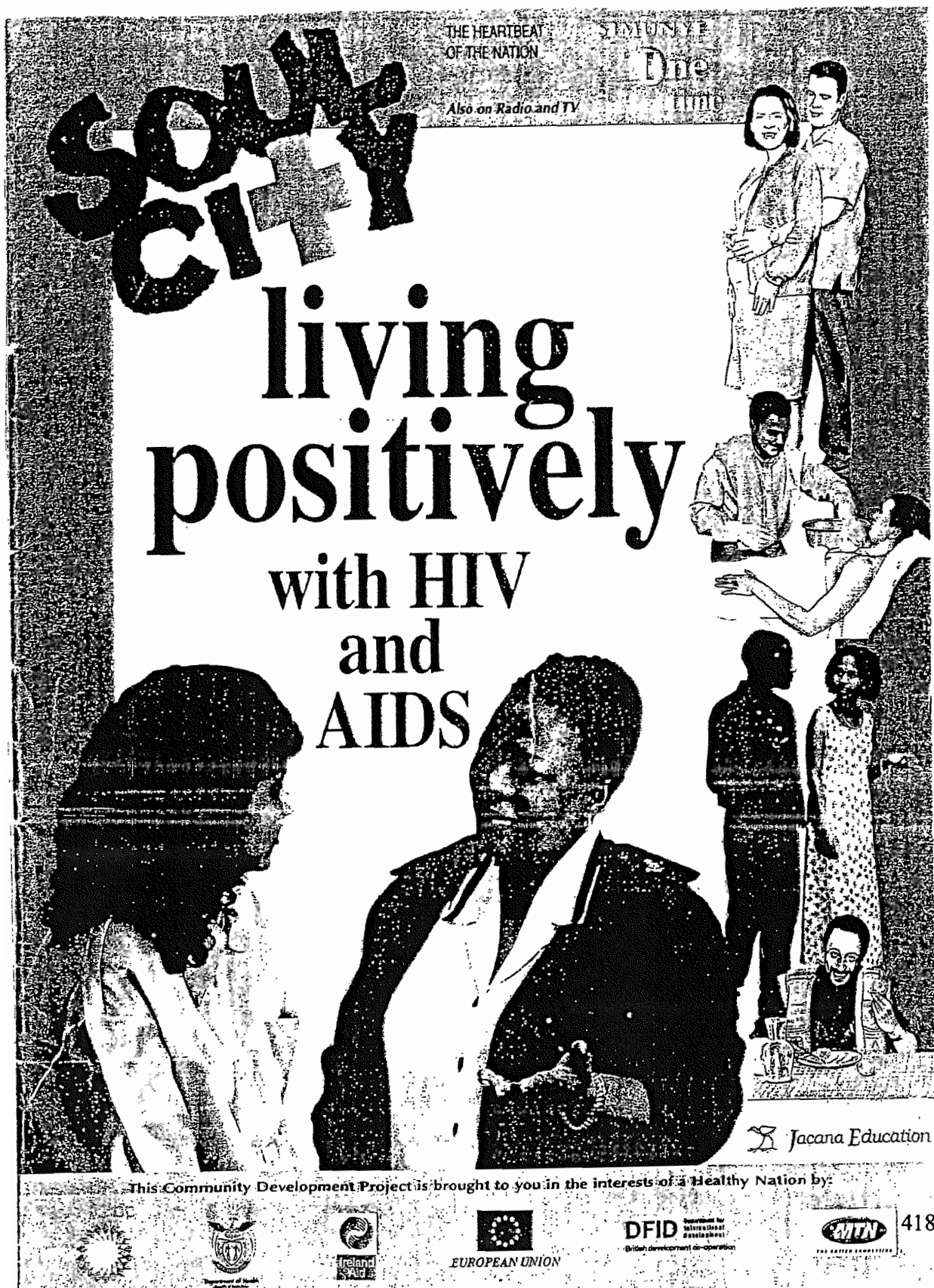
**FOR PARTICIPATING IN THE WORKSHOP SESSIONS OF GENDER-BASED
HIV PREVENTION INTERVENTION PROGRAMME
CONDUCTED ONCE A WEEK IN NORTHERN KZN HIGH SCHOOLS
IN AUGUST–NOVEMBER 2001**

Presented: November 2001

Sisana Majeke

Researcher: Gender-based HIV prevention intervention programme

**APPENDIX 2.13: LIVING POSITIVELY WITH HIV AND AIDS COVER AND
TABLE OF CONTENTS (Soul City: Living positively with HIV and AIDS, 2001)**



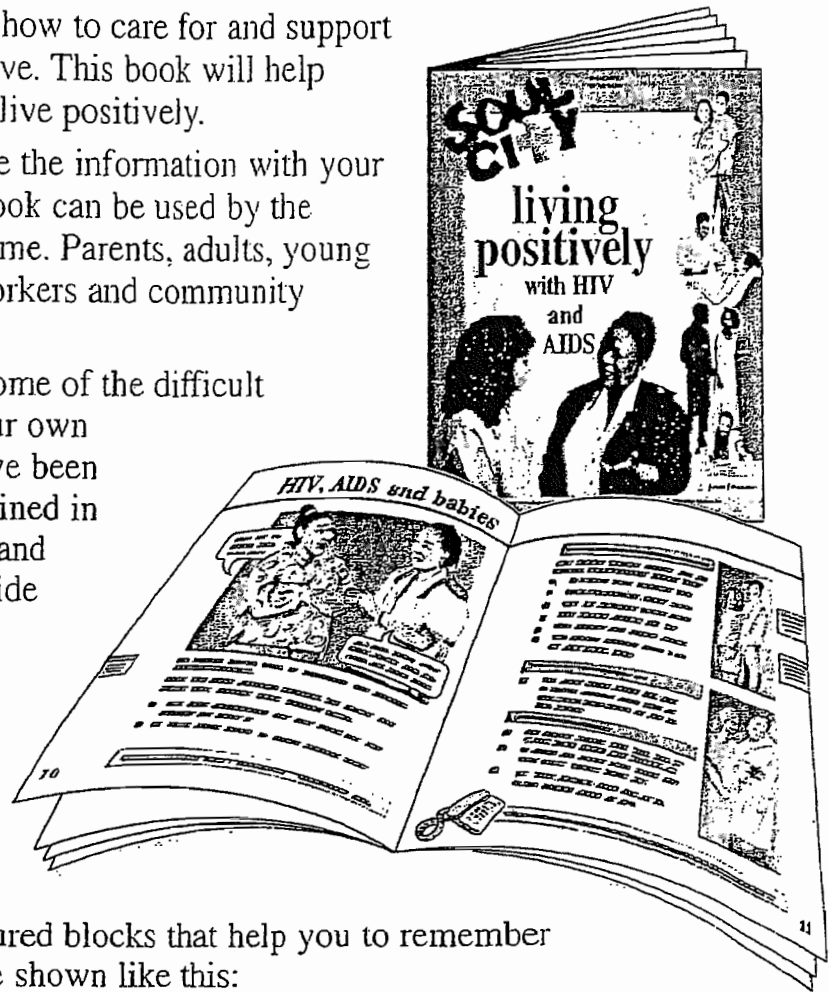
How to use this book

Everybody needs to know how to care for and support people who are HIV positive. This book will help people who have AIDS to live positively.

Read these pages and share the information with your family and friends. This book can be used by the community and in your home. Parents, adults, young people, teachers, health workers and community workers can use it.

You may not understand some of the difficult words if English is not your own language. These words have been underlined. They are explained in isiZulu, isiXhosa, seSotho and Afrikaans in boxes on the side of each page. The boxes look like this:

English
isiZulu
isiXhosa
seSotho
Afrikaans



In this book there are coloured blocks that help you to remember important things. These are shown like this:

Remember!

You don't need to be ashamed. Anyone can get HIV and AIDS.

Sometimes there are other special things to think about. These are shown in coloured blocks like this:

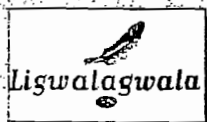
Did you know?

HIV is an STD because you can also get it from having unprotected sex. You can prevent the spread of all STDs by always using a condom.

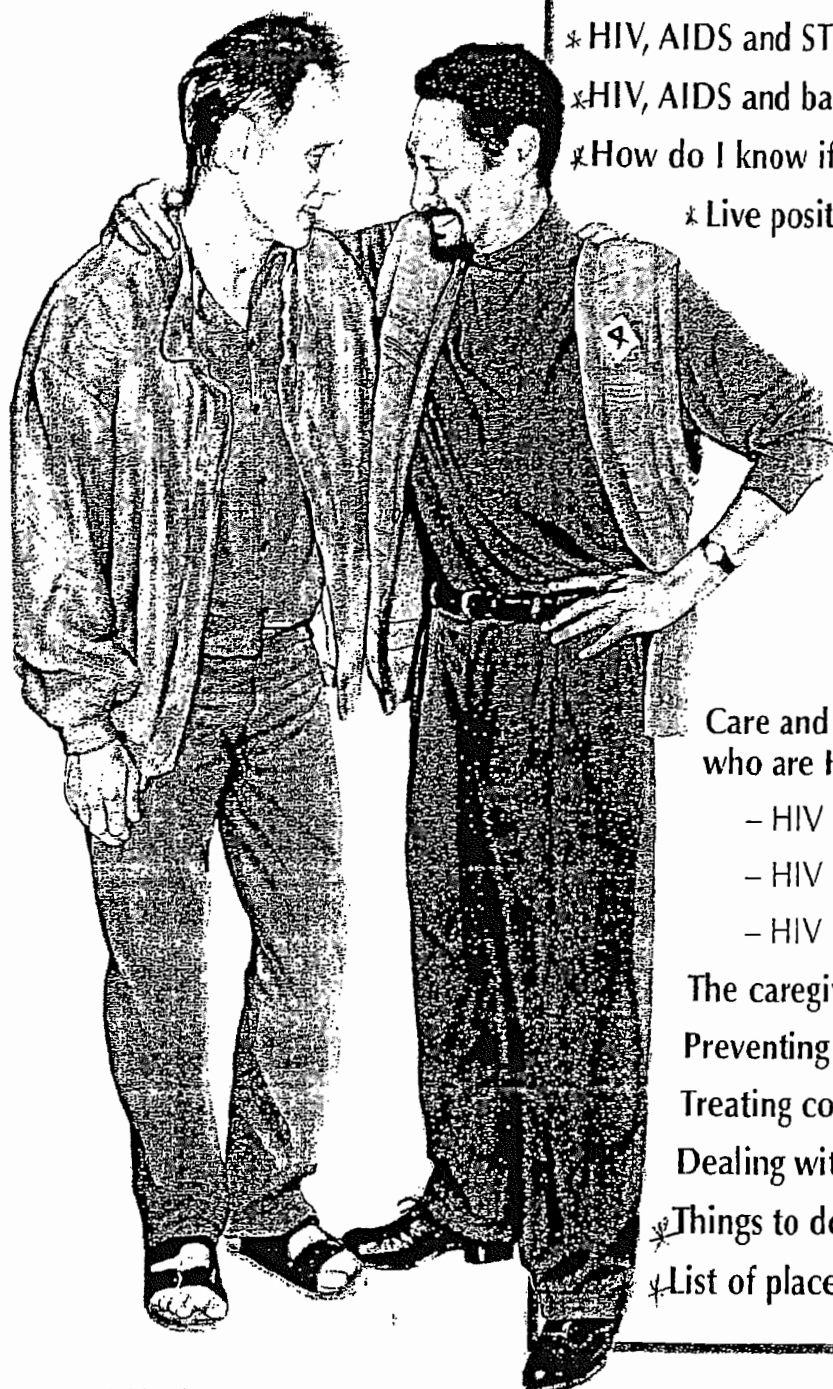


Community Information

It is your right to get pre-test counselling. It is also your right to get post-test counselling, even if your test results are negative.



Contents



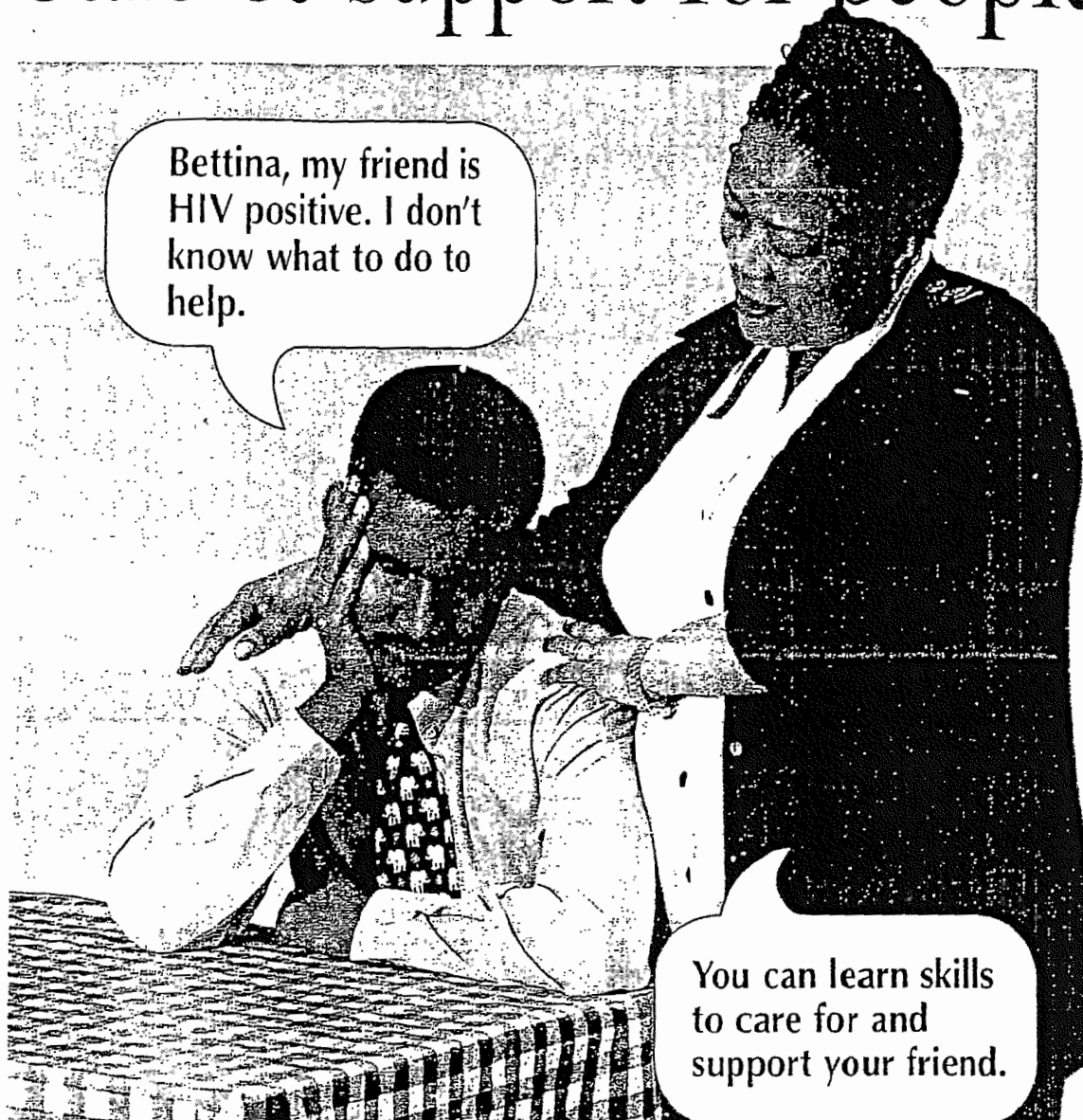
* Why are HIV and AIDS still spreading?	2
* Unprotected sex can lead to HIV and AIDS	6
* HIV, AIDS and STDs	8
* HIV, AIDS and babies	10
* How do I know if I am HIV positive?	12
* Live positively with HIV and AIDS	14
– Talk to someone who can help you	16
– Pule's story	18
– How to tell someone you are HIV positive	20
– How to tell your children you are HIV positive	22
– Take care of your mind and body	24
Care and support for people who are HIV positive	26
– HIV positive and healthy	28
– HIV positive and sick	30
– HIV positive and near death	31
The caregiver	32
Preventing infections at home	34
Treating common sicknesses at home	36
Dealing with death and dying	42
* Things to do while you are strong	44
* List of places to help you	48

ILANGA
THE VOICE OF THE PEOPLE

Sowetan
Building the Nation

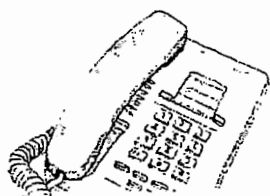
DIE BURGER

Care & support for people



Even if we are not infected, we are all living with HIV and AIDS. You may be HIV positive yourself, or you may know someone who is HIV positive. It may be someone you love, like a parent, a partner or a friend. We can all support one another by helping to cope with the disease and to live with it positively.

A person with HIV and AIDS will stay healthier if there is someone to give them support. Many people believe that only women can take care of sick people. This is not true. Everyone can help to care for someone who is HIV positive.



If you have any questions about HIV and AIDS, call the free AIDS Helpline on 0800 012 322.

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who are HIV positive

Some people do not have anyone to care for them. This section of the book can help them learn about things they need to do for themselves. It can help them to know what care and support they should be asking for from family and friends. Read pages 17, 20 and 21.



The different stages of HIV and AIDS

Different people find out they are HIV positive at different stages of the disease. They may find out when they are not sick. But as their immune system gets weak, they start getting sick very easily. At some stage they will get very sick and will not get better. This book divides the disease into three stages.



- How to care for a person who is HIV positive and healthy – read pages 28 and 29.

- How to care for a person who is HIV positive and sick – read page 30.



- How to care for a person who has AIDS and is near death – read page 31.



Tips are given on how to care for and support people living with AIDS at these different stages. There is also advice for people who are caregivers for the person with HIV and AIDS – read page 32.

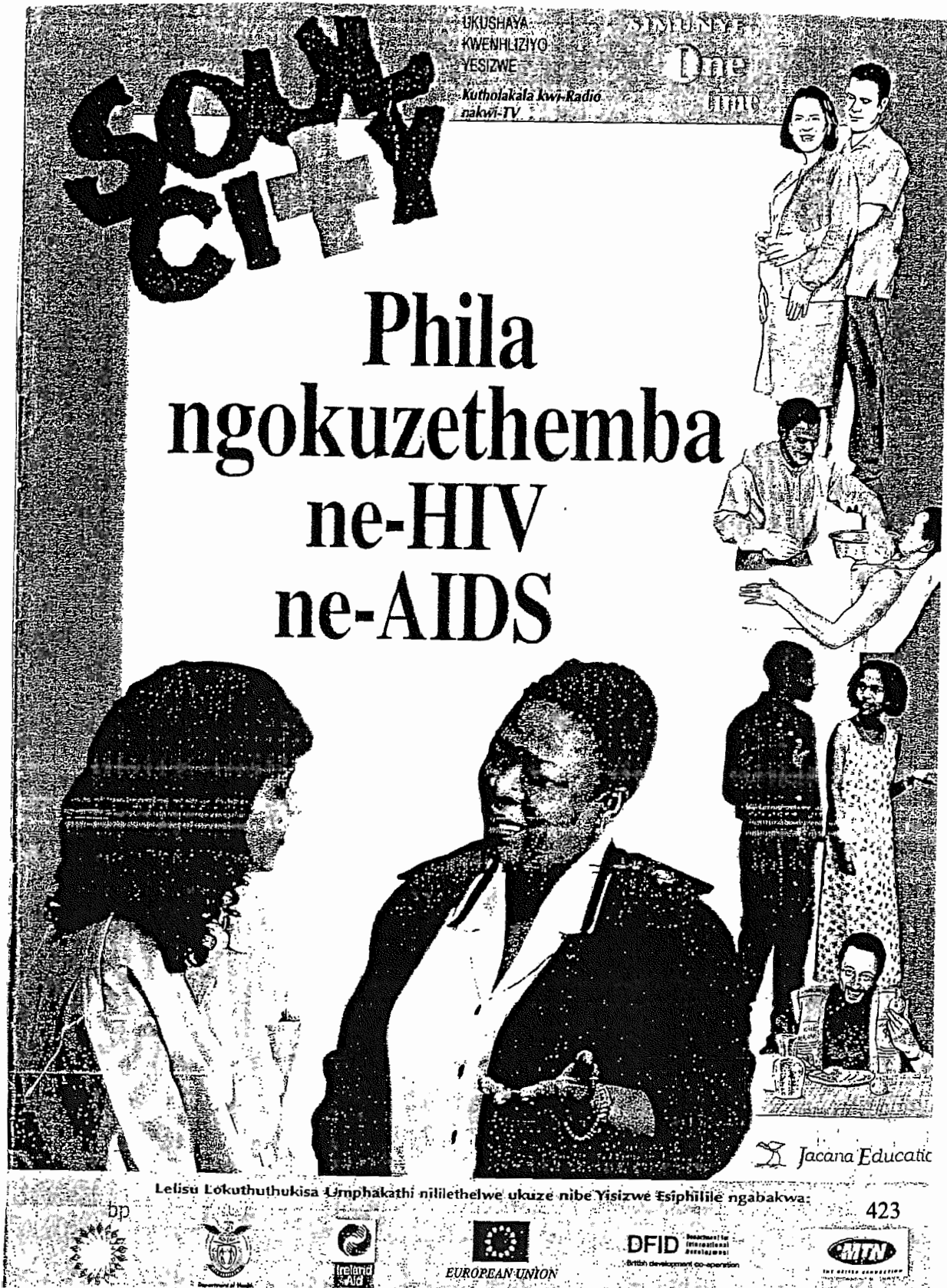
Remember!

You can ask the health worker to teach you skills on how to care for the sick at home.

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APPENDIX 2.14: *Philangokuzethemba ne-HIV ne-AIDS* cover and table of contents

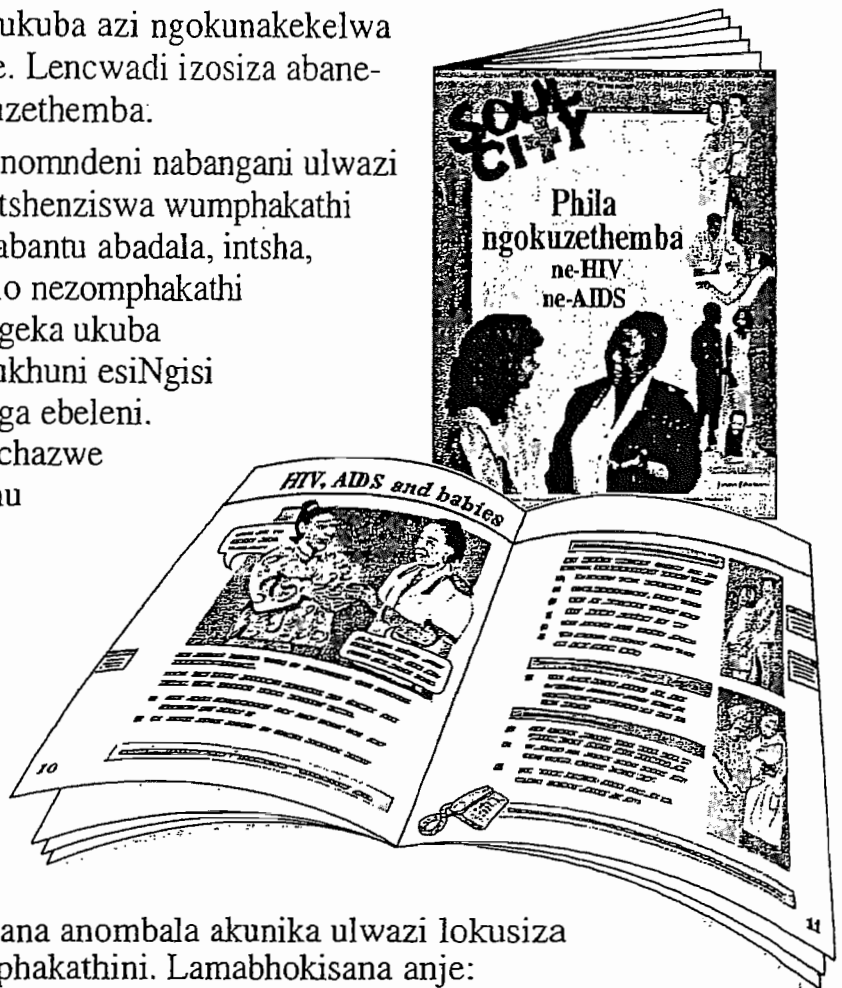
(Soul City: *Phila ngokuzethemba ne- HIV ne-AIDS*, 2001).



Indlela yokusebenzisa lencwadi

Wonke umuntu kudingeka ukuba azi ngokunakekelwa kwabantu aba-HIV positive. Lencwadi izosiza abane-AIDS ukuba baphile ngokuzethemba.

Funda lamakhasi wabelane nomndeni nabangani ulwazi olutholile. Lencwadi ingasetshenziswa wumphakathi kanye nemindeni. Abazali, abantu abadala, intsha, othisha, izisebenzi zezempilo nezomphakathi zingayisebenzisa. Kungadingeka ukuba uhunyushelwe amagama alukhuni esiNgisi uma siwulimu ongalincelanga ebeleni. Lamagama adwetshelwe. Achazwe ngesiZulu, isiXhosa, isiSuthu nangesiBhunu ebhokisini eliseceleni kwekhasi. Lamabhokisi azobukeka kanje:



Kulencwadi kunamabhokisana anombala akunika ulwazi lokusiza ukwenza izinto ngcono emphakathini. Lamabhokisana anje:

Khumbula!

Akudingi ukuba uzenyeze. Noma ngubani angayithola i-HIV ne-AIDS.

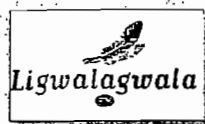
Kunamanye futhi amabhokisana akusiza ukuba ukhumbule izinto ezibalulekile. Wona akhonjiswa kanje:

Uthi ubuwazi?

MIV is 'n Seksueel Oordraagbare Siekte, want jy kan dit ook kry deur onbeskermdse seks te hê. Jy kan die verspreiding van alle Seksueel Oordraagbare Siektes keer deur altyd 'n kondoom te gebruik.



Ulwazi lomphakathi: Kuyilungelo lakho ukuthola izeluleko zochwepheshe ngaphambi kokuhlolwa. Kuyilungelo lakho futhi ukuthola izeluleko emva kokuhlolwa, ngisho ngabe kutholakale ukuthi u-positive.



Okuqukethwe



Kungani i-HIV ne-AIDS kubhebhetheka?	2
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Phila ngokuzethemba ne-HIV ne-AIDS	14
– Xoxisana nomuntu ongakusiza	16
– Indaba kaPule	18
– Ungamtshela kanjani omunye ukuthi u-HIV positive	20
– Ungazitshela kanjani izingane zakho ukuthi u-HIV positive	22
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Asibanakekele sibaxhase



Ngisho noma ngabe singangaba naso lesisifo, kodwa siphila naso. Kungenzeka ukuthi nawe u-HIV positive, noma kukhona omaziyo onaso lesisifo. Kungenzeka kube ngumuntu omthandayo, njengomzali wakho, isithandwa sakho noma umngani. Sonke singaxhasana ngokuthi simsize lowo muntu ukuze angalahlekelwa yithemba.

Umuntu one-HIV ne-AIDS angahlala ephila uma kukhona abamxhasayo. Abantu abaningi bakholwa wukuthi abesimame kuphela abanganakekela abantu abagulayo. Akunjalo. Sonke singalekelelana ukuze sinakekele lowo o-HIV positive.



Uma unemibuzo nge-HIV ne-AIDS, shayela abe-AIDS
Helpline ucingo kulenombolo ethi 0800 012 322 426

abantu aba-HIV positive

Ezinye iziguli azinabantu abazinakekelayo. Lengxenywe yalencwadi ingabasiza ukuze babe nolwazi ngezinto abangazenza. Ingabafundisa ngokuthi yiluphi usizo abangalucela emndenini nakubangani. Funda ikhasi 17, 20 no-21.



Izigaba ezihlukene ze-HIV ne-AIDS

Abantu abahlukahlukeni baze babone ukuthi ba-HIV positive uma lesosifo esibaphethe sesikwesinye isigaba. Kungenzeka bathole ukuthi ba-HIV positive ngisho noma bengaphethwe yilutho. Kodwa ngesikhathi amasosha omzimba eya ngokukhathala, bayaqala bagule kalula. Kwesinye isikhathi bagula kakhulu bangabi ngcono. Lencwadi ihlukanisa lesisifo ngezigaba ezintathu.



- Ukunakekelwa komuntu o-HIV positive kodwa ophila kahle - funda ikhasi 28 no-29.

- Ukunakekelwa komuntu o-HIV positive kodwa ogulayo - funda ikhasi 30.



- Ukunakekelwa komuntu one-AIDS osegulela ukufa - funda ikhasi 31.



Sikunikeza izeluleko ngokuxhaswa nokunakekelwa kwabantu abaphila ne-AIDS. Kukhona nezeluleko ezingasiza labo abanakekela abantu abane-HIV ne-AIDS - funda ikhasi 32.

APPENDIX 3: INFORMATION DOCUMENT FOR PARTICIPANTS AND PARENT OR GUARDIAN

Research Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective

Introduction: I am Sisana Janet Majeke, a Professional Nurse and Midwife who is registered as a part-time student at the University of Natal in the Centre for Gender Studies in Durban. I am currently employed as a Senior Lecturer at the University of Zululand, KwaDlangezwa, in the Department of Nursing Science. I am inviting you to participate in a research study that I am conducting of which the title is stated above.

The HIV/AIDS pandemic exerts an increasing challenge throughout the world, in South Africa and more so in KwaZulu-Natal. Sensitising youth on gender-equality and respect, decision-making in sexual relationships and contributing to HIV prevention through changing their sexual behaviour is South Africa's greatest development challenge.

Purpose of the study

The aim of the research study is to expose school-going boys and girls to a gender-based life building skills HIV prevention programme through active participation of participants in all sessions of the programme, which will be conducted during the second phase.

Research Methodology

This study has three phases, the first, second and third phases. It takes the form of a quantitative approach together with self-administered questionnaires that will be used during the first or orientation and last or evaluation phases. An action research, with a qualitative approach, will be the primary method used for the intervention programme that will be conducted during the second phase of this study. A combination of innovative strategies will be used which include focus groups discussions, games and role plays. I am also requesting participants' permission to record their views (anonymously) on flip charts and with the tape recorder during the second or intervention phase.

This is an action-based research study of peri-urban and rural youth, boys and girls, in the age group 13 to 19 years of age in high schools of Northern KwaZulu-Natal. They will be selected on a voluntary basis, using purposive sampling. It will be based on analysis of their perceptions, decision-making and practices in sexual relationships, I and my assistants will obtain this as baseline data during the first phase with the aim of empowering them with gender-based life and HIV prevention skills in the context of gender.

There should be no risk or discomfort to you or your child as participant when sharing his/her own perceptions of gender, sexuality, relationships, rights, power and decision-making in sexual relations, and prevention of HIV infection. There is no cost required from you or your child.

Your / your child's participation will mean that you / s/he will meet with me and other participants at your/ her/his school, once a week, on a day and time that will be agreed upon with you and school authorities.

Anonymity and confidentiality will be maintained to ensure that the name of the school and the participants who took part in the study and the records and tapes will never be revealed, either during the study or when the study is reported or published.

Permission to conduct the study and its procedures have been approved by appropriate experts who are members of the Ethical Research Committee of the University of Natal, Department of Education and Culture and school authorities.

Your decision to participate in this study is completely voluntary. You are under no obligation to participate. You have the right to choose whether to participate in this study or not to participate. You have the right to withdraw at any time if you so wish without penalty or any negative effects on you.

If you agree to participate you will be required to take this information sheet and discuss it with your parent/guardian at home. If your parent/guardian also agrees you will both be required to sign and return the consent form to me.

If you have any questions about the study, please feel free to call or contact me, the researcher, Sisana Majeke. I can be reached at the following telephone numbers 035-9026514/12. If you have further questions and or complaints you may contact research Supervisor: Doctor Catherine Burns at the University of Natal, Durban. You can also contact a member of the Research Ethics Committee at the University of Natal, Durban.

APPENDIX 4: CONSENT FORM FOR PARTICIPANT AND PARENT OR GUARDIAN

Research Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

I am Sisana Janet Majeke, a Professional Nurse and Midwife who is registered as a part-time doctoral student at the University of Natal in the Centre for Gender Studies in Durban. I am currently employed as a Senior Lecturer at the University of Zululand, KwaDlangezwa, in the Department of Nursing Science. I am inviting you / your child to participate in a research study that I am conducting the title of which is stated above. I have explained the study including the purpose, how the study will be conducted to you /your child, in the previous information document for this study, distributed earlier.

If you have any questions, please feel free to call or contact me, the researcher: Sisana Majeke. I can be reached at the following telephone numbers: 035-9026514/12. If you have further questions and or complaints you may contact my research Supervisor: Doctor Catherine Burns at the University of Natal, Durban. You can also contact a member of the Research Ethics Committee at the University of Natal, Durban.

Your decision to participate or allow your child to take part in this study is completely voluntary. You are under no obligation to participate. You have the right to choose whether to participate in this study or not to participate. You have the right to withdraw at any time if you so wish without penalty or any negative effects on you.

If you agree to participate you will be given a copy of this form to keep for your own use.

Informed consent:

The information regarding the research study has been explained to me verbally and /or I have read it on my own. I understand the information and what my involvement in the study means and I voluntarily agree to participate in the study by signing this document

Participant's signature..... Date.....
Researcher's / Witness's signature..... Date.....

The information regarding the research study has been explained to me verbally and / or I have read it on my own. I understand the information and what my child's involvement in the study means and I allow my child to voluntarily participate in the study by signing this document or making a mark below.

Parent/guardian's signature..... Date.....
Witness's signature..... Date.....

APPENDIX 4b: *Ulwazi ngocwaningo nesi Isivumelwano sokubamba iqhaza ocwaningweni*

Isihloko Socwaningo: Intsha efunda ezikolweni, ubudlelwane bayo bezocansi nokuvikelwa kwesandulelangculazi (HIV) eNyakatho yakwaZulu-Natali: Imibono yezobulili (yabesifazane nabesilisa)

Isingeniso:

Mina ngingu, Sisana Janet Majeke, onguMhlengikazi noMbelethisi ofunda ngasese, kwezokufunda ngozobulili, emnyangweni wemfundo ephakeme noma eNuvesi (University) yaseNatali, eThekwini. Ngisebenza ukufundisa abahlengikazi nababelethisi emnyangweni wemfundo ephakeme noma iNuvesi (University) yakwaZulu, KwaDlangezwa. Ngiyakumema ukuba ubambe iqhaza kulolucwaningo engizolwenza olunesihloko esishiwo ngenhla.

Ukwanda kwesandulelangculazi (HIV) kwenza inselele yenyuke kakhulu ezweni lonke, naseningizimu Afrika, ikakhulu kazi KwaZulu-Natali. Ingingizimu Africa ibhekene nenselele enkulu yokuqwashisa intsa ngokuhlonipha ukulingana ngokobulili nezinqumo ezithathayo kwezobudlelwane bezocansi nokubaqwashisa ngezindlela zokuvikela isandulelangculazi (HIV)

Injongo yocwaningo

Injongo yalolucwaningo ukwenza ithuba lokuthi intsha efundayo yamantombazane nabafana ize emihlanganweni ezobzobanjwelwa esikoleni ixoxe ngokubaluleka kokuhloniphana ngokulinganayo ngokobulili nange zindlela zokuvivekela isandulelangculazi (HIV).

Inqubo yocwaningo nokungaba inzuzo kwabazobamba iqhaza kulolucwaningo.

Lolucwaningo luzoba sezingeni lentsha, ezogqugquzelwa ukuba isho izimvo zayo. Isigaba sokuqala socwaningo sizocela intsha ukuba isho izimvo zayo ngokuphendula uhla lwemibuzo (questionnaire) ebhalwayo. Isigaba sesibilisizovula ithuba lokuba intsha ibe nezingxoxo kabanzi ngezimvo zayo ngalokhu okucwaningwayo. Ngicela imvume yokuthi ngisebenzise isigcinimazwi (tape recoder) ukuqopha izingxoxo nemizekeliso yayo intsha.

Abamenywayo ukuba babambe iqhaza kulolucwaningo

Abafundi abayintsha yesifazane nabesilisa abneminyaka eyishuminantathu (13) kuya kweyishuminesishiyagalolunye (19) abafunda ezikoleni eziphakeme (high schools) zasemakhaya nasemalokishini, bayokhethwa ngoyo bamba iqhaza kulolucwaningo ngokuthanda kwabo nangemvume yabazali noma abongameli babo.

Izinto ezingaba ingozi noma inzuzo

Ukubamba iqhaza kulolucwaningo kumahala, Akukho ngozi noma izinto ezingaphatha kabi intsha uma ixoxa ngokuhloniphana ngezimvo zayo kulolucwaningo. Intsha ezobamba iqhaza kulolucwaningo izozuza kakhulu ngokuhloniphana ngokulinganayo kwezobulili nangengokuvikelwa kwesandulelangculazi.

Imihlangano yalolucwaningo

Ukubamba kwakho iqhaza kulolucwaningo kusho ukuthi kuzomele uze emihlanganweniezbanelwa esikoleni sakho njalokanye ngesonto, emva kwesikole, ngo 2 kuya ku 4 ntambama, kusukela ku August kulonyaka nakozyo.

Ukugcinwa kwemfihlo nokuvikelwa kwamalungelo akho

Igama lakho nelesikole sakho liyogcinwa liyimfihlo futhi alisoze ladalulwa noma livezwe kunoma iziphi izincwadi ezibhaliwe nagalolucwaningo. Nemininingwane eqondene nawe uma iqoshiwe kusigcinimazwi iyogcinwa iyimfihlo. Uma kunesidingo sokuthi udluliselwe kosolwazi abaphambili, ngemvume yakho kuyokwenziwa, nacho futhi kuyogcinwa kuyimfihlo.

Osolwazi, abangamalunga ekomidilwezocwaningo base Nyuvesi yaseNatali, bazolubheka lolucwaningonezinqubo zalo, banikeze nemvume yokwenziwa kwalo lolucwaningo. Ukubamba kwakho iqhaza kulolucwaningo kuwukuthandakwakho ngokuphele. Awuphoqiwe neze. Usenganquma ukuyeka ukuba kulolucwaningonoma ingasiphi isikhathi, ngaphandle kokulahlekelwa amalungelo akho, nangaphandle kokujeziswa.

Abantu ongabathinta uma unemibuzo

Uma kwenzeka uba nemibuzo ngalolucwaningo uyacelwa ukuba uthintane no Sisana Majeke ku 035-9026514/13/12. Uma uneminye futhi imibuzo ungathintana no Doctor Catherine Burns ongumaluleki wami kulolucwaningo, noma osolwazi abangamalungu lekomidi lwezocwaniongo eNyuvesi yase Natali, .

Uma uthanda ukubamba iqhaza kulolucwaningo, uzonikezwa lencwadi eyazisa ngocwaningo necela isivumelwano socwaningo, uhambe nayo uye ekhaya, uyoyibonisa umzali noma umongameli wakho, uma ekuvemela ayisayine , bese nigcina ikhopi yalesisivumelwano.

Isivumelwano sokubamba iqhaza ocwaningweni

Uma usufundile isivumelwano esazisayo ngalolucwaningo noma usuke wafundelwa futhi wachazelwa walwazi udaba oluphakathi kulolucwaningo, ngokuphelele, kanti futhi uyavuma ngokungaphoqeelwa ukuba ubambe iqhaza kulolucwaningo, uyacelwa ukuba usayine noma wenze uphawu ngezansi.

Isiginesha yobamba iqhaza	Usuku.....
Isiginesha yoncwani/ noma ufakazi.....	Usuku.....

Uma usufundile isivumelwano esazisayo ngalolucwaningo noma usuke wafundelwa futhi wachazelwa walwazi udaba oluphakathi kulolucwaningo, ngokuphelele, kanti futhi uyavuma ngokungaphoqeelwa ukuba ubambe iqhaza kulolucwaningo, uyacelwa ukuba usayine noma wenze uphawu ngezansi.

Isiginesha yomzali / ongamele umfundi obamba iqhaza	Usuku.....
Isiginesha yoncwani/ noma ufakazi.....	Usuku.....

UNIVERSITY OF NATAL

FACULTY OF HUMAN SCIENCES

RESEARCH ETHICS DECLARATION FOR GRADUATE

STUDENTS

NAME OF GRADUATE STUDENT: SISANA JANET MAJEKE
PROGRAMME: Gender Studies
TITLE OF DISSERTATION: THE IMPACT OF GENDER power imbalances
ON Youth's SEXUALITY ON efforts to prevent transmission
BRIEF DESCRIPTION: OF HIV Infection
THIS will be an action-based and
participatory study of peri-urban and rural youth in
High schools of Northern Kwa-Zulu-Natal.

A. THE PROPOSAL MEETS THE FOLLOWING ETHICAL REQUIREMENTS:

	YES	NO
1. Provision has been made to obtain appropriate informed consent of participants	✓	
2. Potential psychological and physical risks have been considered and minimized.	✓	
3. Provision has been made to avoid undue intrusion and to display appropriate sensitivity with regard to participants and community.	✓	
4. Rights of participants will be safeguarded in relation to:		
4.1. Measures for the protection of anonymity and the maintenance of confidentiality of information collected.	✓	
4.2. Storage of research information.	✓	
4.3. Termination of participants' involvement without compromise.	✓	
4.4. Misleading promises regarding benefits of the research.	✓	
4.5. Particular protection if participants are 'dependents'	✓	
4.6. Publication	✓	

B. THE PROPOSAL MEETS THE PROFESSIONAL CODE OF ETHICS OF THE DISCIPLINE
OF THE RESEARCHER.

YES/ NO | N/A

C. SHOULD THE PROPOSAL BE SUBMITTED TO THE RESEARCH ETHICS SUB-
COMMITTEE OF THE HIGHER DEGREES AND RESEARCH COMMITTEE?

YES/ NO

Signature of Researcher Majeke Date 08/11/2002

Signature of Supervisor [Signature] Date

Signature of Programme Director [Signature] Date

Signature of Chairperson of Higher Degrees and Research Committee 29/11/02
Date
[Signature]

APPENDIX 6: PERMISSION LETTER



**UNIVERSITY OF NATAL
GENDER STUDIES
DURBAN
4041**

Telephone: (031) 2602915
Fax: (031) 2602621
28 April 2001

Dr S. Z. Mbokazi
The Deputy-Director General
Department of Education
Private Bag X9137
Pietermaritzburg
3838

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN HIGH SCHOOLS OF NORTHERN KWAZULU-NATAL PROVINCE

Research Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

I hereby apply for permission to conduct a research study in four high schools in Northern KwaZulu-Natal. The research project is being conducted in fulfillment of requirement for a PhD degree that I am pursuing with the University of Natal in Durban, as a part-time PhD student in the Centre for Gender Studies. I am a Professional Nurse and Advanced Midwife, employed as a Senior Lecturer at the University of Zululand, KwaDalangezwa, in the Department of Nursing Science.

This is an action-based study of the peri-urban and rural youth in high schools of Northern KwaZulu-Natal. It will be based on an analysis of their perceptions, decision-making skills and practices in sexual relationships with a view of empowering them with gender-based life coping-skills in relation to preventing HIV infection in the context of gender. HIV and AIDS epidemic exerts an increasing challenge throughout the world, South Africa and more so in KwaZulu-Natal. Sensitising the youth on gender-equality

and respect, decision-making in sexual relationships and contributing to HIV prevention through changing sexual behaviour, is South Africa's greatest development challenge. It is important to recognise that both women and men are vulnerable to HIV infection. However, women are more vulnerable than men and one of the factors shaping this is the gender-power imbalance that promotes the powerlessness of women and their consequent inability to easily make decisions in their sexual relationships.

Gender norms often determine what women and men are supposed to know about sexuality and sex, and also how they are supposed to behave. Therefore, it is vital to take into consideration that for HIV prevention to be successful, both young women and young men need to be involved in exploring and finding possible strategies or solutions to HIV prevention in the context of gender.

It is essential to ensure that young women and men are empowered with gender equality in order to understand the value of shared responsibilities in decision-making, mutual respect in all gender issues including sexual relations and to make informed decisions such as abstaining from risky sexual practices or engaging in safer sexual behaviour to prevent HIV infection.

Purpose of the study

The aim of the research study is to expose school-going young boys and girls to a gender-based life building skills HIV prevention programme through active participation of participants in all sessions of the programme that will be conducted during the second phase.

Research Methodology

This study has three phases, the first, second and third phases, with a quantitative approach together with self-administered questionnaires that will be used during the first or orientation and last or evaluation phases. Action research, with a qualitative approach, will be the method mainly used for the intervention programme that will be conducted during the second phase of this study. A combination of innovative strategies will be used which include focus group discussions, games and role plays. I am also requesting your permission to record participants' views on the flip charts and with the tape recorder during the second or intervention phase.

This is an action research study of the peri-urban and rural youth, boys and girls in the age group 13 to 19 years of age in high schools of Northern KwaZulu-Natal. They will be selected on voluntary basis, using purposive sampling. It will be based on an analysis of their perceptions, decision-making skills and practices in sexual relationships obtained as baseline data during the first phase with a view of empowering them on gender-based life coping-skills and HIV prevention in the context of gender during the intervention programme that will be conducted in the second phase of this study. Four high schools around the vicinity of University of Zululand have been selected using convenience sampling.

There should be no risk or discomfort to learners who participate in this study when sharing their perceptions of gender, sexuality, relationships, rights, power and decision-making in sexual relations, HIV and AIDS and the prevention of HIV infection. There is no cost required from learners: their participation is free of charge and voluntary.

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Anonymity and confidentiality will be maintained at all times to ensure that the name of the school and the participants who participated in the study and the records and tapes will never be revealed either during the study or when the study is reported or published.

Permission to conduct the study and its procedures have been approved by appropriate experts who are members of the Ethical Research Committee of the University of Natal. Permission to conduct the study has been requested and approval obtained from school Principals of the four high schools.

Conclusion

It is essential that I conduct this research project, not only for the fulfillment of the requirement of my PhD, but also to share and exchange ideas with the youth and contribute to the empowerment of the youth on life-skills and HIV prevention in the context of gender.

I would like to start this project from the third term of this year 2001, as discussed earlier this year.

Please find enclosed my research proposal, information document and consent form for learners as participants and their parents/guardians and the permission letter from the University of Natal for your consideration.

Thanking you in advance and looking forward to your positive written response

Yours faithfully

.....

Sisana J. Majeke (Mrs)

Fax number 035-9026394

Telephone number: 035-9026514/12.

Cell no. 0836975015

CC: Research Supervisor: Doctor Catherine Burns
University of Natal, Gender Studies, Durban, 4041.
Telephone: (031) 2602915, Fax: (031) 2602621

APPENDIX 6: PERMISSION LETTER received from DOE and Culture in 2001



PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI
PROVINSIE KWAZULU-NATAL

DEPARTMENT OF EDUCATION
UMNYANGO WEMFUNDO
DEPARTEMENT VAN ONDERWYS

Telephone : 033-8465131
Fax : 033-8465185

Private Bag X9137
Pietermaritzburg
3200

228 Pietermaritz Street
Pietermaritzburg, 3201

INHLOKOHLOVISI

HEAD OFFICE

PIETERMARITZBURG

Enquiries: Dr S.Z Mbokazi
Imibuzo:
Navrae:

Reference: Permission to do research
Inkomba:
Verwysing:

Date: 12/05/2001
Usuku:
Datum

Mrs S.J Majeke
University of Natal
Gender Studies
Durban
4041

PERMISSION TO DO RESEARCH

1. Authority has been granted to you to do research in Empangeni district schools for academic purposes provided that the results of the research will be submitted to the department.
2. Your co-operation will be highly appreciated.

Dr S.Z Mbokazi
Deputy-Director General
Education Service Delivery Management

APPENDIX 7: PERMISSION LETTER



**UNIVERSITY OF NATAL
GENDER STUDIES
DURBAN
4041**

Telephone: (031) 2602915
Fax: (031) 2602621
23 April 2001

The Principal
Khono High School
Private Bag x 8533
Esikhawini
3887

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN HIGH SCHOOLS OF NORTHERN KWAZULU-NATAL PROVINCE

**Research Title: School-going youth, sexuality and HIV prevention in Northern
KwaZulu-Natal: A gender perspective.**

I hereby apply for permission to conduct a research study in your high school. The research project is being conducted in fulfillment of requirement for a PhD degree that I am pursuing with the University of Natal in Durban, as a part-time PhD student in the Centre for Gender Studies. I am a Professional Nurse and Advanced Midwife employed as a Senior Lecturer at the University of Zululand, KwaDalngwezwa, in the Department of Nursing Science.

This is an action-based study of the peri-urban and rural youth in high schools of Northern KwaZulu-Natal. This will be based on an analysis of their perceptions, decision-making skills and practices in sexual relationships with a view of empowering them with gender-based life coping-skills in relation to preventing HIV infection in the context of gender. HIV and AIDS epidemic exerts an increasing challenge throughout the world, South Africa and more so in KwaZulu-Natal. Sensitising the youth on gender-equality and respect, decision-making in sexual relationships and contributing to HIV prevention through changing sexual behaviour, is South Africa's greatest development challenge.

It is important to recognise that both women and men are vulnerable to HIV infection. However, women are more vulnerable than men and one of the factors shaping this is gender-power imbalance that promotes the powerlessness of women and their consequent inability to easily make decisions in their sexual relationships.

Gender norms often determine what women and men are supposed to know about sexuality and sex, and also how they are supposed to behave. Therefore, it is vital to take into consideration that for HIV prevention to be successful, both young women and young men need to be involved in exploring and finding possible strategies or solutions to HIV prevention in the context of gender.

It is essential to ensure that young women and men are empowered with gender equality in order to understand the value of shared responsibilities in decision-making, mutual respect in all gender issues including sexual relations and to make informed decisions such as abstaining from risky sexual practices or engaging in safer sexual behaviour to prevent HIV infection.

Purpose of the study

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Research Methodology

This study has three phases, the first, second and third phases, with a quantitative approach together with self-administered questionnaires that will be used during the first or orientation and last or evaluation phases. Action research, with a qualitative approach, will be the method mainly used for the intervention programme that will be conducted during the second phase of this study. A combination of innovative strategies will be used which include focus group discussions, games and role plays. I am also requesting your permission to record participants' views on the flip charts and with the tape recorder during the second or intervention phase.

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Permission to conduct the study and its procedures have been approved by appropriate experts who are members of the Ethical Research Committee of the University of Natal. Permission to conduct the study has been requested from the Department of Education and Culture of KaZulu-Natal.

Conclusion

It is essential that I conduct this research project, not only for the fulfillment of the requirement of my PhD, but also to share and exchange ideas with the youth and contribute to the empowerment of the youth on life-skills and HIV prevention in the context of gender.

I would like to start this project from the third term of this year 2001, as discussed earlier this year.

Please find enclosed my research proposal, information document and consent form for learners as participants and their parents/guardians and the permission letter from the University of Natal for your consideration.

Thanking you in advance and looking forward to your positive written response

Yours faithfully

.....
Sisana J. Majeke (Mrs)
Fax number 035-9026394
Telephone number: 035-9026514/12.
Cell no. 0836975015

CC: Research Supervisor: Doctor Catherine Burns
University of Natal, Gender Studies, Durban, 4041.
Telephone: (031) 2602915, Fax: (031) 2602621

APPENDIX 8: PERMISSION LETTER



**UNIVERSITY OF NATAL
GENDER STUDIES
DURBAN
4041**

Telephone: (031) 2602915

Fax: (031) 2602621

25 April 2001

The Principal
Thela High School
Private Bag x 1005
KwaDlangezwa
3886

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN HIGH SCHOOLS OF NORTHERN KWAZULU-NATAL PROVINCE

Research Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

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and respect, decision-making in sexual relationships and contributing to HIV prevention through changing sexual behaviour, is South Africa's greatest development challenge. It is important to recognise that both women and men are vulnerable to HIV infection. However, women are more vulnerable than men and one of the factors shaping this is gender-power imbalance that promotes the powerlessness of women and their consequent inability to easily make decisions in their sexual relationships.

Gender norms often determine what women and men are supposed to know about sexuality and sex, and also how they are supposed to behave. Therefore, it is vital to take into consideration that for HIV prevention to be successful, both young women and young men need to be involved in exploring and finding possible strategies or solutions to HIV prevention in the context of gender.

It is essential to ensure that young women and men are empowered with gender equality in order to understand the value of shared responsibilities in decision-making, mutual respect in all gender issues including sexual relations and to make informed decisions such as abstaining from risky sexual practices or engaging in safer sexual behaviour to prevent HIV infection.

Purpose of the study

The aim of the research study is to expose school-going young boys and girls to a gender-based life building skills HIV prevention programme through active participation of participants in all sessions of the programme that will be conducted during the second phase.

Research Methodology

This study has three phases, the first, second and third phases, with a quantitative approach together with self-administered questionnaires that will be used during the first or orientation and last or evaluation phases. Action research, with a qualitative approach, will be the method mainly used for the intervention programme that will be conducted during the second phase of this study. A combination of innovative strategies will be used which include focus group discussions, games and role plays. I am also requesting your permission to record participants' views on the flip charts and with the tape recorder during the second or intervention phase.

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Anonymity and confidentiality will be maintained at all times to ensure that the name of the school and the participants who participated in the study and the records and tapes will never be revealed either during the study or when the study is reported or published.

Permission to conduct the study and its procedures have been approved by appropriate experts who are members of the Ethical Research Committee of the University of Natal. Permission to conduct the study has been requested from the Department of Education and Culture of KaZulu-Natal.

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I would like to start this project from the third term of this year 2001, as discussed earlier this year.

Please find enclosed my research proposal, information document and consent form for learners as participants and their parents/guardians and the permission letter from the University of Natal for your consideration.

Thanking you in advance and looking forward to your positive written response

Yours faithfully

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Sisana J. Majeke (Mrs)

Fax number 035-9026394

Telephone number: 035-9026514/12.

Cell no. 0836975015

CC: Research Supervisor: Doctor Catherine Burns
University of Natal, Gender Studies, Durban, 4041.
Telephone: (031) 2602915, Fax: (031) 2602621

APPENDIX 9: PERMISSION LETTER



UNIVERSITY OF NATAL
GENDER STUDIES
DURBAN

4041

Telephone: (031) 2602915

Fax: (031) 2602621

25 April 2001

The Principal
Zintombi High School
Private Bag x 1004
KwaDlangezwa
3886

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN HIGH SCHOOLS OF NORTHERN KWAZULU-NATAL PROVINCE

**Research Title: School-going youth, sexuality and HIV prevention in Northern
KwaZulu-Natal: A gender perspective.**

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and respect, decision-making in sexual relationships and contributing to HIV prevention through changing sexual behaviour, is South Africa's greatest development challenge. It is important to recognise that both women and men are vulnerable to HIV infection. However, women are more vulnerable than men and one of the factors shaping this is gender-power imbalance that promotes the powerless of women and their consequent inability to easily make decisions in their sexual relationships.

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Thanking you in advance and looking forward to your positive written response

Yours faithfully

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Sisana J. Majeke (Mrs)

Fax number 035-9026394

Telephone number: 035-9026514/12.

Cell no. 0836975015

CC: Research Supervisor: Doctor Catherine Burns
University of Natal, Gender Studies, Durban, 4041.
Telephone: (031) 2602915, Fax: (031) 2602621

APPENDIX 10: PERMISSION LETTER



**UNIVERSITY OF NATAL
GENDER STUDIES
DURBAN
4041**

Telephone: (031) 2602915

Fax: (031) 2602621

23 April 2001

The Principal
Drama High School
Private Bag x 8521
Esikhawini
3887

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN HIGH SCHOOLS OF NORTHERN KWAZULU-NATAL PROVINCE

**Research Title: School-going youth, sexuality and HIV prevention in Northern
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Yours faithfully

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Sisana J. Majeke (Mrs)
Fax number 035-9026394
Telephone number: 035-9026514/12.
Cell no. 0836975015
CC: Research Supervisor: Doctor Catherine Burns
University of Natal, Gender Studies, Durban, 4041.
Telephone: (031) 2602915, Fax: (031) 260

**APPENDIX 11: SOCIAL CLASS OF THE SAMPLE AND CATEGORIES OF
HIGH AND LOW SOCIAL CLASS**

**RESEARCH PROJECT TITLE: SCHOOL-GOING YOUTH, SEXUALITY AND
HIV PREVENTION IN NORTHERN KWAZULU-NATAL: A GENDER
PERSPECTIVE**

**SOCIAL CLASS OF THE SAMPLE AND CATEGORIES OF HIGH AND LOW
SOCIAL CLASS OBTAINED FROM LEARNERS WHO PARTICIPATED DURING
THE THREE-PHASED STUDY CONDUCTED**

**IN FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY**

**IN THE CENTRE FOR GENDER STUDIES
FACULTY OF HUMANITIES AND SOCIAL SCIENCE
UNIVERSITY OF NATAL**

By

Sisana Janet Majeke

APPENDIX 11: SOCIAL CLASS OF THE SAMPLE AND CATEGORIES OF HIGH AND LOW SOCIAL CLASS

Research Project Title: School-going youth, sexuality and HIV prevention in Northern KwaZulu-Natal: A gender perspective.

Researcher's Name: Sisana Majeke

Institution: University of Natal

Appendix 11: PART OF OTHER SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

Section A: TWO TABLES OF SOCIO-CHARACTERISTICS OF THE SAMPLE

(Reference made to these attached Tables in Chapters 4, 5, 6 and 7)

RELIGION

Table 4a: Religion by Gender (n = 175)

Type of Religion

Sex	Roman Catholic Church	Other Christian Churches	Nazareth Church	Total
Female	20 18%	75 70%	13 12%	108 100%
Male	14 20.9%	34 50.7%	19 28.4%	67 100%
Total count	34	109	32	175
Percentage	20%	62%	18%	100%

GRADES OR EDUCATIONAL LEVEL OF LEARNERS

Table 4b: Grades done by learners at school by Gender (n = 175)

Grade done at School

Sex	8	9	10	11	Total
Female	32 29.6%	5 4.6%	31 28.7	40 37.1%	108 100%
Male	40 59.7%	12 17.9%	10 14.9%	5 7.5%	67 100%
Total Count/ Percentage	72 41.1%	17 17.9%	41 23.4%	45 25.7%	175 100%

Section B: SOCIAL CLASS OF SAMPLE

This section relates closely to the methodology chapter and Chapters 4 and 6. It will discuss aspects related to the socio-economic aspects of the sample that could have been included in the methodology chapter and Chapters 4 and 6 but which were going to make those chapters too long. Hence it was considered better to attach the information as Appendix 11. The socio-economic profile of learners who participated in this study had relevance to some of the variables of the profile of learners and outcomes that were measured in this study. Reference was made to the relevance of social class to other variables of the profile of the sample, as explained in Chapter 4. Further reference was made to the relevance of social class as a way of explaining why some learners responded in either positive or negative patterns in the intervention of this study. Outcomes such as sexual history, HIV and AIDS knowledge have been discussed in Chapters 6 and 7.

SOCIAL CLASS

Three variables were used as the criteria to determine the social class of the learners who participated in this study: occupational class, type of house and degree of crowding in the learner's home. The rationale for using these three variables was because they seemed to be the best proxy-indicators of social class in the absence of being able to measure other

main indicators of the social class. Learners did not have accurate information as to the income levels of their parents or other financial indicators for their financial providers. Consequently, it was important to find other indicators of social class as reported by learners.

It is essential to have an idea of these three variables to determine the social class of learners because social class forms part of the family background. Reference was made to the relevance to the other variables of the profile of learners of some of these three variables and two categories of the social class. In addition, certain outcomes such as sexual activity as reported by learners were discussed in Chapters 4, 5, 6 and 7.

THREE VARIABLES OF SOCIAL CLASS

OCCUPATIONAL CLASS

The occupational class indicators were based on those used for census classifications, calculated according to standard classifications (SOC) (Department of Labour Manual, 2000). The occupational class indicators used were modified from those used by the SOC. In this study, occupational class indicators were based on the following four divisions of occupational class:

1. Managerial and professional class, such as executive officers, managers, doctors, teachers / lecturers, nurses.
2. Service and skilled manual workers, such as service administrators / secretarial / clerical staff or office workers, salesmen / women, police and security staff, skilled manual workers such as artisans, electricians, builders, plumbers.
3. Unskilled manual labourers, domestic workers and vendors. This third category of professionals included factory workers and machine operators, vehicle drivers, labourers, general assistants, domestic workers, cleaners, farmworkers and vendors such as fruit / vegetable street sellers, spaza shop owners.
4. Other financial supporters, who were not the biological parents of learners such as grand parents who were pensioners or self -employed.

Learners who reported that their parents were employed in the managerial and professional category were rated as having parents in the high occupational class compared to those employed in the second or lower professional class categories. This coding was done because of the high income levels associated with parents employed in the managerial and professional category.

It is essential to have an idea about the occupational class category of the parents of learners who participated in this study because this forms part of the family background of the participants. In Chapters 6 and 7 the significance of socio-economic class variables was used to explain why some learners responded positively or negatively to the intervention programme of this study as shown in certain outcomes such as early or delayed debut of sexual activity and or condom use as reported by participants.

TYPE OF HOUSING

The second variable for social class, the 'type of housing' indicator was based on the type of material used to build the houses in which the learners lived. The rating of this category ranged from those houses built with (1) bricks, (2) blocks, (3) mud and (4) other materials, such as grass used to build traditional houses, timber or corrugated iron used to build houses in informal settlements. This classification was used because of the general association of wealthy parents with expensive building materials, compared to poor parents who could only afford to use cheap building materials to build their houses. Consequently, learners who reported that their homes were built with either bricks or blocks were categorised as high social class homes compared to those homes built from other types of materials.

CROWDING

The third variable for social class, the crowding indicator, was used because of the importance of having multiple indicators of social class. This is important so that social class is not reduced to an income determinant only. It was also used because of the importance of space and privacy for sexual relationships, as it would not be acceptable to have a couple share a room with other people on a daily basis since they need privacy and

freedom. It may also have a negative influence, for example on young people's morals as they may be tempted to imitate what they see being done by adult couples.

Crowding was used as an indicator of social class based on the number of adults only. Those who were 20 years of age and above were divided by the number of rooms in the house of the learner's home rather than using the total number of people including children less than 20 years of age. The reason for this is that in the Zulu tradition a number of children, for example about five or more girls, used to sleep with their grandmother in one Zulu traditional house with one room built with grass, as means of keeping an eye on them. They used to sleep on the floor on a special mat made from grass and cotton called *Ucansi*. Once they reached the age of 20 or 21 and above they were then regarded as adults. Usually after the ceremony called *Umemulo* has been conducted where matured women called *Amaqhikiza* told them about good moral principles of sexual behaviour. The young ladies were then allowed to sleep without an adult, in a separate room called *Elawini lezintombi*.

When the comparison of crowding based on the total number of people including adults and children per room and crowding based on the number of adults per room was compared, the following findings were obtained. The results are shown in Table 4.c below.

Table 4c: Comparison of crowding indicators (n=175)

Crowding based on total number of people per room			Crowding based on number of adults per room		
	Frequency	Percentage		Frequency	Percentage
Overcrowding (>2 adults and children per room)	17	9.7%	Overcrowding (>2 adults per room)	9	5.1%
No overcrowding (≤ 2 adults and children / room)	158	90.3 %	No overcrowding (≤ 2 adults per room)	166	94.9%
Total	175	100.0%	Total	175	100.0%

Table 4c shows that the classification of crowding based on the number of adults per room is probably the best for this study rather than basing it on the total number of people, including adults and children. Basing crowding on counting the number of adults per room seemed the better indicator of crowding because it reduced the number of learners who came from overcrowded homes from 17 houses with more than 2 people per room to 9 houses with more than 2 adults per room. It also increased the number of learners who came from homes with no overcrowding from 158 to 166 learners. Thus the use of this indicator of crowding seemed to give a realistic picture of crowding in the homes of learners.

The rating of crowding ranged from one to two. (1) was allocated to the home that had no overcrowding and (2) was allocated to a home if the number of adults was more than two per room. This coding was used because people of high socio-economic status are less likely to be associated with overcrowding than those of low socio-economic status who are mostly associated with overcrowding.

It was important to compare the three variables of social class to find if there were any significant similarities or differences. Crowding was also examined in relation to the other two variables of social class, namely, the four divisions of professional class and the type of material used to build the learner's home.

In the following section on the results of the first phase of this study, in this annexure, the relations of these three variables of social class will be examined in relation to the significant demographics, gender issues and outcomes to identify the high-risk groups of learners who participated in this study.

COMPARISON OF THREE VARIABLES OF SOCIAL CLASS

Table 4d: Comparison of four divisions of professional class and crowding based on the number of adults per room (n=175)

Divisions of occupational class	Crowding (based on the number of adults per room)		
	No overcrowding (≤ 2 adults per room)	Overcrowding (> 2 adults per room)	Total
	FREQUENCY/ PERCENTAGE	FREQUENCY/ PERCENTAGE	Frequency / Percentage
1. Managerial and professional	42 25.3%	0 0%	42 24%
2. Service and skilled manual	48 28.9%	2 22.2%	50 28.6%
3. Unskilled manual, sellers, Labourer / domestic	49 29.5%	3 33.3%	52 29.7%
4. Other financial supporter	27 16.3%	4 44.5%	31 17.7%
Total count/ Percentage	166 95.0%	9 5.0%	175 100.0%

Table 4d shows that three major findings emerged from comparing the four divisions of class and crowding in this study. Firstly, it shows that overcrowding, based on the number of adults per room, is not a major problem. There was a total of 133 (76%) households from the three lower social classes compared with 42 (24%) households that were from the higher social class. Out of the three lower social classes, 124 (93%) reported no overcrowding whilst nine (7%) reported overcrowding.

This was irrespective of whether their parents were earning a high or low or none at all.

In contrast, overcrowding is inversely associated with low-income people, as shown by the few learners who were assigned to the lower three divisions of occupational class categories and also reported that they were staying in homes with overcrowding. Overcrowding was associated least with wealthy people, as one would expect. This was shown by the fact that 42 (25.3%) learners who reported that their parents were in the

first, managerial and professional category of occupational class also reported they were staying in homes with no overcrowding. None of the learners in the first division of occupational class reported they were staying in homes with overcrowding.

The above findings showed that high occupational class coupled with the amounts of money a person earns cannot be used as the sole indicator of social class. Other indicators such as crowding have to be considered. There were two (22.2%) learners in the second occupational class and the another three (33.3%) learners in the third occupational class who reported that they come from homes with overcrowding even though their parents were earning a better salary than the four (44.5%) learners whose financial supporters were in the lowest / fourth category of occupational class. In Chapters 4, 6 and 7 reference was made to the association of these variables as part of social class to some of the variables of the profile of the sample such as home areas, heads of households, condom availability and to other outcomes measured to determine the response of learners to the intervention programme conducted in this study.

FOUR DIVISIONS OF PROFESSIONAL CLASS AND TYPE OF HOUSE MATERIAL

Table 4e: Comparison of four divisions of occupational class versus type of building material of the house.

Divisions of occupational class	Type of material used to build house				Total
	1. Bricks	2. Blocks	3. Mud	4. Shacks & Other type	
	Frequency / Percent.	Frequency / Percent	Frequency / Percent	Frequency / Percent	Frequency/ Percent
1. Managerial and professional	11 22.0%	30 25.9 %	0 0.0%	1 20.0%	42 24.0%
2. Service and skilled manual	19 38.0%	26 22.4%	2 50.0%	3 60.0%	50 28.6%
3. Unskilled manual workers	10 20.0%	42 36.2%	0 0.0%	0 0.0%	52 29.7%
4. Other financial supporters	10 20.0%	18 15.5%	2 50.0%	1 20.0%	31 17.7%
Total count / Percentage	50 100.0%	116 100.0%	4 100.0%	5 100.0%	175 100.0%

The findings of this study showed that the type of material used to build homes was not a problem factor as shown by the above data reported by learners. Not a single learner in the 3rd category of occupational class reported that they stayed in either mud or shack houses, as shown in Table 4e. Only four (2%) and five (3%) learners from other categories reported they were staying in homes built with mud and other informal building materials, or in shacks.

Although it was not statistically significant, it was surprising to see, that one (20.0%) learner in the first occupational class reported staying in a home, constructed from informal building material, even though the parents were in a high occupational class and were assumed to be earning a high salary. They may be staying in or near town to be near work or may have to support a lot of people.

This is a common situation in Zulu families. In Zulu culture the adoption of children is not practiced but extended families are encouraged as is fostering of relatives' children. For example if a woman has a child before marriage and she then gets married to another man who is not the father of that child, she leaves the child at home with either her parents or her brother who is then expected to be the guardian and financial provider of the child. Other children may also be left by their parents due to various reasons, for example migration, death from AIDS and other reasons, as already indicated in Chapter 4. The relevance of this will be examined below as part of the proportions of high or low social class model.

The majority of 116 females (66%) and 50 males (29%) learners, from all occupational classes reported coming from houses built from blocks and bricks. The findings of this study showed that high occupational class together with the high salary a person earns cannot be used as a sufficient indicator of social class. Other indicators, such as crowding and the type of material used to build houses, had to be considered. This study showed that not all people in the high occupational class category live in houses built with expensive materials. The relevance of this will be examined below as part of the proportions of high or low social class model, as reference has been made to the relevance of proportions of high and low model in Chapters 4 and 6.

HIGH AND LOW SOCIAL CLASS MODEL

The social class of 'high or low model' was used. The high social class rating (1) was given to learners who reported that the occupation of their parents was in the managerial and professional category of occupational class, the type of material used to build house in their homes was either bricks or blocks and there was no overcrowding, meaning that the number of adults were equal to or less than two per room. The low social class rating (2) was given to learners who reported an occupational class, type of house material and number of adults per room that did not meet the criteria of high social class.

The social class interpretation was based on the numerical value or score obtained by learners who participated in this study. Hence the lower the numerical value the higher the rating of the learner's social class and the higher the numerical value, the lower the rating of the learner's social class.

HIGH AND LOW SOCIAL CLASS PROPORTIONS

The majority, of learners (134 - 76.6%) were from families of low social class as opposed to 41 (23.4%) learners who were from families of high social class. There was a significant association between social class and gender ($p = 0.019$), with higher proportions of females than male learners from the high social class. There was also a significant association between social class and school area location ($p = 0.02$), with a high proportion of learners in the high social class coming from rural schools. There was a borderline significance between the head of household and social class ($p = 0.045$), with learners from female-headed families that were also single parent families, more likely to have a low social class compared to those learners from male-headed families. Otherwise, there was no association with other demographics, such as religion or home areas of the learners who participated in this study.

Factors contributing to these significantly different proportions of learners in high and low social classes were unknown and not easy to trace. The social class of the high and low model was probably the best model for this data because we realised that the measurement could not be based on the four divisions of occupational classes alone because of the variable relationship between income, overcrowding and type of structure

of houses. The generalisation that most people, but not all, who earn more money, tended to live in less crowded conditions and in better-built houses seemed to be true.

This variable of social class is also important, like other demographics, since the findings of variables such as the social class of the learner's family helped to determine similarities and or differences existing in relation to certain exposures and outcomes that were measured, such as heads of households and knowledge of gender issues and HIV/AIDS, as indicated in Chapters 4 and 6. The association, if any, between the sexual behaviour of learners, such as the age of a learner's first sexual encounter, in relation to the social class of the learner's family, could not be revealed in the data reported by learners in this study.

These socio-demographic aspects could have some influence on the findings of this study. In Chapters 6 and 7 it is indicated that socio-economic variables are critical in explaining why some learners responded positively to the intervention phase and others did not. All these aspects play a major role in the primary socialisation of individuals to various religious and cultural values, norms and gender roles. They also influence the expectations between boys and girls that occur in the infancy, childhood and adolescent stages of life cycle. It is essential to recognise that these culturally defined gender roles and expectations influence the construction of gender- power inequalities that may contribute to young men and women's vulnerability to HIV infection.