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Khutsoane, Magauta Mirriam

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A group of adolescent girls' perceptions of HIV/AIDS and the influence of these perceptions on their sexual practices and development

A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Arts Psychology (Community-based Counselling Psychology).

Declaration

I declare that the research report is my own unaided work. It has been submitted for the degree of Master of Arts (Community-based Counselling Psychology to the University of the Witwatersrand, Johannesburg. It has not been submitted before, for any other degree or examination, to any other university.

_____

Magauta Mirriam Khutsoane

15 August 2007

Dedication

I would like to dedicate this thesis to my parents for their support and patience throughout this process, and for never giving up on me.

To my daughter Tshegofatso Mbali, you have been a true source of inspiration throughout this process.

To my sisters Moipone and Moselantja, and my younger brother Thabang, for sacrificing their lives, and taking parental responsibility for my daughter whilst I was studying.

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Societal transformations in South Africa and elsewhere have contributed to the lengthening of the period between puberty and marriage, particularly for girls; an increase in the number and nature of social contacts by adolescents; and greater opportunities and potential for youth to extend their education and skills development. These changes have increased adolescents' exposure to premarital and unsanctioned sexual activities with all their attendant health and social consequences (Blanc and Way, 1998; Zabin and Kigaru, 1998 in May et al., 2005). In the aftermath of apartheid, many South African youth were assumed to be on a path of increased economic and social opportunities. However, these opportunities are being threatened by an HIV/AIDS epidemic fuelled by high levels of unprotected sexual intercourse among the youth (May et al., 2005).

The scale of the AIDS epidemic among the youth in South Africa is enormous and is continuing its deadly course. Throughout the country, the AIDS epidemic affects a large number of adolescents with serious psychological, socio-economic and educational consequences (Hartell, 2005). Statistics indicate that globally, almost 12 million young people aged 15 to19 years are living with HIV and that a majority of new infections occur within this age group, with even higher rates among females. Globally, more than half of all people living with HIV/AIDS are female. Even in

countries such as South Africa where AIDS awareness is high, HIV/AIDS continues to have a devastating impact on the lives of women and girls (Hallman, 2005). The high rates of HIV/AIDS infection among adolescent girls points

to the need for research on the perceptions of HIV/AIDS among adolescent girls and their impact on sexual practices. The responses generated would contribute to a larger body of knowledge intended to decrease the spread of HIV/AIDS among young women.

1.1 Aim of the study

The study examines adolescent girls' perceptions of HIV/AIDS and how these perceptions influence their reported sexual practices and development. The research questions are as follows:

(a) What are the perceptions of a group of adolescent girls of HIV/AIDS in South Africa, and,
(b) What are the influences that these perceptions may have on their real or expected sexual practices and development?

1.2 Rationale

Reproductive health issues are pertinent for the mental health development of young women in South Africa. The prevalence of problems such as HIV/AIDS and unplanned or unwanted pregnancies among South African female adolescents specifically warrants urgent attention (Lesch & Kruger, 2004).

In Sub-Saharan Africa, more than two out of three newly infected 15- to 24 -year- olds are female. For adolescents between the ages of 15 and 19 years, five or six girls are

infected for every boy (UNICEF, 2005). In South Africa, there are five infected 15-to 24- year-old females for every two infected males the same age (Hallman, 2004,HSRC, 2005).

Previous research conducted in South Africa on adolescent sexuality provided largely quantitative data on the onset of sexual activity, prevalence of teenage pregnancy, contraceptive behaviour as well as knowledge, attitudes and behaviour of adolescents in respect of sexual practices (Western Cape Department of Education, 2001). There has been, however, a substantial increase in qualitative data on sexual behaviour, particularly among the youth. This has been fuelled, in part, by the increase in the prevalence of HIV/AIDS among teenagers, most often girls (Lech & Kruger, 2004).

Despite these efforts little is known about how adolescent girls make sense of their sexual behaviour in the context of HIV/AIDS. Research was previously conducted on the perceptions of adolescents in general (UNAIDS, 2004) but it failed to consider the influence that such perceptions may have on adolescent girls' sexual practices. The research also neglected the fact that there are individual differences in the way people view social problems. With the high rate of HIV/AIDS infection amongst adolescent girls, it is important to understand the meaning that these girls attach to the pandemic and how it affects their sexual practices.
This research thus aims to explore adolescent girls' perceptions of HIV/AIDS and how it may impact on their real or expected sexual practices.

1.3. Definition of terms

This section focuses on the definition of terms relevant to the study such as adolescence, perception HIV, AIDS, sexuality and sexual behaviour.

1.3.1 Adolescence

Adolescence is the period during which the growing person makes a transition from childhood to adulthood (Jersild, Brook & Brook, 1978). Although it is not linked to any precise span of years, adolescence may be viewed as beginning roughly when young people begin to show signs of puberty and continuing until most of them are sexually mature, have reached their maximum growth in height and, having approximately reached their full mental growth as measured by intelligence tests (Jersild, Brook & Brook, 1978).

1.3.2 Perception

According to Drever's (1973) dictionary of psychology, perception is a subjective process of recognizing or identifying something. The perceptions in this study refer to subjective knowledge, awareness and attitudes towards phenomena. In this study the focus is on the HIV/AIDS phenomenon.

1.3.3 HIV

HIV is an acronym for the Human Immunodeficiency Virus**.** It belongs to a group of retroviruses which have a unique

enzyme called reverse transcriptase. HIV was the first known retrovirus to infect the human species. There are two types of HIV which have been identified: HIV 1, which is the most aggressive and predominant type in the world; and HIV 2, which is less easily transmitted and is mostly found in Western Africa. Both viruses however cause HIV, which ultimately leads to AIDS (FPD, 2005; Van Dyk, 2001).

1.3.4 AIDS

AIDS is an acronym for the Acquired Immune Deficiency Virus which is a pathological condition of the immune system defined by a set of signs and symptoms attributed to infection by the Human Immunodeficiency Virus (Bruno, 1996; FPD, 2005; Van Dyk, 2001). When a person has full-blown AIDS, the immune system becomes increasingly compromised and as such the body gets to a point of being unable to fight off the infections that a normal and an intact immune system could suppress (AIDSONLINE, 2003).

1.3.5 Sexuality

Sexuality refers to the capacity to derive pleasure from sexual stimulation and particularly from sexual intercourse (Longman, 1984). It also refers to the individual's identity.

1.3.6 Sexual behaviour

Sexual behaviour refers to a pattern of behaviour related to reproduction of the species or to stimulation of the sex organs for pleasure without the objective of reproducing (Longman, 1984).

1.4 Structure of the research report

This chapter has provided an introduction, the rationale and aims of the study as well as the research questions that the study intends to answer. Chapter 2 presents the theoretical framework used to shape the study, which is the Health Belief Model. It also discusses adolescence as the focus of the study. Adolescent developmental processes are also discussed in detail. In addition, the chapter also introduces a discussion of the Human Immunodeficiency Virus and how it is transmitted, the stages of infection and diagnosis. This is then followed by a section on adolescent risk factors and the structural factors increasing young women's vulnerability to HIV/AIDS. The last part focuses on the surveyed literature on adolescents' perceptions of HIV/AIDS and their impact on sexual behaviour.

Chapter 3 presents the methodology used to collect and analyse data. It begins by introducing the rationale for choosing a qualitative method of inquiry and proceeds to discuss the method used to collect the data, which is the interview method. The chapter also discusses the demographic details of participants and the setting where the study was undertaken. Lastly, it discusses the method that was used to analyse the collected data. The chapter

concludes with a discussion on the ethical issues considered when the study was undertaking.

The research findings are discussed in Chapter 4 and are presented according to the themes generated by the analysis of data. The findings are presented under the following broad themes: knowledge of HIV/AIDS, source of information, attitudes towards HIV/AIDS, risk perception, sexual practices and the factors that expose adolescent girls to the risk of infection.

The discussion of results, strengths and limitations are presented in Chapter 5. This chapter also provides a summary and the conclusions of the study.

CHAPTER 2: LITERATURE REVIEW

2. Introduction

This chapter presents the theoretical framework that was used to shape the study, namely, the Health Belief Model. It begins by discussing the historical background and further discusses the constructs of this model. Adolescent developmental processes and tasks are discussed in the next section. The chapter also discusses HIV/AIDS, including definitions of HIV/AIDS, the transmission of HIV and the clinical stages of this pandemic. The last part of this chapter looks at the biological, social and economic factors that increase young women's risk of being infected with HIV. This would encompass literature relevant to the study, including perceptions of the pandemic and their impact on sexual behaviour.

2.1 Theoretical Framework

The broad theoretical framework for this study was provided for by the Health Belief Model (HBM). This model is significant to this study because it is a model that accounts for health beliefs, attitudes and behaviour and it also provides the researcher with constructs that are useful in answering the questions that the study intends to answer.

The Health Belief Model was developed in the 1950s by the social psychologists, Godfrey Hochbaum, Irwin Rosentock, and Stephen Kegels working in the US Public Health Service (Rosentock, Stretcher and Becker, 1994). The model was developed in an attempt to understand why

people failed to participate in programmes designed to prevent or detect disease. The Health Belief Model was later extended to understand why people do not follow medical regimens or do not respond to symptoms by obtaining the necessary medical care (Diclemente and Peterson, 1994). Since then, the Health Belief Model has been adapted to explore a variety of long-term and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS (Rosentock et al., 1994).

The Health Belief Model asserts that people will engage in preventive behaviour if they perceive themselves to be susceptible to a health condition, if they believe the condition is characterised by a high level of severity (negative health outcomes), and if they feel that the costs of engaging in the preventive behaviour are outweighed by the benefits (Diclemente and Peterson, 1994).

2.1.1 Constructs of the Health Belief Model

The constructs of the Health Belief Model are:

a) Perceived susceptibility: this involves one's subjective perception of the risk of contracting the health threat in question.
b) Perceived severity: this involves the perceptions of both the physical (death and pain) and social consequences (e.g., effects on social relations and family life) of contracting a condition or of leaving it untreated.
c) Perceived vulnerability: this determines "readiness to act," and is thought to be some type of joint

function of perceived susceptibility and perceived vulnerability.

Given the perceived vulnerability, health behaviour options are then evaluated in terms of their perceived benefits and costs:

d) Benefits involve beliefs about the effectiveness of available options for reducing the threat of the disease
e) Costs involve any potentially negative aspect of a particular health action (e.g., pain, expense, danger, stigma, side effects, and inconvenience).

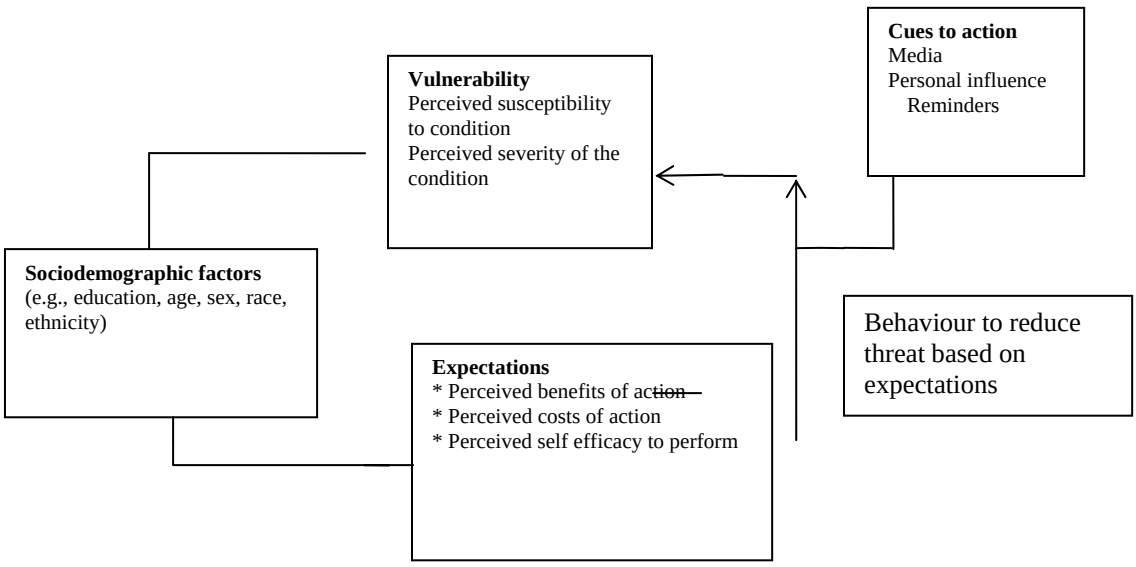
According to DiClemente and Peterson (1994), even if individuals feel vulnerable to any potentially serious condition, they will not change their behaviour unless the perceived cost-benefit ratio for doing so is favourable.

The formulators of the Health Belief Model also assumed that diverse demographic, sociological, psychological and structural variables can affect these constructs and in this way affect preventive behaviour indirectly.

Since its inception, the Health Belief Model has been subject to a number of conceptual modifications and these have included the introduction of concepts such as cue stimulus. A Cue stimulus is assumed to be helpful in promoting action and might be internal (e.g., experiencing symptoms) or external (e.g., personally knowing a person

who has the disease and being exposed to mass media communications) (DiClemente & Peterson, 1994). The notion of self-efficacy was also added to the Health Belief Model to help increase its explanatory power. Self-efficacy involves the perceived likelihood that one can personally perform the preventive behaviour successfully and experience expected positive outcomes (Diclemente & Peterson, 1994). Below is a schematic diagram of the components of the Health Belief Model (adapted from Rosentock et al. 1994).

2.1.1.1 The schematic representation of the Health Belief Model



(adapted from Rosentock et al. 1994).

2.2 Adolescence

The study focuses on adolescents; therefore it is important for one to understand the developmental stages and tasks of adolescence. This section discusses adolescent developmental processes and tasks. Firstly it provides the reader with a historical background on how this stage was previously perceived as well as the current views about it.

2.2.1 Historical background

In many developing countries, the period of adolescence has only recently been recognized as a life stage. Children used to become adults through institutionalised rites of passage such as circumcision and arranged marriages. In addition, girls were not allowed access to education and were perceived as only suitable for marriage and fulfilling wifely roles such as childbearing and performing domestic chores (WHO, 2005; UNFPA, 2005). Typically, they were married soon after menarche or even before. Husbands were generally older than their brides, more experienced with the world outside their immediate family, and socialised to demand and expect deference from their partners (UNFPA, 2005).

Today, there are social changes brought about by western, colonial and economic expansion and by the move towards a global economy and society. Adolescence is now accepted as a distinct phase of life and is associated above all with young people's efforts to find employment outside agriculture. Young people tend to attend school longer and as a consequence marry at

an older age (WHO, 2005). With these changes, adolescents are getting increasing attention in the news, in speeches of politicians, on the agendas of development agencies and in the concerns of religious leaders. There is also a growing recognition of the threats faced by adolescents around the world, including lack of education and vulnerability to illness (UNICEF, 2005).

Adolescence is typically perceived as a difficult period for most young people. During this time, they must attempt to cope with decisions regarding marriage, education, employment, reproductive health, nutrition, sexuality and childbearing, which will all influence and determine their future life course. HIV/AIDS complicates this phase even more because, despite the tasks that adolescent are faced with, they also have to cope the psychosocial ramification that this pandemic might have for them (Futterman, 2003).

2.2.2 Developmental processes and tasks in adolescence

2.2.2.1 Physical development

Growth spurt

The term growth spurt refers to the accelerated increase in height and weight that occurs with the onset of adolescence. This increase varies widely in intensity, duration and age of onset from one child and context to another. The adolescent growth spurt takes place for about four-and-a-half years and is brought on by hormonal changes in both boys and girls.

For an average boy, peak growth occurs at about age thirteen whereas for an average girl it takes place two years earlier, that is, at approximately age eleven. The growth spurt is usually completed shortly after age fifteen in boys and may continue until age seventeen. In girls, the growth spurt begins and ends about two years earlier and slow growth may continue for several years after the spurt is completed (Van den Berg, 2004; Weiten, 1998).

Puberty

This is the stage during which sexual functions reach maturity, which marks the beginning of adolescence. It is during puberty that the primary sex characteristics and structures necessary for reproduction develop fully. In the female, these include ovaries, the vagina, uterus and other internal structures. Girls also start to menstruate. However, today there have been generational changes in the timing of puberty. Today's adolescents begin puberty at a younger age and complete it more rapidly than their counterparts did few decades ago, a factor that can be attributed to improvements in nutrition and medical care (Weiten, 1998). The physical changes that occur during this period are signs of sexual awakening (Geer & O'Donohue, 1987). According to psychosocial developmental theorists, adolescents are faced with the task of satisfying their sexual desires in a socially acceptable way (Van Dyk, 2001).

2.2.2.2 Cognitive development

Beliefs and attitudes are functions of a person's cognition. Cognitive factors are important determinants of social behaviour. It is therefore essential to understand adolescents' cognitive development. Cognition refers to how we acquire information about the world, how we represent and transform such information into knowledge, and how we store, retrieve and use that knowledge to direct our behaviour (Meyer, in Van Dyk, 2001). According to Piaget's cognitive developmental stages, adolescents are capable of hypothetical thinking, which enables them to plan and identify the possible future consequences of present actions (Hook, Watts & Cockcroft, 2001). The individual's capacity for abstract and critical thought also develops, along with a sense of self awareness when social expectations require emotional maturity (WHO, 2003).

Adolescents have a complex understanding of the negative impact of HIV/AIDS (Van Dyk, 2001). In a study conducted with boys and girls in Sao Paulo, Brazil, the first association made by these young people in relation to HIV/AIDS was fear, disgrace and death. Some of them knew someone who had died of AIDS. In South Africa, adolescents made the same associations as did those in Sao Paulo. However, they also understood that there are other variables that can prolong the life of an HIV infected person, such as medication, care and healthy lifestyles (Van Dyk, 2001).

2.2.2.2.1 Identity development

The premiere challenge of this stage is to form a clear sense of identity. This struggle involves working out a stable concept of oneself as a unique individual and embracing an ideology or system of values that provides a sense of direction. Teenagers may test their identity by belonging to groups and gangs and by falling in love with members of the opposite sex. It is also at this stage where peer pressure provides criteria for the development and recognition of one's identity (Weiten, 1998).

The psychosocial developmental theorists argue that adolescence is usually a time for exploration with different ideologies, roles, experiences and careers, which will ultimately result in a firm choice of identity. They also argue that in each stage there are tasks and goals that each individual must complete or accomplish. Failure to accomplish these goals will result in conflicts in other stages, impacting negatively on the individual's identity (Cockcroft, 2001). Furthermore, these theorists argue that society should, given the above, offer adolescents sufficient time, space and social freedom to experiment with their identity formation. HIV/AIDS makes adolescence more complicated because exploring one's sexuality is a normal part of development; however, if this process is compromised because of a fear of contracting HIV/AIDS then the stage may not be negotiated properly. Alternatively, if adolescents overcome the fear and engage in risky sexual behaviour it may result in infection which may also have a negative impact on development.

2.3 HIV and AIDS

The definitions of HIV and AIDS were provided in the first chapter. The next section is a detailed discussion on the transmission and progression of the disease.

2.3.1 Transmission of HIV

HIV is transmitted through the exchange of certain bodily fluids from an infected to a non-infected individual. Sexual fluids and blood products comprise the major modes of transmission (Phillips & White, 1991 in Pawn & Prenner, 1997; Van Dyk, 2001). HIV can be transmitted through:

- Unprotected vaginal or anal intercourse with an infected person,
- Injection with contaminated, e.g. among intravenous drug users;
- Blood transfusion with contaminated blood; and,
- Contaminated perinatal fluid exchange from mother to child

2.3.2 Clinical stages of HIV

HIV infects cells in the immune system and the central nervous system. The main cell the HIV infects is called the T-helper cell, which has a CD protein on its surface. HIV uses the CD4 cell to enter the cells it infects. This is why the T-helper cell is referred to as CD 4 cell lymphocytes. Once inside the T-helper cell, the HIV takes over the cell and the virus then replicates. In this process, the infected

cell dies. The new virus seeks other T-helper cells to infect and repeat the cycle (AIDSONLINE, 2003).

If unchecked, the progression of HIV infection eventually destroys the immune system. In the later stages, the decline of the immune system leads to opportunistic infections such as cancer and pneumonia. This group of illnesses combined with the decline in the immune system due to HIV is known as AIDS. AIDS is caused by the HIV infection. It is the most advanced stage in the course of HIV infection. When a person has AIDS, the body's immune system can no longer fight off certain types of infections. Such an individual may be placed on antiretroviral medication to boost his or her immune system or the process may eventually lead to death.

HIV progression can be broken down into four distinct stages. These are listed below as follows:

2.3.2.1 Stage 1: The primary HIV infection

This stage of infection lasts for four weeks and is often accompanied by a short flu-like illness that occurs just after infection. During this stage there is a large amount of HIV in the peripheral blood and the immune system begins to respond to the virus by producing HIV antibodies.

2.3.2.2 Stage 2: Clinically asymptomatic stage

The stage lasts for about an average of ten years and, as the name suggests, it is a stage during which the individual is free from major symptoms, although there may be swollen glands. People remain infectious during this stage; HIV antibodies are detectable in the blood, so the HIV test will show positive results.

2.3.2.3 Stage 3: Symptomatic HIV infection

During this stage the immune system loses the struggle to contain the HI virus. The HI virus becomes more pathogenic. The immune system loses the struggle to contain the HI virus for three main reasons, namely:

- The lymph nodes and tissues become damaged or 'burnt out' because of the years of activity;
- The HIV mutates and becomes more pathogenic, in other words, stronger and more varied, leading to more T-helper cell destruction; and,
- The body fails to keep up with replacing the T-helper cells that are lost.

As the immune system weakens, the symptoms will develop. Initially, many of the symptoms are mild, but as the immune system deteriorates further they will worsen.

2.3.2.4 Stage 4: progression from HIV to AIDS

As the immune system becomes increasingly compromised, the body become unable to fight off infections that a normal and an intact immune system could suppress (AIDSONLINE, 2003).

2.3.3 Biological factors influencing HIV/AIDS transmission in women and girls

HIV/AIDS is now a major threat to women around the world and heterosexual sex is the most common way by which it is acquired. Women, as compared to men are twice more likely to contract HIV/AIDS as a result of sexual contact with an infected partner (Baylies & Bjura, 2000; Wijeyaratne et al., 1994). Male to female transmission of HIV/AIDS appears to be two to four times more efficient than female to male transmission. This is due to the nature of the female reproductive system which makes them more susceptible than the male anatomy to contamination by the virus (Kitts & Roberts, 1996).

The physiology of women's reproductive system has a large surface area which makes it easier for them to be infected with the HI virus (Doyal, 1995). Furthermore, there is a higher concentration of HIV that can be carried in semen than there is in the vaginal fluids. This makes it easier for men to transmit the virus to their uninfected partners than vice versa (Kleintjies et al., 2005).

Young women are at a higher risk of being infected with HIV as compared to older women. The immaturity of young women's reproductive organs makes them even more vulnerable to HIV infection than more mature women by providing more enhanced opportunity for exposure and infection (Summers, Kates & Murphy, 2002). This is due to the fact that the intact but immature genital tract surface in young women is not effective as a barrier to HIV than the mature genital tract of older women (Kitts & Roberts, 1996; UNAIDS, 2004). Furthermore, the risk for young girls is greatest because the lining of the neck of the womb is not yet fully developed.

2.3.3.1 Sexually Transmitted Infections and HIV/AIDS

Young women are also particularly vulnerable to other sexually transmitted infections. These infections also leave females more vulnerable to AIDS as they often go undetected and therefore untreated. This is because women view vaginal discharge as a normal female complaint related to their intimate life or as one of the many natural discomforts associated with being a woman (Kitts & Roberts, 1996).

Young girls are also more vulnerable because they are experiencing physiological changes for the first time. Some of them might be confused by these changes and a lack of knowledge might influence them to risk their health by engaging in early sex. Their feelings of desire lead them into adventure and exploration of themselves but it can also lead them into risky situations.

2.3.4 Social factors influencing HIV/AIDS transmission in women

2.3.4.1 Gender Roles

While physiological factors increase the risk of transmission in women from unprotected sex and accelerate the course of illness in a woman who is living with HIV, women's social location can also place them at risk of HIV/AIDS infection (Baylies & Bjura, 2000). Stereotypical gender roles place women at a heightened risk of infection (Rivers & Aggleton, 1998). In a patriarchal society, such as South Africa, multiple partners are encouraged for men whilst women are expected to be passive and give but not receive pleasure (Chege, 2005). Furthermore, women have limited control over their own lives, including their sexuality. As a result they cannot control the nature and timing of sexual activity, nor can they negotiate safer in sexual behaviour (Baylies & Bjura, 2000; Rivers and Aggleton, 1998)

2.3.4.2 Gender-based violence

The very high levels of gender-based violence against women and girls in South Africa, which includes sexual abuse, rape and domestic abuse are another reason why more women than men acquire HIV (Hjort, 2004). Research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of being infected with HIV (UNAIDS, 2004).

Gender-based violence takes the form of verbal or physical force, coercion or life threatening deprivation directed at an individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty, and that perpetuates female subordination (Pitanguy et al., 1994, in HSRC, 2004). The most common form of violence perpetrated against women is violence at the hands of their intimate partners (HSRC, 2004).

A recent review of some of the existing studies suggests that gender-based violence makes women vulnerable through several mechanisms. First and most obviously, there is a possibility of HIV transmission through forced or coerced sexual acts; secondly, trauma associated with violent experiences can impact on later sexual behaviour. Thirdly, violence or the threat of violence may limit women's ability to adopt safer sex practices within on-going relationships (HSRC, 2004).

A study in Kigali, Rwanda among women in stable relationships showed that HIV positive women are more likely to have experienced a history of physical and sexual violence at the hands of male partners than were women without HIV. Among younger women in a Tanzanian city, HIV positive women were more likely to have experienced physical or sexual violence at the hands of their current partner. The same pattern is documented in South Africa at antenatal clinics in Soweto where HIV infection was found to be more common in

women who had been physically abused by their partners than those who were not (Dunkle et al., 2004). The fear of violence may prevent a woman from requesting the use of protective measures or refusing sex. She may fear that her partner would suspect her of being unfaithful or of ‘sexual promiscuity’ and respond violently to the request (Hjort, 2004; Pettifor et al., 2004).

2.3.4.2.1 Sexual violence

Sexual violence against women and girls is a problem of epidemic proportions (UNAIDS, 2004). Reports from various studies have highlighted the fact that often girls have no choice but to have sex with their sexual partners and indeed many of their first sexual experiences may have been coerced. In 1999 for an example, a Department of Health study found that 7% of the women had been raped or coerced to have sex against their will. The SAPS, 2001 also reflect this pattern in their statistics where it was reported that 52 107 rapes and attempted rapes were reported in 2002. In addition, 40 % of the rape survivors were girls under eighteen. This pattern is also repeated in the RHRU and MRC in UNAIDS, 2004 study where it was found that 10% of sexually experienced young women said they had been forced to have sex (UNAIDS, 2004). These findings from the three studies support Shefer’s statement (as cited in Lesch and Kruger, 2004) that forced sex is a frequent finding in recent research on adolescent sexuality. This is troubling, considering that most perpetrators do not always think of wearing protection during this act and might have raped other women without having used a condom.

Sexual violence exposes women's vulnerability as they are physiologically vulnerable to infection during unprotected sexual intercourse, as highlighted in the section discussing biological factors. Furthermore, it compounds their risk as it creates a risk of trauma when the vagina is dry. Sexual violence may cause tears in skin, which also increases the risk of HIV transmission. In addition, in cases of gang rape, exposure to multiple assailants increases the risk of transmission.

Young women are especially vulnerable to this practice as men may rape them with the belief that having sex with a virgin "cleanses" an HIV infected person (Human Rights Watch, 2005).Their risk is accentuated by the customary practice of virginity testing, which publicly marks them as targets for men who seek virgins as sexual partners (HSRC, 2004).

2.3.5 Economic Factors and HIV/AIDS transmission in women and girls

Given that the burden of new HIV infections in developing countries is concentrated among the youth in general and young females in particular, there is an emerging awareness that even with knowledge on how to protect oneself from infection, such information may not always be usable in daily situations of the economic and social disadvantage that characterises the lives of many young people, especially females (Elford; 1997,UNAIDS, 2004 in Halllman, 2004).The risk of HIV infection for young

people in developing countries is increased by socio-cultural, political and economic forces such as poverty, sexual exploitation, coercion and rape, lack of access to education, migration, war and civil disturbance (Sweat & Denise, 1995, in Kuate-Defo, 1998; UNICEF, 2004).

A large proportion of Africa's population is very young and most of them live in deep poverty with few possibilities of quality education, jobs with a living wage and proper health care (Hjort, 2004). Adolescent girls living in poverty may be particularly vulnerable to sexual exploitation through the need to trade sex in order to survive (WHO, in Rivers & Aggleton, 2000). In certain areas, many resort to sex with older men, known as 'sugar daddies', in order to earn money for themselves and their families to survive and to pay school-related fees, thereby fostering and accelerating HIV transmission (Global Aids Alliance, 2004). Such transactional sex involves non-marital sexual relationships, often with multiple and older male partners, which reflects males' superior economic position and access to resources on one hand and women's difficulties in meeting basic needs and the cultural value of men having multiple sexual partners on the other (Jewkes & Wood, 2001, in UNAIDS, 2004).

2.4 Adolescent risk factors

The academic literature indicates that adolescents are among the subgroups in the population who are perceived to be most at risk of being infected with the virus, due to high- risk behaviour which might foster the incidence and

prevalence of the virus (Kuate-Defo, 1998). This section discusses risk factors that expose adolescents and adolescent girls in particular to the risk of contracting HIV/AIDS.

2.4. 1 Adolescent girls' sexual behaviour

There has been a substantial increase in international research efforts into sexual behaviour and reproductive health during adolescence. This is, in part, influenced by the concern over the spread of the Human Immune-deficiency virus and AIDS (Cleland and Fery, 1995 in Kuate –Defo, 1998). South Africa is experiencing one of the fastest growing epidemics through heterosexual transmission (Hartell, 2005). Considering this factor and the area of focus for this study, it is imperative to review adolescent girls' sexual behaviour and how it exposes them to HIV/AIDS.

2.4.1.1 Age of first sexual encounter

Many young people become sexually active in their teens, and many before their fifteenth birthday (UNAIDS, 2004). Factors such as increasing urbanization, poverty, exposure to conflicting ideas about sexual values and behaviour and the breakdown of traditional sexuality and reproduction information channels are perceived to encourage premarital sexual activity among adolescents (UNAIDS, 2004). For example, among girls in certain parts of Africa and South Asia the first sexual experience usually takes place at 15 to 16 year of age. In South Africa a number of studies have also documented the same pattern whereby it was found

that the mean age for the first sexual encounter was 16 years for boys and 17 for girls (Pettifor et al., 2004)

This pattern was observed among a large sample of girls in KwaZulu-Natal. In a study by Manzini (in WHO, 2003), almost half of the sample had already had their first sexual experience at the age of 16. These findings pose a serious concern because adolescents may not have sufficient knowledge about sexuality and protection during intercourse, thus putting themselves at risk of contracting sexually transmitted infections, including HIV.

2.4.1.2 Number of sexual partners

Unprotected sex with multiple sexual partners increases the risk of HIV acquisition and the risk is increased in the context of South Africa's AIDS epidemic. This finding, as documented by various studies (National Survey; 2003; Population Council Study, 2003) also raises concerns for adolescents. Adolescence is characterised by the development and exploration of sexuality. This period may therefore frequently involve a high turnover of sexual partners (Futterman, 2004; Lear, 1995 in Macphail, 2004). However, the RHRU, (2004) study found that youth in South Africa had only one sexual partner during the year preceding the study, with females reporting this more than males (RHRU, 2004).

2.4.1.3 'Age mixing'

Another, another factor that is seen to expose girls to HIV infection is 'age mixing'. Research findings have indicated that engaging in sexual relations with older partners is the

norm for adolescent girls. Girls have few partners who are of similar ages and even fewer who are younger (Kelly et al., Konde Lule et al., Calves & Meekers, 1997, in Luke & Kurtz, 2002). According to a study done among black adolescents on sexual risks behaviours associated with having older sex partners, it was found that 62% of adolescent females reported that their typical sex partners were their senior by at least two years. These adolescents were likely to report never using condoms during their most recent sexual encounter. This ‘age mixing’ may be fuelled by the myth among men in some places that having sex with a virgin can cure HIV and the belief that young girls are free from HIV infection (UNAIDS 2005).

The relationship characteristics, such as age and educational differences do not favour the adoption and maintenance of behaviour protective against sexually transmitted infections, including HIV/AIDS (DiClemente et al., 2002). They instead undermine young women’s ability to influence when sexual intercourse occurs and to negotiate condom use if there are suspicions of infidelity among their partners, thus increasing their risk of HIV infection (DiClemente et al., 2002). The motivations for adolescent girls to engage in sexual relations with older partners vary from trying to find love to financial reasons. However financial reasons seemed to be the main motivation as reflected in section 2.3.5.

2.4.2 Knowledge, risk perception and sexual behaviour

This section focuses on adolescents' awareness of HIV/AIDS, risk perception and sexual behaviour, such as abstinence and condom use. It starts by reviewing studies done on HIV/AIDS awareness and its impact on sexual behaviour. Previous studies have noted that though awareness is high, this often fails to translate into substantial behaviour change (Macintyre et al., 2004; Mwite, 2000). Some studies have also argued that knowledge alone is not sufficient to facilitate behaviour change or as an important determinant of HIV preventive behaviour (DiClemente & Peterson, 1994).

AIDS awareness is generally high in South Africa. However, this basic awareness often fails to translate into meaningful behaviour change, as evident from recent surveys showing that substantial numbers of young people continue to participate in unprotected sexual activity (Lesch and Kruger, 2004). For example, a study by Mbengashe (1996), on AIDS knowledge and attitudes among black high school children in Port Elizabeth revealed that despite having a relatively high level of awareness, the youth still indulged in high risk behaviour and regard themselves as invulnerable to HIV/AIDS. The study noted a discrepancy in knowledge of the disease and sexual practices of the youth. For example, of the 268 respondents who were interviewed, 67% had never used a condom during sex (Mwite, 2000)

Another study conducted among adolescents in Kwa-Zulu Natal confirmed that 98% of the participants who were interviewed knew about HIV/AIDS and possible modes of transmission and ways of protecting oneself against the disease, however, among this group only 61% felt confident that they used condoms effectively (Rutenberg et al., 2001).

A UNAIDS studies have however shown that this is not the case. In fact, when young people are provided with accurate information on sex and HIV/AIDS, they are more likely to delay their sexual activity and use condoms when they finally do have sex. The transition to adulthood study concluded that youth who were exposed to sex education were more likely to delay debut or use protective measures when engaging sex (Population Council, 2001).

Risk perception

Risk perception is a key construct of research applying the Health Belief Model and other behaviour change models. In relation to HIV, risk perception is an indicator of perceived susceptibility to infection, a measure of one understanding of AIDS transmission as well as willingness to consider behavioural changes (Macintyre et at., 2004). The present study examines adolescent girls' perceptions of HIV/AIDS, including their sense of vulnerability to this pandemic.

In order for young people to take precautions to protect themselves from HIV they have to believe that they are at risk of becoming infected with HIV/AIDS (Brummelhuis &

Herdt, 2003). Craig (1992) however argues that as part of the transition to adulthood, adolescents have a personal fable, which forms part of identity formation. This is their belief that they are unique and nothing bad will happen to them. This myth that they are at no risk can be detrimental to their health, as they might engage in risky sexual behaviour.

This myth is reflected in a number of studies globally and nationally. For example, a study conducted with adolescent boys and girls in Sao Paulo found that young people think that everyone is at risk, but paradoxically they are not at risk because of their way of life. They believe that sexual intercourse with a commercial sex worker or a drug addict is risky, and if they reduce the frequency of intercourse with these individuals they are not at risk (Brummelhuis & Herdt, 2003).

In South Africa, a study on HIV and sexual behaviour among the youth revealed the same pattern whereby 36% of the youth believed they were at no risk at all of contracting HIV and 35% reported being at small risk. More females than males perceived themselves to be at great risk for HIV (Pettifor et al., 2004). It is interesting to find that young women perceived themselves to be at risk as this could contribute towards preventive behaviour change. A study by Macintyre et al. (2004) demonstrates the same trend among adolescents in KwaZulu-Natal whereby it was found that 20% of the sample of adolescents with high risk behaviour perceived themselves to be at no risk because they abstain or use condoms during intercourse. However, this was inconsistent with their behaviour (Macintyre et al., 2004).

Behaviour change

Condom use

Adolescents generally have mixed feelings about the importance of using a condom. In a study conducted on the sexual health, knowledge, attitudes and experiences of adolescents, many young people agreed that sex without a condom is risky but some saw occasional sex without condoms as not a big deal. Some adolescents also believed that unless you have many sexual partners you do not need to use a condom (Pettifor et al., 2004). In the same study, of the 59% of women who had sex, 57% reported that they were using a method of pregnancy prevention, 58% reported that they were using injectable contraceptives, 34% reported using male condoms and 13% reported using oral contraceptive pills. (Pettifor et al., 2004). In another study conducted among Thai adolescents, participants indicated that they only use condoms to prevent pregnancy (Thato et al., 2003).

With the high rate of injectable contraception (as compared to condoms) it is evident that the prevention of HIV/AIDS is considered secondary to pregnancy. The key concern that women and girls have is not falling pregnant (UNAIDS, 2004). This places more women at risk of contracting HIV/AIDS and other sexually transmitted infections (UNAIDS, 2004). According to another study done among black adolescents on high sexual risky behaviour associated with having older sex partners, it was found that adolescent females have sex partners who are two years

older than them and that their relationship dynamics do not favour the adoption and maintenance of behaviour protective against STIs and HIV infection (Diclemente et al., 2002).

This chapter has attempted to provide the reader with a review of the literature relevant to the study. It also provided a discussion on HIV and AIDS. Lastly it has attempted to show the factors responsible for transmission among women and girls and in particular factors exposing adolescent girls to the risk of contracting HIV.

CHAPTER 3: METHODS

Introduction

This chapter discusses the research methods employed in this study. Firstly, it provides the reader with rationale for using an exploratory method of inquiry. The chapter also introduces the participants' demographic details. It also discusses the setting where the research was conducted and the method used to collect and analyze the data. In conclusion, the chapter discusses the ethical issues that were taken into consideration in conducting the research.

The present study was exploratory in nature, trying to understand what perceptions adolescent girls attach to HIV/AIDS and how these influence their sexual practices. Thus, a qualitative method of inquiry has been employed. In qualitative studies, the researcher tries to understand and describe the ways in which different individuals make subjective sense of their lives. The objective of qualitative research is to promote better self understanding and to increase insight into the human condition (Babbie, 2004).

3.1 Research Questions

The research questions for this study were as follows:

(a) What are the perceptions of a group of adolescent girls of HIV/AIDS

(b) What influence do these perceptions of HIV/AIDS have on adolescent girls' reported sexual practices and development?

3.2 Research Participants

The participants in this study were selected from a community of learners who attend Tetelo Secondary School in Protea North, Soweto, in Johannesburg. The school has a total population of 1 500 learners. The school was chosen because the girls' group was easily accessible. It was also convenient for the learners as they resided in the area where interviews were conducted. Twelve participants were interviewed. Qualitative samples are usually small in size and this is because there is no concern about prevalence or incidence of phenomena under investigation. There is therefore no requirement to ensure that the sample is of sufficient scale to provide estimate or to determine statistically significant discriminatory variables (Ritchie & Lewis, 2003).

For sampling purposes, a purposive and convenience sampling method was used. Participants were chosen based on their ability to provide needed information, their

availability as well as their willingness to take part in the study. All the participants were adolescent girls aged between 15 and 19 years. The participants presented as being cognitively able to participate in the interviews. The demographic characteristics of participants are tabulated below (See table below)

3.2.1 Background characteristics of participants

Age	Racial group	First language	Grade
15	African	IsiZulu	10
15	African	IsiZulu	10
16	African	IsiZulu	11
16	African	IsiZulu	11
17	African	S. Sotho	10
17	African	S. Sotho	11
17	African	S. Sotho	11
17	African	S. Sotho	11
18	African	S. Sotho	12
18	African	IsiZulu	12
18	African	IsiZulu	11
19	African	IsiZulu	12

3.3 Interview

Qualitative research is quintessentially interactive, meaning that the researcher is involved face to face with participants in the study. In experiments or surveys, for example, participants interact with standardised sets of procedures or written questionnaires; researchers have little or no contact with the participants. A qualitative study takes the researcher into the field, into complex and varied interactions with the participants. This implies that knowledge constructed during qualitative studies is interpretive. Researcher make meaning of or interprets what they learn as they go along (Rossman & Rallies, 2003).

The aim of this study was to explore adolescent girls' perceptions of HIV/AIDS. Thus, an exploratory method of inquiry, namely, the interview was used as a tool to collect data. Exploratory research is an excellent means of breaking new ground and generating new insights into the nature of an issue we know little about (Marlow, 1993). The interview method was sufficiently flexible for the study and allowed the interviewer to explore some of the participants' responses in depth and to repeat or rephrase questions where the participants did not understand clearly what the questions required. In addition, the researcher was also able to probe for more specific answers to questions so as to obtain a deeper and fuller understanding of the participants' perceptions (Bailey, 1994; Berg, 1995, Ritchie & Lewis, 2003). The interviewer used English as medium of discussion; however, code switching occurred as some learners found it easier to express themselves in IsiZulu

and South Sotho at times. Their responses were then translated into English. Each participant was interviewed and the interviews were conducted for about 30 to 35 minutes with each participant. The participants' responses were audio-taped, with their full consent.

3.2.1 Interview schedule

The schedule consisted of general open-ended items which were drawn from the Health Belief Model, including the following:

a) What do you know about HIVAIDS?

b) How did you come to know about HIV/AIDS?

c) Do you know of any sexual practices that put girls at a risk of being infected with HIV/AIDS?

d) Do you think girls your age are at risk of being infected with HIV/AIDS and why?

e) Has your knowledge of HIV/AIDS changed the way in which you express your sexuality?

f) Do you think HIV/AIDS will have an impact on your sexual practices

3.4 Researcher reflexivity

Given the interpretive nature of the research, the researcher's biography shapes the project in important ways. It is crucial therefore that researchers develop an acute sensitivity to who they are in their work (Rossman & Rallies, 2003).

HIV/AIDS poses a serious health risk to women, men and children worldwide. Despite all efforts made, a cure has not been found and HIV continues to have a devastating impact on the economy and health of many South Africans. The researcher has always had an interest in HIV/AIDS, having worked as an HIV/AIDS counsellor before she developed a general interest in how people make sense of this pandemic. Her involvement in the Knowledge, Attitudes, Behaviour and Perception (KABP) study among mineworkers in the Goldfileds area (Virginia-Free State) lightened this interest, especially because older people held various negative or erroneous views regarding this pandemic.

During her training, the researcher was involved in a project that researched HIV positive mothers and HIV positive pregnant women, the majority of them were young women. This sparked the researcher's interest as most women were probably infected whilst in their teen years. Her passion to contribute to the knowledge in this field grew out of this programme. Furthermore, during her internship, the researcher counselled many HIV/AIDS clients who related their daily struggles whilst living with the pandemic.

3.5 Setting

The research was conducted after school hours at the target school. The interviews took place in a room next to the school. This obviated the need for participants to make additional transport arrangements, however, some participants were more comfortable at their own homes and in such instances a private room was used to avoid any distractions.

3.6 Data analysis

The aim of qualitative data analysis is often the discovery of patterns among the data, patterns that can aid in the development of a theoretical understanding of young adolescents' perceptions of HIV/AIDS (Babbie, 2004). Data obtained from the interviews were transcribed and analyzed by means of thematic content analysis. This is a method used to organize and make sense of data. It allows the researcher to form new concepts, formulate conceptual definitions and to examine the relationship among concepts.

Qualitative research is usually rich in detail and as a result, the information collected needs to be reduced into manageable elements in order to make analysis of the data a simpler process. The researcher focused on themes as units of analysis and used open coding by assigning initial codes or labels. Codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study. They are usually attached to chunks of varying sizes of words, phases, sentences or whole paragraphs, connected or unconnected to a specific setting (Miles & Huberman, 1994, in Neuman, 1997) in an attempt to condense the mass of data into categories (Berg, 1995).

Open coding is the part of the analysis that pertains to the naming and categorization of phenomena through close examination of data (Babbie, 2004), for example, the researcher used the following codes P1: Q1 to represent participant 1 and question 1. It brings themes to the surface and from deep inside the data. It was guided by the research question and led to new questions. It also moved the researcher towards theory and generalization (Babbie, 2004; Berg, 1995). During open coding, the data were broken down into discrete parts, for example, *Question 1: what do you know about HIV/AIDS?* Responses to this question were grouped together as shown below, closely examined, compared for similarities and differences. Questions were also asked about the phenomena as reflected in the data (Babbie, 2004):-

- P1: Q1 HIV/AIDS is a killer disease that is contracted through sexual intercourse,
- P2: Q1 HIV is virus that causes AIDS
- P3: Q1 HIV/AIDS is a disease that cannot be cured

The second step that was employed after open coding was axial coding. In this regard, the researcher focused more on the coded themes than on the data. It is during this phase that the researcher asked about causes and consequences, conditions and interactions, strategies and processes and looked for categories that clustered them together. Additional codes or new ideas which emerged during this phase were also explored in detail and included in the literature review. For example, peer pressure was

identified as a practice that exposed girls' vulnerability to HIV/AIDS. Axial coding stimulates thinking about linkages between concepts or themes and it raises new questions. It can suggest dropping some themes and examining others in more depth (Neuman, 1997).

Another step that was used in the analysis process was selective coding. This step involved scanning data and previous codes. In this regard, the researcher looked selectively for cases that illustrated themes and made comparisons and contrasts after the data collection was completed. During this process, major themes or concepts ultimately guided the researcher's study. The researcher reorganized specific themes identified in earlier coding and elaborated more than one major theme (Neuman, 1997).

The last step that was taken is termed successive approximation. This process involved repeated iterations or cycling through steps and moving toward a final analysis. The researcher moved from vague ideas and concrete details in the data toward a comprehensive analysis with generalizations. The researcher began with research questions and a framework of assumptions and concepts. This included probing the data, asking questions of the evidence to see how well the concepts fits the evidence and reveal features of the data. Once the process was completed, the researcher created new concepts from the evidence and adjusted some of the concepts to fit the evidence better (Neuman, 1997).

3.7 Ethical considerations

The researcher obtained permission to conduct the research from Committee of Human Ethics at the University of the Witwatersrand. Permission to gain access to the targeted school was granted by the Department of Education (see Appendix A) and permission to gain access to the school premises and to recruit participants was granted by the school principal of Tetelo Secondary School (Appendix B). The researcher recruited participants by giving them information sheets (see Appendix D) to read and contact her if they were interested to participate in the study.

Parents were also given two consent forms to complete (see Appendix C). The first form was for permission for their children to participate in the study and the second one for permission to audio-tape the interviews.

The participants were given an information sheet explaining the purpose of the study (see Appendix F). In addition, participants were also issued two assent forms. The first one explained to them that participation in the study was voluntary; no one was forced to participate and that they should not participate unless they felt completely comfortable (see Appendix G). It also explained that there were no rewards for participating and they could withdraw from the study at any point. In addition, it made mention of the fact that all information was confidential.

The second assent form was intended to ask participants' permission to audiotape their responses. The assent form

also included information that the tapes would be destroyed after the data has been analyzed.

This chapter has provided a description of the methods used to collect the data. It discussed the rationale for using qualitative research in general and the interview in particular as a method used to collect the data. It also provided the participants' demographic details and a description of the setting in which the research was conducted.

CHAPTER 4

4.1Research findings

AIDS has had the most devastating impact worldwide and in particular, sub-Saharan Africa. Its prevalence is continuing to rise in most countries in the world. With a feasible vaccine still years away the most efficient means of fighting this pandemic, amongst other strategies, the focus on behavioural changes such as reductions in risk behaviour remains the only way to reverse the epidemic (Van den Berg, 2004). Efforts have been put in place to curb the spread of this disease through sex education in schools and communities. Despite the widespread knowledge of the consequences of HIV/AIDS and of preventive measures to avoid infection, risky sexual practices remain rampant among the youth in South Africa. It is therefore imperative to understand adolescent girls' perceptions of HIV/AIDS, as this would help in tracking trends in knowledge, risk perception and behaviour change among them and also to help prevent the spread of HIV/AIDS.

This chapter presents the findings generated from the raw data. These findings are presented under the following broad themes: perceptions of HIV/AIDS, factors that expose adolescent girls to the risk of contracting the virus and lastly the impact of these perceptions on adolescent girls' sexual practices.

4.1.1 What are adolescent girls' perceptions of HIV/AIDS?

Findings from this study suggest that adolescent girls do have a general knowledge about HIV/AIDS including the transmission of HIV. Among other things, the data also suggest that participants are aware of the consequences of contracting the HI virus

4.1.1.1 HIV as a health and death threat

The majority of participants in this study perceived HIV as a causative agent for AIDS leading ultimately to death. Some participants perceived it as an incurable disease whilst others perceived it as a killer disease. In addition, they also perceived it as a sexually transmitted infection. The following excerpts illustrate these findings:

HIV is a virus that causes AIDS and kills and is contracted through unprotected sexual intercourse (Respondent 12)

HIV/AIDS is an incurable disease that is killing most people (Respondent 1)

HIV/AIDS is a killer disease that is contracted through unprotected sex (Respondent 3)

The above excepts suggest that there is a general fear of contracting HIV among adolescent girls. Participants seemed particularly concerned about the physical

consequences of contracting this disease. Being infected with HIV in South Africa also still carries a lot of stigma. This is because people are scared of being ostracised from and of being discriminated against by their communities (Pelzer, 2003).

There was an awareness that HIV is not curable and that it is also affecting a lot of people. This could be due to adolescent girls' personal experiences of seeing people infected with HIV and some dying from AIDS related illnesses.

The data also suggest that adolescent girls in this study are well informed about HIV transmission, with all of them knowing that the virus is spread mainly through sexual intercourse. See the excerpts below.

HIV is a killer disease that is contracted
Through unprotected sex (Respondent 3)

HIV is a sexually transmitted disease
that is affecting most people (Respondent 8)

HIV is a virus that is killing most people and
Can be contracted through having unprotected sex
with an infected person (Respondent 7)

This is particularly true in South Africa where most infections are spread through sexual intercourse as concluded by various studies (HSRC, 2005, UNAIDS, 2005). This finding concurs with the literature reviewed earlier which concludes that levels of HIV/AIDS knowledge are high among the South African population.

4.1.1.2 HIV/AIDS as a career

Two participants indicated that they viewed HIV/AIDS as a career for some people because of the government support grant system that has been put in place to support infected individuals and the free educational material that are usually handed out in HIV/AIDS awareness campaigns.

> I see HIV/AIDS as career for most people especially in poverty stricken areas, as we know HIV infected individuals now have access to grants, so some people go to the extent of infecting themselves with the hope that they will have access to these grants. In certain cases you know that when there are outreach campaigns that there is going to be free t-shirts, music, etc, (Respondent 3)

> As girls we have this mentality that my HIV is better than yours so I am going to have access to a government grant'. Its like people get infected intentionally knowing that the government will give them grants but they are actually killing themselves (Respondent 7)

The data reveals that adolescent girls particularly those from impoverished backgrounds may engage in risky behaviour knowing that they will gain access to support grants. For prevention purposes, this perception could help identify trends and misperceptions surrounding access to social support grants for individuals infected with HIV and what impact they have on people's sexual practices.

4.1.1.3 Perception of risk

Perception of risk has been theorized to be an important antecedent to adopting protective behaviour. If individuals do not think that they were personally at a risk of HIV infection chances of them changing behaviour would be very low. In the present study, perceptions of risk are divided into two categories namely: a) adolescent girls with low risk perception and low risk behaviour, and b) adolescent with low risk perception and high risk behaviour.

In the first category, adolescent girls perceived themselves to be at a lower risk because they were not sexually active. This group saw HIV/AIDS as a serious problem for their peers as evidenced by the following statements from two respondents:

Yes, adolescent girls are at a high risk of being infected with HIV because they …… (Respondent 1)

Highly so…they are at a high risk because ….. (Respondent 7)

The second category presents adolescent girls with low risk perception and high risk behaviour. Responses indicated that this group does not take HIV/AIDS seriously. Their responses suggest that they may have a personal fable as they believe HIV is something that happens to "other people".

In addition, adolescent girls in this group were more concerned about the prevention of pregnancy, as indicated by an excerpt from one participant

Not really, we girls are more concerned
about preventing pregnancy than HIV (Respondent 3)

This is particularly troubling considering that most people become infected in their teens and there is a high use of injectable contraception among youth as compared to condom use. Various studies in South Africa have documented the issues around pregnancy and HIV. For example, the study by Rutenberg et al., (2002), found that pregnancy prevention takes priority over disease prevention, as seen in the current study.

4.1.2.1 Proximity of the Epidemic

The experience and personal knowledge of someone living with HIV/AIDS is also thought to influence risk perception. The argument behind this experiential theory is that AIDS does not become real or that denial is preferable, including denial of risks until one witnesses someone ill or dying of AIDS (Macintyre et al., 2004). The following excerpts allude to this fact:

I learned about HIV/AIDS from home, because my sister
was infected. I saw how she suffered until she died (Respondent 1)

I came to know about HIV/AIDS from my two school mates who were
infected and they used to teach us about the dangers of this disease (Respondent 2)

The statements above give an account of how some participants came to know about HIV/AIDS. In the current study, participants who personally knew someone who was infected with the virus perceived themselves to be at a lower risk of contracting the virus. These participants also saw HIV/AIDS as a concern for their peers because of their sexual behaviour. This finding supports the theory that experience and personal knowledge influences one's risk perception. The proximity of the epidemic also has an influence on their sexual behaviour as discussed in the section dealing with impact of perceptions on their sexual practices.

4.1.2. What puts adolescent girls at the risk of being infected with the virus?

The physical and psychological changes that are intrinsic to the development of young people contribute in special and virtually unavoidable ways to their vulnerability to HIV infection. These range from thin, delicate and easily lacerated membranes in the immature genital tract of a girl, through lack of experience and assurance on the part of both girls and boys, to an almost compulsive urge to experiment, take risks and show oneself as an adult. This section presents factors that are perceived as responsible for exposing adolescent girls to the risk of HIV infection (Kelly, 2000).

4.1.2.1 Early onset of sexual intercourse

Consistent with the literature reviewed earlier, participants in this study cited early sex as one of the factors that exposes adolescent girls to the risk of being infected with the virus. The exceprts below support this finding:

> Adolescent girls are at risk because they engage in sex at an early age and at this time they usually do not have the right information about sex or HIV/AIDS (Respondent 1)

> Adolescent are at a higher risk because they become sexually active before they are even matured (Respondent 3)

The data suggest that adolescent girls are aware of the consequences of engaging in early sex, particularly if one does not have the right information. In addition, the data suggest that early sexual intercourse is perceived as an activity that kills. Sexuality is an important facet of adolescent development, and therefore, if the process is halted by challenges such as HIV it may have a negative impact on adolescents' sexual identity.

Although many social customs discourage sexual relations before marriage, available evidence suggests that that premarital sex is common among young people. Studies have shown this trend to be more common among young people in the urban areas (Kaufman & Stavrou, 2002; Mahay & Gupta, 2002 in Adedimeji, 2005). Responses from this study indicate that adolescent girls are aware that premarital sex is common among their peers.

4.1.2.2 Peer pressure

Peer pressure has been perceived to have a negative influence on adolescent girls' sexual activities. This is reflected in the percentage of girls who cited peer pressure as one of the factors that put adolescent girls at the risk of HIV infection.

Most girls have sex because their friends are doing it (Respondent 1)

Girls engage in sex because they want to belong and to be seen as 'cool' by their friends (Respodent 10)

These findings are consistent with the literature reviewed earlier and with other studies which have concluded that peer group norms and values do influence adolescent behaviour, including behaviour related to the onset of sexual activity, attitudes toward HIV, condom use and safer sex behaviour (Swartz et al,2005).

4..1.2.3 Experimentation

Adolescence is a period characterized by the development and exploration of sexuality (Krahe & Reiss, 1995, Lear 1995, in Macphail, 2004). The participants in this study indicated that adolescent girls are at risk of being infected with the virus because of their inclination towards sexual experimentation. The following statements support the information above:

As adolescents, even though we know about condoms, we still want to experiment how it feels to have sex without a condom its like we want to satisfy our curiosity (Respondent 2)

As girls we have this mentality that the world is coming to an end therefore we need to experiment things including sex without a condom (Respondent 8).

4..1.2.4 Ignorance

A smaller number of participants indicated that only those that are ignorant and do not take HIV/AIDS serious are at a risk of being infected with HIV/AIDS.

> I don't think all the people are vulnerable, it is rather those who are ignorant and those who still believe that HIV/AIDS does not exist who are at risk (Respondent 6)

> It is not that we do not take HIV serious we do, but not to the extent that we may refuse sex because we do not have a condom at that time (Respondent 3)

This finding suggests that some adolescent girls may still be ignorant about the impact of HIV despite the knowledge of protective measures. In addition, this may also suggest that they put pleasure before their health. This is concurrent with the literature reviewed earlier which suggested that ignorance is one of the factors contributing to adolescents and youth vulnerability to HIV infection. Most young people allege that they know something about HIV/AIDS but many claim ignorance of ways that could be lethal for their health (Kelly, 2002). The data also demonstrate that there are various factors that may contribute to sexual decision making such as availability of condoms at the time of intercourse.

4..1.2.5 Alcohol use

Participants in this study identified alcohol use as one of the factor that exposes them to the risk of being infected with HIV. The following excerpts from two interviewed participants demonstrate this point:-

> The reason why I say yes we are at a risk is because as teenagers we like going to parties and get drunk, as a result we end up ignoring the use of condoms (Respondent 3)

> Girls are also at a risk because of alcohol use. In most cases they go out with their boyfriends and they convince them that using condoms will not be necessary, as a result they end up believing them because they cannot make the right decision when drunk (Respondent 1)

These transcript remarks demonstrate that alcohol use is perceived to have an impact on adolescent girls' sexual decision making. This presents a challenge to prevention programmes targeting vulnerable youth, especially the ones using alcohol and drugs. Macphail (2004) states that alcohol use often leads to unplanned episodes of casual sex. Alcohol and drug abuse among adolescents is a problem in its own right as well as being associated with risky sexual behaviour (Jessor et al., 1991; Fortenberry et al., 1997, in Rutenberg et al., 2001). Teenage experimentation with drugs and alcohol frequently leads to the adoption of high-risk behaviours or engagement in unplanned episodes of casual

sex (Weatherbun and Project Siama, 1992, in Macphail, 2004). The National Survey 2004 found that 24% of the youth had sex while under the influence of alcohol (Pettifor et al., 2004). These sexual behaviours in conjunction with drugs or alcohol use (and abuse) may increase the likelihood of becoming infected with HIV. During this time adolescents are often unlikely or unable to protect themselves appropriately as they demonstrate an inclination to sexual experimentation, often with multiple partners.

4.1.2.6 Trust

Trust emerged as one of the sub-themes and as one of the factors that exposes adolescent girls to the risk of being infected with HIV.

> A friend of mine once told me that she sees no
> need to use a condom because she trusts her boyfriend,
> and she also said that if she suggest protected sex it would seem like she
> does not trust her boyfriend (Respondent 12).

This finding suggests adolescent girls believe in pledging their fidelity by risking their lives, even if they know how to protect themselves against the disease. In addition, this may also be due to the fact that insisting on safer sex may imply that one of the parties is either infected or is sleeping around. This is consistent with the literature identified by Kelly 2002, which found that one of the factors that exposes adolescents to HIV/AIDS is the trust they show when they enter into a relationship.

In many instances, young people engage in sexual intercourse without the necessary protection as they feel that insisting on protection might demonstrate a lack of trust in their partner as reflected by the above excerpts. In several cases where they first use condoms, they may stop after some weeks or months of a relationship, arguing that there is no longer any need as they are faithful to each other. In addition, the length and intensity of a relationship influences condom use, the longer a relationship lasts the greater the likelihood that condom use will be discontinued (Maharaj, 2006).

4.1.2.7 Lack of parental guidance

One participant mentioned that lack of parental guidance exposes girls to the risk of being infected with the virus. According to her, parents especially mothers could play a major role in preventing the spread of HIV/AIDS among adolescent girls. In support of this finding, Adams and Berzonky (2003) argue that parent-child relationships, parental control, and parent-child communications have all been implicated in adolescent sexual behaviour. According to them, better parent-child relationships are associated with postponing intercourse, less frequent intercourse and fewer sexual partners. They also outline mechanisms which may underlie the association between family and adolescents, for example, poor parent-child relationships may enhance the susceptibility to peer influences or increase the propensity to associate with deviant friends.

if our parents could talk to us about sex I think we
would be eliminating one problem towards preventing HIV/AIDS.
Our parents especially our mothers, find it difficult to talk to

us about sex related issues thinking that this would encourage us to become sexually active.

This statement suggests that parental involvement in adolescent sexuality is limited. The data show that adolescent girls acquire sex information mostly from their peers and from school as demonstrated by the excerpts below. In this instance, school-based life orientation programmes in particular were consistently ranked as the most prominent source of HIV/AIDS information. Some participants mentioned that they knew HIV-infected learners from their school who were educating them and relating their experiences to them. Only one participant personally knew someone who was infected with HIV and died from AIDS related illness.

I came to know about HIV/AIDS through a life orientation subject at our school whereby we would learn about how HIV is transmitted and other things such as (Respondent 8)

I firstly learned about HIV/AIDS from school in the Life Orientation Programme, and also from a youth organisation that I usually attend on Wednesdays at Protea North (Respondent 7).

I came to know about HIV/AIDS from home, because my older sister was infected by it. I saw the pain she went through before she died, it was really hard for her' (Respondent 2)

In addition, participants suggested that for prevention purposes parents need to be empowered to help curb the spread of HIV among adolescents. The Love life campaign

has already embarked on a campaign with their logo ‘love them enough to talk about sex’ current one stating ‘if you are not talking to your children about sex then who will? This is made very interesting in an effort to promote open communication between parents and children about sexuality.

4.1.3 What impact do these perceptions have on adolescent girls’ sexual practices?

Participants were generally not forthcoming about their sexual activities. The majority of participants in this study are still young and reported were not sexually active at the time of conducting interviews. In the past decade, significant of attention has been given to providing young people with increased knowledge about HIV and with increased behavioural skills to practice safer sex. The HIV literature has shown that knowledge of HIV transmission is a necessary, but not sufficient prerequisite for teens’ HIV preventive behaviours (Kirby & DiClemente, 1994). The following themes emerged from the data about what impact the perceptions of HIV/AIDS had on their sexual practices. These are divided into two broad categories, namely:-

(a) positive impact, and,
(b) no impact

4.1.3.1 Positive impact

4.1.3.1.1 Delayed sexual debut

Delaying sexual debut is one of the strategies recommended to avoid HIV infection, particularly among the youth. Most studies have however proven that adolescents engage in sexual practices at an early age and are most likely not to use protection at this time. The following excerpt confirms this fact:-

I have seen what HIV does to people and
I think I am more informed to make the right
decisions like delaying first sexual encounter
until I am matured enough (Respondent 1)

Unlike my peers who rush into things, I have decided
To wait until I am old enough to understand the facts
About sex and HIV/AIDS before I engage in any sexual
Activity (Respondent 9).

The data reveal that personal experiences may have an impact on adolescent girls' sexual practices as seen in the above statement. The data also reveal that the experience of seeing someone suffer from HIV or die of an AIDS related illness has an impact on adolescent girls' sexual practices. In addition, the data suggest that the level of maturity also helps in sexual decision making.

4.3.1.2 Condom use

Condoms are highly effective in preventing the spread of STIs, HIV and unintended pregnancies. When used consistently and correctly, male condoms can provide as much as 94% reduction in the risk of HIV contraction. The majority of participants also stated that should they decide to

engage in sexual activity, they would use condoms as precautionary measures. This is demonstrated by the excerpts below:-

Certainly yes, if I decide to engage in sex I would use a condom (Respondent 12)

Yes, I think I am informed enough to make the right choice like using a condom should I decide to engage in sex (Respondent 3).

This finding suggests that some adolescents believe condoms are effective in preventing the spread of HIV. This finding is consistent with the study conducted among young people in KwaZulu-Natal where participants named condom as a key method of preventing the disease (Maharaj, 2006). Various studies have revealed that adolescents generally have mixed feelings about the importance of using condoms as protective measures against HIV. For example, in a study conducted on the sexual health, knowledge, attitudes and experiences among adolescents in South Africa many young people agreed that sex without a condom is risky but some saw occasional sex without condoms as “no big deal”. Some adolescents also believed that unless you have many sexual partners you do not need to use a condom (Pettifor et al., 2004). In the same study, of the 59% of women who had sex, 57% reported that they were using a method of pregnancy prevention, 58% reported that they were using injectable contraceptives, 34% reported using male condom and 13% reported using oral contraceptive pills. (Pettifor et al. 2004).

4.3.1.3 Testing

'Since knowing about HIV/AIDS, I decided that when I am old enough to engage in sex my partner and I will go for testing so we know our status before we engage in sex' (Respondent 12)

Voluntary Counselling and Testing (VCT) for HIV infection is an important component of prevention and intervention programmes designed to curb the spread of HIV infection (Peltzer et al., 2004). In the current study, only one participant mentioned testing as a method of preventing the spread of HIV/AIDS. This could suggest that adolescent prevention programmes are not focusing sufficiently on VCT. In addition, this could be explained by the low risk perception among this group suggesting that they do not see the need to go for testing because of their way of life. The researcher suspects that more information could have been revealed on their attitudes towards HIV, had the she probed more on the theme.

This findings suggest that adolescent girls know different mechanisms which can be used to prevent HIV. However, few of them mentioned abstinence and being faithful and this could be due to the fact that majority of them were not sexually active at the time of the interviews. In addition, the prevention methods cited suggest that this group recognises sexual intercourse as the main mode of transmitting HIV as compared to injecting drug use and mother-to-child transmission.

The National Survey (2003) examined attitudes towards HIV testing. The study revealed that twenty percent of young people had never been tested for HIV and more interestingly female were more likely to report having been tested for HIV as compared to males. Another study by Peltzer et al. (2004) conducted among students in South Africa, America and India revealed that American students had a much more positive attitude toward HIV testing than their South African and Indian counterparts.

4.3.2 No impact

In the second category, participants indicated that their knowledge does not necessarily influence their behaviour. This is the same group with high risk behaviour and low risk perceptions. This group however indicated they had intentions of taking the disease more seriously in future. This finding confirms that of another study conducted earlier which found that ignorance of HIV is still common among girls despite their knowledge as discussed in the literature review. The excerpts of participants' responses given below do illustrate this fact:-

Not really, we girls are more concerned about
preventing pregnancy than HIV (Respodent 3)

The knowledge doesn't necessarily influence me
to an extent of refusing unprotected sex because
I am concerned HIV, maybe when I am older I will
learn to take it more seriously
(Respondent 8)

These findings revealed that negative perceptions of HIV/AIDS do not have an impact on the girls' sexual practices. This could be due to inclination to experiment and their low risk perception. In addition, this finding is consistent with other studies conducted in South Africa on knowledge, attitudes and behaviour which concluded that knowledge does not translate into behaviour change as seen in the current study. Furthermore, this group also seems to be more concerned about preventing pregnancy instead of HIV/AIDS. This group also indicates that maturity plays a role in sexual decision making, as did in the first group. However, the difference in this instance is that in this group the participants are already sexually active and not using protective measures. By the time they decide to use protective measures some might have already contracted sexually transmitted infections, including HIV.

CHAPTER 5

5.1 Discussion of results

In the absence of a cure or vaccine for HIV/AIDS, prevention strategies which impact on safer sex practices remain central in curbing the spread of HIV/AIDS. The South African government together with both Non-Governmental Organisations and the private sector have made efforts towards prevention strategies to curb the spread of HIV/AIDS among the youth through, amongst others, the love life campaign, provision of life skills education in school and youth friendly services like the HIV/AIDS line etc. The purpose of this study was to explore the following research questions:

(a) What are adolescent girls' perceptions of HIV/AIDS?
(b) What impact do these perceptions have on their expected or real practices and development?

In the light of the theoretical framework guiding this study, namely, the Health Belief Model which focuses on the attitudes and beliefs of individuals, this section will focus on the meaning and relevance of this study's findings to youth prevention programmes.

Although the participants in the current study feared contracting HIV/AIDS, not all showed intentions of behaviour change such as delaying sexual debut, condom use, abstinence and testing. The data suggest that some participants have a sense of invulnerability. This is despite the knowledge they posses about both the transmission of HIV and the awareness that it is a killer and an incurable disease.

The study also revealed that there is no clear relationship between adolescent girls' perceptions of HIV/AIDS and the risk perception. Some adolescents in this study seemed to have a low risk perception including those who were engaging in high risk behaviour, such alcohol use and practising unsafe sex.

It is clear from this study that there are generally negative perceptions associated with HIV/AIDS such as it being a health threat leading to death. Of interest to the researcher is the fact that participants were more concerned about the physical consequences of contracting the disease.

According to the Health Belief Model, perceived susceptibility which is a subjective perception of the risk of contracting the health threat in question may play a role in changing ones' behaviour. The reasoning behind this theory is that an individual will not change his or her behaviour unless he or she perceives himself or herself to be at risk of the disease in question. In the current study, some adolescent girls did not see themselves as being at risk, but

rather saw HIV/AIDS as a problem for their peers because of their way of life. There is a justified low risk perception among adolescent girls with low risk behaviour. However, risk perception did not increase among adolescent girls with high risk behaviour as shown in this study.

The study revealed differences among older girls' sexual practices and young girls' sexual practices. Older adolescents in this study were more likely to be sexually active and had a low risk perception of contracting HIV, whilst younger adolescents were more likely not to be sexually active

The study also revealed that sexually active adolescents also had a low risk perception of contracting the disease. In addition, despite their knowledge of all the factors which could expose them to the risk of being infected, they still demonstrated an inclination towards experimentation. They appeared to be more concerned about preventing pregnancy instead of HIV. The data show that there is a high level of risk behaviour among adolescent girls despite their knowledge of HIV/AIDS, the risk factors involved and the different mechanisms of its prevention. There is a contradiction among this group's perception of risk and perceived severity and perceived benefits. The analysis revealed negative perceptions towards the disease on the part of the participants. It also revealed their knowledge of prevention mechanisms, although there is some discrepancy regarding their knowledge on one hand and their behaviour on the other. The two seem to be running parallel to each other. There were however no negative perceptions towards

use of precautionary measures. One could argue from a developmental perspective that this could be due to their personal fable or to the perception that they are immune to HIV/AIDS.

It is clear from this study that adolescent girls are aware of what could put them at a risk of being infected with the virus; however, there was no connectedness between this awareness and their risk perception as this one group perceived itself to be at a low risk of being infected.

HIV/AIDS is a serious health concern among women particularly younger ones. There is currently no cure for this disease and the best way of containing the epidemic is through prevention. The most efficient means of fighting the HIV/AIDS pandemic includes, amongst other strategies, the focus on behavioural change including the postponement of sexual debut and the usage of precautionary measures such as condoms (Kelly, 2002 in Van den Berg, 2004). In keeping with the Health Belief model's perceived benefits concept which refers to one's belief in the efficacy of the advised action to reduce the risk, the study revealed that some adolescent girls believed in the recommended behavioural strategies such as delaying sexual debut, consistent use of condoms, abstinence and testing.

There were no differences in perceived benefits among sexually active adolescent girls and those who were not sexually active at the period of the study

Cue stimulus is also believed to be effective in promoting both internal and external action. The study revealed that few adolescent girls in this study personally knew someone who was infected with the virus. The analysis revealed that this group was positively influenced by these experiences and had intentions of using precautionary measures in future and of delaying their sexual debut.

5.2 RECOMMENDATIONS

Young people are especially vulnerable to HIV but they are also our greatest hope for changing the spread of this pandemic. Therefore, the following recommendations are made:

(a) As discussed earlier peer influence can have both beneficial and harmful effects. Efforts can therefore be made to make full use of it for the purpose of HIV prevention. Peers should be employed to reinforce information amongst other young people about the need to adopt and maintain responsible sexual behaviour.

(b) HIV prevention information alone is not sufficient to promote behaviour change; in this regard adolescent girls should be equipped with subtle but effective aspects of sexual behaviour such as sexual negotiation and sexual decision making. This would equip them with the necessary skills to resist peer

pressure and the ability to know that affirming one's fidelity and trust in a relationship does not have to amount to placing one's life at a risk.

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(c) HIV education need to address the myths and gaps which exist in adolescents' knowledge of HIV prevention such as misperceptions of the value of access to social grants.

(d) HIV prevention programmes also need to be geared towards targeting people who have stronger influence over adolescent girls such as parents, by encouraging them to talk about sexuality and HIV. Parents have to be empowered with skills and knowledge with regards to both HIV/AIDS and the need for them to address the vulnerability of girls to HIV/AIDS through open communication about sex.

(e) Adolescent girls using alcohol seem to be at a higher risk of contracting HIV as a result of their risky sexual behaviour. Prevention interventions should therefore target teen girls in high risk environment so as to encourage them to avoid alcohol.

5.3 Value of the study

This study adds to the existing literature on adolescent perceptions of HIV/AIDS, particularly adolescent girls.

This study is also explorative in nature as it allowed the researcher to go in depth and generate new themes which could be used for preventive purposes.

The sample size employed in this study was small. However, for qualitative purposes it enabled sound findings to be revealed. In addition, the sample offers important data on teens who are at high risk of HIV infection.

5.4 Limitations of the study

The information presented in this study has certain shortcomings, amongst which are the following:

(a) The sample size was not racially inclusive. Therefore, in order for the study to have relevance to the general population a far more extensive study would have to be conducted.

(b) The researcher acknowledges that adolescent girls may have underreported some behaviour that they were uncomfortable discussing during the interviews. The researcher relied on self-report behaviours and as such these may have presented an optimistic picture.

Suggested future research

Clearly adolescent programmes could benefit from more comprehensive studies on adolescents' perceptions of HIV/AIDS and their impact on sexual behaviour. It would therefore be beneficial if further studies were to be conducted on this subject using various methodologies.

Conclusion

The findings of this study are important for mapping the perceptions of HIV/AIDS among adolescent girls and what impact these perceptions have on their sexual practices. These findings further highlight the factors which put adolescent girls at risk of being infected with the HI virus. In addition, adolescents in high-risk context need to be provided with necessary skills in helping them to practice safer sex and to avoid infection

REFERENCE LIST

Aids Epidemic Update: December 2003. **www.unaids.org**. Accessed 03 March 2003.

Babbie, E. (2004). **The practice of social research**. Thomson and Wadworth, Belmont.

Biology and Safer Sex. (2000). **www.health ucds.edu. Accessed 04 January 2004.**

Brummelhuis C. & Herdt, M.(2003). **Culture and sexual risk**. Pacific Grove: Brook/ Cole Publishing Company.

Craig,G.J. (1992).**Human Development**. New York: Simon& Schuster Company.

De la Rey, C., Duncan, N., Shefer, T. & Van Niekerk, A. (1997). Women and AIDS in South Africa. **Contemporary Issues in Human Development: A South African Focus (pp. 250-273).** Halfway House: International Thompson Publishing.

Dorrington, R., Bradshaw,D. & Butlender, D. (2002). **HIV/AIDS profile in the provinces of South Africa: indicators for 2002.**

Doyal, L. (1995). **What makes women sick: Gender and political economy of health**. Houndmills: Macmillan Press.

DiClemente, R.J. & Peterson, J.L. (1994)). **Handbook of HIV Prevention**. New York: Kluwer.

Drever, J. (1964). **A Dictionary of Psychology**. Harmondsworth. Penguin

Geer, J.H & O'Donohue, W. (1987). **Theories of Human Sexuality: perspectives in sexual behaviour research and therapy**. New York: Plenum.

Gibney, L., DiClemente, R.J. & Vermund, S.H. (1999).**Preventing HIV in developing countries: Biomedical and behavioural approaches**. New York: Kluwer Academic / Plenum.

Hallman, K. (2004) **Socioeconomic disadvantage and unsafe sexual behaviours among young women and men in South Africa.** No. 190. Population Council.

Heaven, C.P. (1995). **Contemporary adolescence: A social psychological approach.** South Melbourne: Macmillan Education Pty Ltd.

Henning, E, Van Rensburg, W. & Smit, B. (2004). **Finding your way in qualitative research.** Pretoria: Van Schaik Publishers.

Hook, D., Watts, J. & Cockcroft, K. (2002). **Developmental Psychology**. Lansdowne:UCT Press.

Huba,G., Melchoir, L., Panter, A., Trevithick, L. et al. (2000). **Risk Factors and characteristics of youth living with HIV and /or at high risk for, HIV. http**://.**www.proquestmail.com. Accessed 25 March 2004.**

Hurlock, E.B. (1949). **Adolescent development.** New York: McGraw-Hill Inc.

Human Science Research Council (2005). **HIV/AIDS Update**. Accessed 15 March 2005. www.hsrc.co.za

Jersild, A., Brook, J. & Brook, D. (1978). (3rd ed). The Psychology of adolescence. New York: Macmillan.

Kaizer Family Foundation (2004). **Hot prospects, Cold Facts: A National survey of South African Youth**. **http://.org/southafrica. Accessed 15 April 2004.**

Kaufman, C. & Stavrou. **"Bus fare, please": The economics of sex and gifts among adolescents in urban South Africa.** 2002 No 166. Population Council

Kuhler, R.G. (1952). **The psychology of adolescent development.** New York: Harper.

Lerner, M.R. & Spencer, G.B. (1980). **Adolescent development: a lifespan perspective.** New York: McGraw-Hill.

Lesch, E. & Kruger L. (2004). **Reflections on the sexual agency of young women in a low-income rural South**

African community. South African Journal of Psychology, 34 (3), pp.464-486

Maharaj, P. (2006). **Reasons for condom use among young people in KwaZulu-Natal: prevention of HIV, Pregnancy or both?** 32 (1).

Macintyre, K., Rutenberg, N., Brown, L. & Karim, A. (2004). Understanding Perceptions of HIV risk among adolescents in Kwa-Zulu-Natal**. AIDS and Behaviour, 8 (3)**

Marlow, C. (1993). **Research methods for generalist social work.** Pacific Grove: Brooks/Cole.

Mwite, E. **A sociological probe into gender relations and HIV/AIDS risk reduction among female students at the University of the Witwatersrand.** Thesis (M.A.)--University of the Witwatersrand, 2000.

Nnko,S. & Pool, R. (1997). Sexual Discourse in the context of AIDS: dominant themes on adolescent sexuality among primary school pupils in Magu district. **Health Transition Review, 7(3), 85-90**

Reed, W., Larson,B., Bradford, Jeylan, T. & Mortimer Publishers. (2002). **Adolescence's Preparation for the Future, Perils and Promise**: **A report of a study group on Adolescence.** Illinois: Blackwell Publishing.

Padgett, D.K (1998). **Qualitative methods in social work: challenges and rewards**. London: Sage publications.

Park, I .,Sneed, C., Morisky, D.E Alvear,S. and Heast,N. (2002). **Correlates of HIV risk among Ecuadorian Adolescents. AIDS Education and Prevention**: New York. **http//:www proquest.com Accessed 25 March2004.**

Pettifor, A.E., Roes, H.V, Steffenson, A., Hlongwa-Madizela, L., Macpall, C., Vermaak, K. & Kleinschmidt. (2004). **HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. http//:www.kff.org.southafrica. Accessed 21 April 2004.**

Rivers, K. & Aggleton, P. (2000) **Adolescent sexuality, gender and HIV Epidemic.** London: Thomas Coram Research Unit.

Rossman, G.B. & Rallis S.F. (2003). **Learning in the field: an introduction to Qualitative Research**. California: Sage Publications.

Rutenberg, N., Kaufman C., Macintyre, K., Brown, L. & Karim, A. (2001). **Pregnant or positive: Adolescent childbearing and HIV Risk in South Africa**. 2002 No 162. Population Council.

Schonfield, M.(1993). **The Sexual behaviour of Young People**. London: Longmans, Green.

Shefer, T. (2003). Heterosexuality. In Ratele, K. & Duncan, N. (Eds). **Social Psychology: Identities and Relationships** (pp 289-302). Landsdowne: UCT Press

Smetherham, J. (2004, May 13).**More women having sex for gifts**. The Star.

Shucksmith, J. &Henry, B.L. (1998**) Health Issues and Adolescents**: growing up and speaking out. New York: Routledge.

Singh, S.P. (2001). **Sex Education, AIDS and Sexuality**. Delhi: Authorpress.

Stewart, H. McCauley, A., Baker, S., Givaudan, M., James, S., Leenen, I., Pick, S., Reddy, P. Rewthong, U, Rumakom, P and Walker, D. (2001).Reducing HIV Infection among youth: what schools do. Poplation Council.

Thom,. A. & Cullinan K. (2003, December). **Sex and the Students**. Fair Lady: December 2003

Thato, S., Charron-Prochownik, D., Dorn, L.D. Albrecht, S.A & Stone, A.C. (2003). **Journal of Nursing Scholarship. Indianapolis: Second Quarter 35,(2) 157**

Templeton, A. (2004, May 19). Shocking new data on women with HIV. **This Day,**: p24.

UNAIDS**, AIDS Epidemic Update**, (2005). www.unaids.org. Accessed 15 May 2005.

World Health Organisation (2005). **AIDS Epidemic Update.**

Van den Berg, D.N.(2004). **Contextual factors affecting adolescents' risk for HIV/AIDS infection: implications for education**. Dissertation: University of Pretoria

Van Dyk, A.(2001). **HIVAIDS, Care and Counselling**: A Multidisciplinary Approach. Cape Town: Pearson Education.

APPENDIX A:
Semi-structured Interview Schedule

1. What do you know about HIV/ AIDS?

2. How did you come to know about HIV/AIDS?

3. Do you know of any sexual practices that put girls at a risk of being infected with HIV/AIDS?

4. Do you think girls your age are at risk of being infected with HIV/AIDS and why?

5. Has your knowledge of HIV/AIDS changed your sex life and how?

6. Do you think HIV/AIDS will have an impact in your sex life and
sexual practices in future?

APPENDIX B

59 King Edward Road
Lombardy East
2090
04 October 2005

The Principal
Tetelo Secondary School
Protea North
Soweto

Dear Sir/Madam

RE: REQUEST TO DO RESEARCH IN YOUR SCHOOL

I am a student at Wits University enrolled for a Masters degree in Community and Counselling Psychology. As a requirement I am expected to conduct research in order to write a thesis. I would therefore like to ask your permission to conduct research with your learners. My research topic is:

"Adolescent girls' perceptions of HIV/AIDS and the influence these perceptions have on their expected or real sexual practices and development".

The expected participants in the study should be adolescent girls between ages fifteen and eighteen from different racial backgrounds. I have earmarked your school because it meets the requirements of this study. The research will be done through the conducting of interviews with the selected learners after school hours and the interviews will take approximately an hour per learner. The learner's participation is voluntary and they may refuse to participate or withdraw at anytime during the course of the interview. The research process will start towards mid November 2004.

Your assistance in this regard will be highly appreciated.

Yours faithfully,

M.M. KHUTSOANE (Miss)
Student No: 041345OD

APPENDIX C
CONSENT FORM (Parent or guardian)

Hello, my name is Magauta Khutsoane, and I am conducting research for the purposes of obtaining a Masters degree at the University of Witwatersrand. My area of focus is the perceptions of adolescent girls' of HIV/AIDS and the impact that such perceptions may have on their real or expected sexual practices and development. Today HIV/AIDS affects most of the youth particularly those who are vulnerable and sexually active. The aim of the study is to explore whether HIV/AIDS pandemic has caused adolescents to change their real or expected sexual practices. This research will hopefully contribute to a large body of knowledge on perceptions of HIV/AIDS. This can help in planning appropriate interventions in combating the epidemic. I wish to ask your permission to invite your daughter to participate in the study.

Participation in this study will entail being interviewed by me, at a time and place that is convenient for you. The interview will last for approximately one hour. With your permission your daughter's interview will be recorded to ensure accuracy. Participation is voluntary and no person will be advantaged or disadvantaged in any way for choosing to participate or not to participate in the study. All of your daughter's responses will be kept confidential and no information that could identify you would be included in the research report. The interview material (tapes and transcripts) will not be seen or heard by any person in this organization at any time, and will only be processed by myself. At the end of the study all the tapes will be destroyed. She may refuse to answer any questions she would prefer not to and she may choose to withdraw from the study at any point.

If you choose to allow your daughter to participate in the study please fill in your details on the form below.

Thank you for taking time to allow your daughter to participate in my study.

I……..agree that ……. ……. be interviewed by Magauta Khutsoane for her study on adolescent girls' perceptions of HIV/AIDS and the impact that these perceptions might have on their sexual practices. I understand that:

- Participation in this research is voluntary
- That she may refuse to answer any questions she might not feel comfortable with or about.
- She may withdraw from the study anytime, and that,
- No information that may identify her will be included in the research report, and her responses will remain confidential

Signed_____

Consent form (Audio-taping for parents)

I _____ consent to 's interview with Magauta Khutsoane for her study on Adolescents' perceptions of HIV/AIDS and the influence of these perceptions on their sexual practices and development being recorded. I understand that:

- The tapes or transcripts will not be seen or heard by any person except the researcher
- All tape recordings will be destroyed after the research is complete
- No identifying information will be used in the transcripts or the research report

Signed_____

APPENDIX D
Participant Information Sheet

My name is Magauta Khutsoane, and I am conducting research for the purposes of obtaining a Masters degree at the University of Witwatersrand. My area of focus is the perceptions of adolescent girls' of HIV/AIDS and the impact that these perceptions may have on their real or expected sexual practices and development. Today HIV/AIDS affects most of the youth particularly those who are vulnerable and sexually active. The aim of the study is to explore whether HIV/AIDS pandemic has caused adolescents to change their real or expected sexual practices. This research will hopefully contribute to a large body of knowledge on perceptions of HIV/AIDS. This can help in planning appropriate interventions to combat the epidemic. We would like to invite you to participate in this study.

Participation in this study will entail being interviewed by me, at a time and place that is convenient to you. The interview will last for approximately one hour. With your permission this interview will be recorded to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not to participate in the study. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview material (tapes and transcripts) will not be seen or heard by any person in this organization at any time, and will only be processed by myself. At the end of the study all the tapes will be destroyed. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate please fill in your details on the form below and place it in the sealed box provided. I will empty the box at regular intervals, and will contact you within two weeks in order to discuss your participation. Alternatively I can be contacted telephonically on 072 779 47223 or via e-mail at Gauta4kk@yahoo.com.

Thank you for taking time to consider participating in my study.

APPENDIX E

CHILD ASSENT FORM

I…… agree to be interviewed by Magauta Khutsoane for her study on adolescent girls' perceptions of HIV/AIDS and the impact of these perceptions on their real or expected sexual practices and development. I understand that my participation is voluntary and that I can withdraw at anytime during the interview.

Signed…….. Date……..

Assent form (Audio-taping for participants)

I _____ consent to my interview with Magauta Khutsoane for her study on Adolescents' perceptions of HIV/AIDS and the influence of these perceptions on their sexual practices and development being recorded. I understand that:

- The tapes or transcripts will not be seen or heard by any person except the researcher
- All tape recordings will be destroyed after the research is complete
- No identifying information will be used in the transcripts or the research report

Signed_____