

CONTEXTUAL FACTORS AFFECTING  
ADOLESCENTS' RISK FOR HIV/AIDS  
INFECTION: IMPLICATIONS FOR EDUCATION

Dirk Nicolaas van den Berg

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**CONTEXTUAL FACTORS AFFECTING  
ADOLESCENTS' RISK FOR HIV/AIDS  
INFECTION: IMPLICATIONS FOR EDUCATION**

by

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Submitted in fulfilment of the requirements for the degree:

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**Promoter: Professor Doctor Linda van Rooyen**

## **DECLARATION**

I, Dirk Nicolaas van den Berg, declare that this dissertation is my own work. It is submitted for the Degree of the Master of Education at the University of Pretoria. This dissertation has not been submitted before for any degree or examination at any other university.

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D.N. van den Berg

2004-10-28

### **DEDICATION**

This study is dedicated to my parents Dirk and Beryl van den Berg, my wife Helga van den Berg and two children, Marianné and Dirk. Your encouragement, sacrifice and love made the completion of this study possible.

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**“Trust in the Lord with all thine heart; and lean not to  
thine own understanding. In all the ways  
acknowledge Him and He shall direct your paths”.**

**Proverbs 3:5,6**

**SUMMARY**

**CONTEXTUAL FACTORS AFFECTING ADOLESCENTS' RISK FOR  
HIV/AIDS INFECTION: IMPLICATIONS FOR EDUCATION**

**by**

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**PROMOTER: PROF. DR. LINDA VAN ROOYEN**

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**DEGREE: MEd: MASTER OF EDUCATION**

The primary aim of this study has been to investigate contextual factors that affect the adolescent's (especially the young girl's) risk with regard to HIV/AIDS infection and the implications thereof for education. Initially it was important to conduct an orientational background analysis to provide the necessary background material. The investigation revealed that the number of people living with HIV/AIDS continues to increase and that life expectancy in South Africa may drop dramatically. A further fact that became apparent is that more girls are living with HIV/AIDS than their male counterparts.

The important role of the school as an institution serving society and its important role in the prevention of HIV/AIDS infection emerged very clearly in this study. The fact that the school should address the contextual factors that increase the risk of the young girl with regard to HIV/AIDS infection gave rise to the formulation of the primary research problem: Which contextual factors affect the adolescent's (especially the young girl's) risk to become HIV/AIDS infected and what are the possible implications for education?

Chapter 2 presented a study of the influence of parenting styles and the possible ways in which these might predispose the adolescent (especially the young girl) to HIV/AIDS infection. Other aspects of the family in contemporary society such as its vulnerability and deterioration were investigated with regard to the possible predisposing of girls to become HIV/AIDS infected. The focus in this chapter also included gender inequalities, perceptions of traditional gender roles, and physiological factors that might increase the risk of the young girl with regard to HIV/AIDS infection.

In Chapter 3 the socio-economical situation of women and young girls and the manner in which this increases their risk to HIV/AIDS infection was investigated. It became apparent that socio-economic factors such as poverty, violence against women, sexual behaviour and prostitution, as well as conflict and displacement increase the young girl's risk with regard to HIV/AIDS infection.

In Chapter 4 several implications that the adolescent's (and especially the young girl's) risk with regard to HIV/AIDS infection poses to education were discussed. This chapter also focused on challenges for the educational manager and educators with regard to effective management of schools that may be severely affected by HIV/AIDS. This chapter is concluded with a suggested framework for developing and implementing an HIV/AIDS policy for schools in an effort to prevent HIV/AIDS infection.

Chapter 5 concludes this study with a reflection upon the findings of the study and a presentation of specific recommendations that may contribute towards reducing the risk of the adolescent (especially the young girl) with regard to HIV/AIDS infection.



**KEY WORDS**

Adolescent

Contextual factors

Empowerment

Gender

Girl

HIV/AIDS

Poverty

Sexuality

School

Violence

## **SLEUTELTERME**

Adolesent

Kontekstuele faktore

Bemagtiging

Geslag

Meisie

MIV/VIGS

Armoede

Seksualiteit

Skool

Geweld

## **ACRONYMS**

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>FGM</b>	Female Genital Mutilation
<b>HIV</b>	Human Immunodeficiency Virus
<b>NGO</b>	Non-Governmental Organization
<b>PID</b>	Pelvic Inflammatory Disease
<b>SGB</b>	School Governing Body
<b>STI</b>	Sexually Transmitted Infection
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	Voluntary Counselling and Testing
<b>VD</b>	Venereal Disease
<b>WHO</b>	World Health Organization

**This research Report is written in the third person. References to myself will thus be reported as “the researcher”.**

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## CHAPTER 1

### BACKGROUND AND ORIENTATION

#### 1. AIM OF THIS CHAPTER

The aim of this chapter is to provide background information in order to determine the contextual factors that affect adolescents' risk<sup>1</sup> for HIV/AIDS infection. These contextual factors and the risk they carry with regard to HIV/AIDS infection is also the problem that will be addressed in this dissertation, while chapter 1 aims at providing a scientific exposition against which the dissertation must be read.

#### 2. INTRODUCTION AND ORIENTATION

##### 2.1 General statistics

General statistics regarding HIV/AIDS are startling. According to figures, estimates of 36,1 million people worldwide are living with HIV/AIDS (UNAIDS 2001a:17). In Southern Africa life expectancy may fall to 40 by the year 2010 (Coombe 2000a:1). Young females are more vulnerable than males as infection amongst girls 15-19 years of age rose from 12.7% to 21% in 1999. By 2001 at least 4.7 million South Africans were reported to be HIV positive, 56% of them women. According to Coombe (2000a:11), sexuality is only one of many contributing factors in South Africa's complex social mix that amplify the spread of HIV/AIDS. It also appears that the adolescent, and especially the young girl as a sexual being, is vulnerable to HIV infection. This research will explore some contextual factors that may contribute to and affect the adolescent's, and especially the young girl's, vulnerability to HIV infection.

##### 2.1.1 The youth

When it is considered that 40% of the South African population is less than 15 years of age (Van Rooyen 2001:10), that 49,3% of the South African youth between the ages of 15-24 is infected with HIV and that the HIV infection rate among girls is 5 times higher than among

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<sup>1</sup> Regarding the concepts "risk" and "vulnerable" also refer to paragraph 9.1 of this chapter.

boys, one recognizes that HIV/AIDS is “not only a health issue; it is a social, economic and cultural issue which is battering the very foundations of our communities and governments” (Coombe 2000b:2). Since researchers have identified HIV/AIDS nearly a generation ago, more than 20 million people around the world have died from the disease. An estimated 40 million are living with HIV today, including almost 3 million children under the age of 15 (UNAIDS 2002a:3).

#### **2.1.1.1 A factual profile with regard to youth sexuality**

The WHO (2002:11) states that sexual activity begins in adolescence for the majority of people and that in many countries unmarried girls and boys are sexually active before the age of 15. With regard to South African youth and sexuality, research on adolescent sexuality presents the following facts (Kaiser Family Foundation 2001:23):

- 25% of the South African youth do not know that sexual intercourse with a virgin cannot cure HIV/AIDS.
- It was found that 33% of youths between the ages of 12-17 years have already had sexual intercourse.
- Those that have already been pregnant amount to 4%.
- A total of 9% indicated that they had never heard of HIV/AIDS.
- Of the sexually active girls, 16% acknowledged the fact that they exchange sexual intercourse for money, food, drinks or other gifts.
- The research indicates that 25% of the girls and 7% of the boys admitted that they had been forced to have sexual intercourse. In a study of girls living on the streets of Cape Town (Le Roux 1994:268), all the girls stated that rape and sexual assault were dangers that they encountered and feared. Gangs often regard the girls in their area as their property and available for sexual intercourse.

- The use of a condom is often viewed as an insult and proof of distrust. It is regarded as an indication that the person using it or requesting its use probably already has a sexually transmitted disease (Le Roux 1994:266).

### **2.1.1.2 Youth sex workers**

According to a report on sex workers (Kaiser Family Foundation 2001:25), it was found that:

- 52% of the clients that visit sex workers prefer girls 18 years and younger. This need arises from the myth that sexual intercourse with a virgin can cure aids and that young girls are perceived to be healthy and not infected with HIV/AIDS. In this research, girls as young as 13 years were found to operate as sex workers.
- 60% of the sex workers were clients of policemen.
- young girls are afraid to insist that men use condoms. Sondheimer (1992:75) found that when children practise survival sex, their clients prefer and pay more for penetrative sex without a condom.
- sex workers do not visit health clinics, because of the stigma that is associated with their occupation (Nairne 2000:15). They use prescription and traditional (muti) medicine and they wash themselves with disinfectants and other household cleaners.
- there is a belief that whites and foreigners are not HIV infected. The problem of HIV/AIDS is associated with stigmatised people (Mathews 1990:514), such as homosexuals, prostitutes and promiscuous people.



## **2.2 Historical background with regard to HIV/AIDS**

### **2.2.1 The essence of HIV and AIDS**

HIV is the acronym for Human Immunodeficiency Virus. There are in fact two HI types or strains of viruses, named HIV-1, which has nine sub-types, and HIV-2, which is less infectious and predominantly found in West Africa (UNAIDS 2001b:1). Both viruses originated from viruses found in African apes and monkeys that somehow infected humans within the last 100 years. Both HIV-1 and HIV-2 viruses cause the disease AIDS.

HIV and AIDS were first identified in the United States (Yeats 2001:10), which led to the wrong understanding that the virus originated from that part of the world. According to evidence, HIV has its origin in Africa, as it belongs to a family called Retroviruses. These viruses have the ability to become a permanent part of the cell by building their genetic material into the cell's genetic material.

When a person is infected with HIV, the white blood cells that fight illness are broken down and the immune system starts to function poorly, causing the person to become "immunodeficient". HIV is therefore a cause of immunodeficiency. According to Yeats (2001:10), it takes several years for HIV to cause immunodeficiency, and, when it happens, the person develops AIDS (Acquired Immunodeficiency Syndrome).

A person with AIDS has poor defence against other viruses, bacteria and infections. According to Swart-Kruger & Richter (1994:259), AIDS is a known killer, because people infected with HIV eventually become chronically ill and die.

### **2.2.2 Symptoms of HIV/AIDS infection**

According to research (Sanders 2001:18), a person may develop flu-like symptoms within 10 to 21 days after infection. This may disappear for up to 20 years, but the average time it takes an HIV infected person to develop full-blown AIDS, is nine years. The early symptoms of HIV/AIDS are:

- prolonged fever
- persistently swollen glands, especially in the neck, armpit or groin

- ❑ persistent diarrhoea
- ❑ weight loss of more than 10% of normal body mass
- ❑ night sweats
- ❑ changes in mental behaviour, such as confusion or forgetfulness

These symptoms are, according to Van Rooyen & Louw (1994:110), known as “Aids Related Complex” (ARC), but not yet AIDS. When the patient develops illnesses such as pneumonia, cancers, illnesses of the central nervous system and other organs, full-blown AIDS is diagnosed and the patient is unable to recover because of a poor immune system, and soon afterwards dies.

#### **2.2.2.1 Clinical stages of HIV/AIDS infection**

The World Health Organisation (WHO) has developed a staging system, which provides a clear picture of how HIV/AIDS progresses (Sanders 2001:18).

- ❑ **The “Window period”**

After initial infection an HIV-positive person develops a flu-like illness, with fever, swollen glands and muscular pains. These symptoms disappear and the patient feels normal. A laboratory test will show the patient is HIV-negative. This can last for up to six months. The virus remains active and continues to destroy the white blood cells that protect the body from infection.

- ❑ **Stage 1**

The early stage of infection is characterised by symptoms such as swollen glands, fever, headache, tiredness, sore muscles and diarrhoea. This occurs a few weeks to a few months after infection.

□ **Stage 2**

This stage is characterised by repeated infections of the upper airways, mouth ulcers and unintentional weight loss, shingles, rashes and other skin diseases, fungal infections and severe cracks in the corners of the mouth.

□ **Stage 3**

Clinical features at this stage include:

- weight loss
- persistent fever and diarrhoea
- thrush in the mouth, back of the throat and sometimes the female genitals
- white patches, with what looks like hair growing out of them occur in the mouth called oral hairy leukoplakia
- tuberculosis of the lungs (pneumonia) and severe infections in other places in the body

□ **Stage 4**

- The weight loss has progressed
- the patient has chronic, persistent diarrhoea
- the brain is affected and the patient may become confused and show signs of mental disorder
- other “opportunistic infections” occur, because the body’s immune system is not working. Germs, which do not affect people with normal immune systems, can cause severe infections such as:
  - tuberculosis in parts of the body away from the lungs
  - thrush in the oesophagus
  - pneumonia
  - herpes
  - fungal and parasitic infections throughout the body
  - infections in the brain
  - infections being distributed throughout the body by the blood
  - certain types of cancer may occur

The average survival time after having been diagnosed with HIV/AIDS is, according to Sanders (2001:18), 18 months.

In African countries, where it is very hot, HIV causes diarrhoea, rapid weight loss and dehydration, that lead to death within six weeks after infection. This is called “Slim’s disease” (Van Rooyen & Louw 1994:111).

### **2.2.3 HIV transmission**

Transmission of HIV/AIDS occurs when blood, semen or vaginal fluid of an infected person passes into the body of another person (Swart-Kruger & Richter 1993:15). The virus can also be found in other body fluids such as saliva or urine, but the concentration in these fluids is very low and carries less risk of transferring the infection (Yeats 2001:10).

It is important to note that HIV can further only be transmitted to another person’s body through direct injection under the skin, for example by a needle, or through thin, moist surfaces such as the eye (Yeats 2001:11).

#### **2.2.3.1 The most common ways of HIV transmission**

The most common ways of HIV transmission appear to be:

- through heterosexual and homosexual intercourse (oral, anal or vaginal). During sexual intercourse body fluids containing HIV come into direct contact with the thin, moist lining of the vagina or opening of the penis (Van Rooyen & Louw 1994:110). The thin, moist lining of the mucous membrane consists of microscopic cells that tear apart during sexual intercourse, and allow the virus to enter the blood through the mucous membrane. The virus then spreads through the body. According to Van Rooyen & Louw (1994:110) and Yeats (2001:11), this is the most common way that HIV is transmitted.
- by the transfusion of infected blood to non-infected persons, or contact with objects that had been contaminated with HIV infected blood (Van Rooyen & Louw 1994:110) such as the case of HIV infected drug abusers who share

hypodermic needles to inject drugs. In most countries blood donations are tested thoroughly for HIV infection (Yeats 2001:11), and it is now rare that HIV is transmitted by blood transfusion.

- from an HIV infected mother to her child, either before or shortly after birth. This is described as “vertical transmission”. Mother-to-child transmission (hereafter referred to as MTCT) accounts for 4-10% of all HIV infections in Africa. The reason for this is probably that both pregnancy and HIV infection occur most commonly in young, adult women when they are most sexually active (Yeats 2001:14).

### **2.2.3.2 Less common ways of HIV transmission**

Less common ways of HIV transmission appear to be:

- people who have medical occupations have a small risk of infection. Van Rooyen & Louw (1994:111) state that the risk of infection is only 0,3%.
- infection by blood transfusion, as most countries thoroughly test donated blood for HIV and other diseases (Yeats 2001:11)

### **2.2.3.3 Ways HIV is not transmitted**

Ways that HIV is not transmitted appear to be:

- insects such as mosquitoes do not transmit HIV
- sharing food or drink does not transmit HIV
- shaking hands does not transmit HIV
- toilet seats do not transmit HIV
- being in the same room and breathing the same air as HIV infected persons does not transmit HIV
- swimming pool water does not transmit HIV
- general friendly kisses do not transmit HIV
- to donate blood does not transmit HIV

- touching an HIV/AIDS patient or sharing cutlery does not transmit HIV.

#### **2.2.4 Myths about HIV/AIDS**

Among the rumours and stories about HIV/AIDS, the most recently prevalent is that having sexual intercourse with a virgin can cure AIDS (Sanders 2001:5). A consequence of this is that many young girls have been raped in the mistaken belief that the rapist would be cured from his disease. The young raped girl (and even babies as young as nine months) now has HIV/AIDS and could pass it to her baby. Research indicates that one in three HIV-positive mothers passes the virus to her baby.

The fact that AIDS and HIV are inextricably linked (Sanders 2001:5) is also being ignored. There is a belief that other factors than HIV, such as poverty, malnutrition, TB and drug abuse cause AIDS. Science has, however, proven that there is no way that a person can develop AIDS without first being infected by HIV. It has been suggested that widespread malnutrition, TB and malaria increase the rate of HIV infection by weakening people's immune systems and thus lowering their resistance to HIV infection (Swart-Kruger & Richter 1993:264).

A study undertaken in Alexandra reports adolescents to believe that it is impossible for them to get AIDS, and that it is a disease of the older people (Swart-Kruger & Richter 1993:267). This belief is contradictory to the fact that adolescents worldwide have been identified as a high-risk group for HIV-infection (DiClemente 1990:11). Sexually active girls hide this from their mothers in the belief that, by doing so, they will not fall pregnant or even contract AIDS.

A further myth in general is that it is possible to identify infected people by their physical appearance. According to Swart-Kruger & Richter (1993:32), it is a general tendency among adolescents to use physical appearance as a basis regarding safety in sexual encounters.

According to Serote (1993:264), a perception among black people is that AIDS is something that the government introduced to reduce the number of black people and to scare black people so that they will have fewer children.

As mentioned in paragraph 2.2.3.3 of this chapter, there are several ways in which HIV/AIDS cannot be transmitted and, according to Van Rooyen & Louw (1994:111), these are also myths concerning the transmission of HIV/AIDS, and it is generally believed that infection takes place because of them.

### **2.2.5 Prevention of HIV/AIDS infection**

The saying “prevention is better than cure” is especially true with regard to HIV infection, as no cure has been discovered yet (Sanne 2001:32). The best possible solution to the spread of HIV/AIDS appears to be prevention (Sanne 2001:33). A person who does not engage in sexual intercourse and does not inject drugs (or who uses clean, sterile needles and syringes for injections) has almost no chance of contracting HIV/AIDS (World Health Organisation 1994:24). People who are mutually faithful and have sexual intercourse only with each other, are not at risk of HIV/AIDS infection by sexual means, if both are HIV-negative at the start of their relationship and neither gets infected through blood or other means (transfusions, injecting drugs with contaminated needles or syringes).

People who use high quality condoms correctly every time they have sexual intercourse can protect themselves from HIV infection. A condom is the simplest and most effective way to protect oneself from HIV infection (Yeats 2001:16). A condom creates a barrier against germs and body fluids exchanging between partners during sexual intercourse.

According to Swart-Kruger & Richter (1993:275), the most serious problem in the prevention of HIV/AIDS infection is finding methods to reduce risk behaviour among populations. There appear to be sexual practices which carry a risk of HIV transmission and those which do not (World Health Organisation 1994:24). Activities such as masturbation, massage, rubbing and touching of genitals that prevent contact with blood, semen or vaginal secretions may not prevent HIV infection. Activities such as fellatio (mouth on penis without taking semen into the mouth), cunnilingus (mouth on the vagina), anilingus (mouth on the anus) and deep, wet kissing are considered to carry some risk of HIV infection, as a small number of people have contracted HIV through these activities. Practising activities such as anal sexual intercourse with the penis in the rectum not using a condom, vaginal sexual intercourse with the penis in the vagina not using a condom, any

sexual act that causes bleeding and the taking of semen into the mouth during oral-genital sexual intercourse is a definite risk of HIV infection.

In the absence of a cure to this date the best prevention is education. Education is important (Van Rooyen & Louw 1994:108) so that people can have knowledge of HIV and realize their responsibility to live virtuously in order not to be infected with HIV. The main aim in education (Van Rooyen & Louw 1994:110) has become to guide the child toward abstinence and toward practising sexual relationships only within a monogamous marriage. To this Le Roux (1994:282) adds the promotion of responsible sexual behaviour, improvement of children's socio-economic status and reduction of their vulnerability to sexual and other forms of exploitation.

### **3. STATING THE RESEARCH PROBLEM**

The research problem of this study is based on the following facts with regard to HIV/AIDS infection:

- The global number of people living with HIV/AIDS is estimated at a staggering 40 million (in this regard also refer to paragraph 2.1 of this chapter). The total number of people who died because of HIV/AIDS in 2001 amounts to 3 million, of which 580 000 are children younger than 15 years and 2,4 million adults across the world. An estimated 5 million people around the world became infected with HIV/AIDS in 2001 and 800 000 of them are children (UNAIDS 2002:22). These daunting statistics project that in the 45 most affected countries, 68 million people will die earlier than they would have in the absence of HIV/AIDS. By 2010 the average life expectancy in some African countries, including South Africa, might drop to 30 years (Beeld 2003c:2).
- In sub-Saharan Africa approximately 3.5 million new HIV/AIDS infections occurred in 2001, bringing the total number of people living with HIV/AIDS in the region to an escalated 28.5 million (UNAIDS 2002b:23).
- According to UNAIDS (2002b:23), some researchers assume that the very high prevalence rate in some countries has reached its peak, but this appears not to be



the state of affairs, as the prevalence rate among pregnant women in countries like Botswana, Zimbabwe, Namibia and South Africa shows similar escalating patterns.

- UNAIDS (2002b:46) further projects that in South Africa there will be more than 17 times as many deaths among 15-34 year old persons between the years 2010-2015, as there would have been without HIV/AIDS. Beeld (2003c:2) states that in South Africa and Zimbabwe HIV/AIDS would have killed two thirds of boys that are 15 years of age today, by the year 2015. Even if the risk of HIV/AIDS infection were decreased by 50%, still 47% of South Africa's 15-year-old boys of today would have died by 2015. As mentioned in paragraphs 2.1 and 2.2.4 of this chapter, young females appear to be more vulnerable to HIV/AIDS infection than males of the same age group, as infection amongst girls 15-19 years of age rose from 12.7% to 21% in 1999. By 2001 at least 4.7 million South Africans were reported to be HIV positive, 56% of them women. This may imply that even more girls than boys would have died because of HIV/AIDS in South Africa by the year 2015.

With the above facts in mind it appears that the rate of infection is increasing and that the HIV/AIDS pandemic, with no evident cure in the near future, is mounting its impact. From the discussion in paragraph 2.2.5 of this chapter, it may be claimed that HIV infection can be prevented through education and positive changes in sexual behaviour. Even though this has taken place, research shows that the HIV infection rate of girls and women is much higher than that of boys and men. Paterson (1996:1) states that young women are worst affected. The peak age of infection appears to be between 15 and 24, with a female-to-male ratio of two to one in this age group. Beeld (2003c:2) adds that a survey in 277 South African High Schools recently revealed that only 18% of the schools follow a sexual education programme, while 60% of the schools surveyed acknowledge that learners have a great risk to become HIV/AIDS infected.

If these infection rates continue to escalate and the projected mortality rates among young people (adolescents) become a reality, it may have devastating consequences for communities, countries and the world as a whole. Although prevention strategies have been in place for several years (UNAIDS 2002a:47), the prevalence rate remains unacceptably

high in sub-Saharan countries. What has to be done? Why are prevention strategies such as sexuality education in schools not curbing the infection rate? Why is the infection rate among girls higher than that of boys? What factors hamper effective prevention for adolescents against HIV/AIDS infection and therefore contribute to HIV/AIDS infection among adolescents? What are the implications for a school in its efforts to prevent HIV/AIDS infection among adolescents? How can a school contribute to curb the spread of HIV/AIDS?

With these questions in mind, the research problem of this study can be formulated as follows: **Which contextual factors affect the adolescent's risk (especially the young girl) to become HIV/AIDS infected and what are the possible implications for education?**

The above research question is based on previous research and the introduction to this chapter that has indicated that:

- ❑ 20% of the world and 40% of the South African population are less than 15 years of age
- ❑ 49,3% of the South African youth between the ages of 15 – 24 are infected with HIV of which only 50% have a chance to reach the age of 40 years
- ❑ HIV infection rate among girls is 5 times higher than among boys
- ❑ women are more vulnerable to HIV infection, but it is men that drive the epidemic. Men have more sexual partners than young girls (the average young man has four partners per week, compared to the girl who has one sex partner per week)
- ❑ young men have more power in sexual relationships, e.g. they decide when sex should take place, whether a condom will be used, etc.
- ❑ most HIV/AIDS programmes focus on girls; men are usually excluded (Van Rooyen 2001:11).

With regard to young men and sexuality, it appears that young men more often:

- ❑ engage in sexual violence
- ❑ reveal harmful attitudes and threatening behaviour towards their sexual partners
- ❑ have inadequate knowledge with regard to HIV/AIDS
- ❑ believe in myths

- ❑ practise drug injection than girls of the same age
- ❑ engage in same sex behaviour than girls
- ❑ become older men representing community leaders, husbands and policymakers that infect younger women and girls (“sugar daddy syndrome”) and bring the HIV/AIDS infection back to their families than young girls (Scalway 2001:1,3).
- ❑ young men grouped in gangs often regard the girls in their area as their property and available for sex
- ❑ young men under the age of 18 years are more in demand as prostitutes than older women.

When considering the above findings from previous research, the primary research question can *inter alia* be differentiated into the following secondary questions:

- ❑ What is the influence of social and cultural factors on the adolescent’s risk with regard to HIV/AIDS infection and especially on the vulnerability of the young girl with regard to HIV/AIDS infection?
- ❑ What kind of risk behaviour does the adolescent engage in, and why?
- ❑ To what extent are correct and valid information, health and educational services and contraceptives available to the adolescent?
- ❑ What is the influence of alcohol and other drugs on HIV-related risk behaviour of adolescents?
- ❑ What is the influence of the adolescent’s childhood, upbringing and relationships on his or her beliefs and risk behaviour?

#### **4. THE AIM OF THIS STUDY**

The aim of this study will, because of the nature thereof, diverge into primary and secondary objectives.

The primary aim of this research is to identify contextual factors affecting adolescents’ risk with regard to HIV/AIDS infection and the vulnerability of the young girl with regard to HIV/AIDS infection, in order to effectively plan and develop preventative educational strategies for adolescents and especially for young girls in such a way that they can be more assertive and thus less vulnerable with regard to HIV infection.

In order to fulfil the primary aim and answer the stated problem question, the following secondary objectives have to be achieved:

- ❑ to determine the influence of social and cultural factors on the adolescent's and the young girl's risk with regard to HIV/AIDS infection.
- ❑ to investigate the risk behaviour and reasons for this behaviour that the adolescent and especially the young girl engages in.
- ❑ to examine the influence of alcohol and other drugs on HIV-related risk behaviour of adolescents.
- ❑ to determine what the social and cultural life of the adolescent entails.
- ❑ to determine the influence of the adolescent's childhood, upbringing and relationships with his or her parents on personal views, beliefs and risk behaviour.

## **5. THE SIGNIFICANCE OF THIS STUDY**

Adolescents and especially young girls in South Africa are faced with possible HIV/AIDS infection on a daily basis due to contextual factors that increase their vulnerability. With adequate understanding of the contextual factors that contribute to the vulnerability of the young girl with regard to HIV/AIDS infection, educational managers and educators may offer more effective guidance and support to adolescents and hence prevent HIV/AIDS infection.

This study will also contribute to the existing knowledge base with regard to the vulnerability of the young girl in the light of factors such as child-rearing styles, and family types. As the study develops, more of these factors will become evident. This study also presents a framework for developing and implementing an HIV/AIDS school policy as a preventative strategy with regard to HIV/AIDS infection.

The significance of this study is accentuated in the problem statement, which indicates that the study investigates contextual factors that increase the vulnerability of the adolescent and especially the young girl with regard to HIV/AIDS infection and the implications thereof for education. The findings of the study also result in recommendations that attempt to alleviate the vulnerability of the young girl and improve education delivery in the light of the HIV/AIDS pandemic.

## **6. METHODOLOGY**

### **6.1 Theoretical framework**

Before conducting the study, it was necessary to revisit and consider the theoretical framework which would serve as a basis and point of departure for the study. It was within the boundaries of the theoretical framework that the researcher had to conduct the scientific thought proceedings and actions. Factors and issues that could possibly complicate the study, were narrowed down to the following:

#### **6.1.1 Biochemical individuality**

The general health of a person is determined by a wide variety of variables of which his or her biochemical individuality is only one important variable (Holford 1998:15). Other variables can e.g. be nutrition, personal hygiene, or immunity. When, in this report, reference is made to the health of the adolescent or in particular the young girl, it is made with the full acceptance and acknowledgement of his or her biochemical uniqueness. All research results were interpreted with this fact in mind.

The concept “biochemical uniqueness”, for the purpose of this study, will be based on the following explanation: All human beings inherit their evolutionary dynamics from their biological parents. These dynamics, together with their genetically inherited strengths and weaknesses, and the interaction of their genetics with their environment, determine “health”, (for an explanation of the concept “health”, also refer to paragraph 6.1.2 below.)(Holford 1998:4). It is the complex interaction of these factors that ensures that each individual is born biochemically unique (Williams 1977:15).

#### **6.1.2 The concept “health”**

The concept “health” will, in a positive sense, refer to the soundness of the body and mind, and not just absence of disease. “Positive health”, also referred to as “functional health” (Holford 1998:1), refers to the general state of health of a person, in this context, an adolescent, with particular reference to the young girl.

### **6.1.3 The criteria for “positive health”**

The criteria for “positive health” will be: feelings of well-being (the inner life of the child), the absence of ill-health (disease signs and symptoms) and a healthy lifestyle (sufficient exercise, a balanced diet and sound living conditions) (Holford 1998:4). “Health” thus refers to the total health of a person, i.e. his or her physical, mental and/or psychological health.

### **6.1.4 The criteria for “lack of good health”**

The criteria for “lack of good health” will refer to feelings such as stress and unhappiness, the presence of signs and symptoms of disease, an unhealthy lifestyle which reflects insufficient exercise, malnutrition, poor living conditions and health risk behaviour – factors that render the girl as being vulnerable.

### **6.1.5 The study as a social epidemiological study**

According to Weiss & Lonnquist (2000:35), a study that focuses on the causes and distribution of diseases and impairments within a population from a socio-cultural perspective, is classified as a social epidemiological study. In this particular research, the aim is to identify the causative contextual social and cultural factors within the South African population that could increase the adolescent’s, and in particular the young girl’s, vulnerability to HIV/AIDS infection. This research therefore qualifies as a social epidemiological study.

Social epidemiologists explain social inequalities regarding health by means of three theories, the psychosocial, the social production of disease and the ecosocial theory (Krieger 2001:669):

- Psychosocial: This theory examines the phenomenon that only a certain number of all the people who are exposed to microbes, become infected and not all people who are infected, develop a disease. In this regard John Cassel (1921-1976) explains that certain groups of natural factors have the potential of altering human resistance significantly and as such make specific individuals comparatively more vulnerable to

ever-present microbes in the natural world that cause diseases such as tuberculosis, schizophrenia and suicide. Amongst the psychosocial factors that explain this theory, the most apparent are: social disorganization, rapid social change, marginal status in society, social isolation, bereavement - the defence against these factors is social support. This theory promotes the idea that efforts towards minimizing disease encompass the enhancement of social support rather than limiting exposure to stressors.

- Social production of disease: This theory assumes that economic and political institutions and decisions enforce and proliferate economic and social dispensation and inequality that are the primary causes of social inequalities in health (Krieger 2001:670). In light of such an ideology aspects such as community empowerment, social transformation, and amendments to social inequalities that relate to race, gender and sexuality are advocated.
  
- Ecosocial theory and related multi-level frameworks: These are graphic descriptions of modern structures to explain existing and unpredictable models of disease spreading that do not remain in a specific facet but are multidimensional and dynamic (Krieger 2001:271).

## **6.2 Epistemological commitment**

The word “epistemic” is derived from *episteme*, the Greek for “truthful knowledge”. This implies that epistemological research has the overriding goal of searching for knowledge that is truthful. According to Mouton (2001:138), it is impossible to produce scientific results that are absolutely true for all times and contexts. The researcher also holds the opinion that all knowledge and “truths” are relative to the context of their applications. Knowledge and “truths” are subjective and spiritual, based on own experiences and insights. The researcher adheres to the universal law of cause and effect as the substantiation of events and phenomena that occur in society and ground the generation of knowledge. The researcher will therefore aim to generate knowledge that is truthful to the contextual realities that increase the adolescents’ and especially the young girl’s vulnerability to HIV/AIDS infection and the implications thereof for education.

### **6.3 Research approach**

In the context of a scientific study the concept “approach” refers to the researcher’s specific paradigm, his conceptual framework which will *inter alia* determine his way of thinking and the course of his investigation. According to Klos (1995:10), “An approach reflects an attitude or a point of view. The object of research is not presented as a mere given, but has to be established by determined effort informed by a particular approach”. Neuman (1997:61) adds that approaches in research prescribe what good social research involves. Approaches justify, validate, and guide ethical behaviour in research. The following approach will be used:

#### **6.3.1 Positivistic approach**

The positivistic approach in social science is described by Neuman (1997:63) as an organized method that combines deductive logic with empirical observations in order to discover and confirm or reject a set of causal laws that can be used to predict general patterns of human activity. The positivistic approach lays down specific methodologies in order to unlock and generate knowledge. In this study contextual factors (law of cause and effect - in this regard refer to paragraph 6.2) that increase the young girl’s vulnerability to HIV/AIDS infection will be explored and described by means of specific methodologies, in order to bring the implications for education to light. In this study, for example, determining the possible predisposition of the girl within a certain family type to HIV/AIDS infection will “generate new knowledge” and thus expand the existing knowledge base of family types and the relation thereof with factors that increase the girl’s vulnerability. This study also suggests a framework for the development and implementation of an HIV/AIDS policy in schools in order to prevent HIV/AIDS infection, and as such also “generates new knowledge”.

#### **6.4 Paradigmatic perspective**

In light of the fact that this study intends to investigate, highlight, and expand the understanding of contextual factors that increase the adolescents’ and especially the young girl’s vulnerability with regard to HIV/AIDS infection and the implications thereof for education, a qualitative research approach is preferred.



Qualitative research is concerned with understanding the social phenomenon from the participants' point of view (McMillan & Schumacher 2001:16). According to Ericson (1986:125), the aim of qualitative research design is to gain greater insight into man's situation. The approach focuses on subjective experiences of individuals or groups with sensitivity regarding the contexts in which people interact with each other. The emphasis is on better understanding of human behaviour and experiences (Garbers 1996:15). Within the qualitative conceptual framework the influence of relative powers on social relationships is taken into account (Garbers 1996:292).

## **6.5 Research methods**

### **6.5.1 The concept “method”**

The scientific researcher must utilize a method to gain access to a certain phenomenon (Van Rensburg & Landman 1986:114). The concept “method” is derived from the Greek words “*meta*” and “*hodos*”, which mean “way in which”. The concept “method” is described as “a means or manner of procedure; especially, a regular and systematic way of accomplishing anything”, and in the plural: “the procedures and techniques characteristic of a particular discipline or field of knowledge” (Reader's Digest Universal Dictionary 1988:971).

For the purpose of this study the concept “method” will refer to the use of scientific methodology guided by qualitative evidence obtained from non-interactive systematic research methods (McMillan & Schumacher 2001:12).

### **6.5.2 Modes of inquiry**

#### **6.5.2.1 Conceptual analysis**

The aim of a conceptual analysis as a non-interactive qualitative mode of inquiry is to describe the meanings, use and application of concepts in a study (McMillan & Schumacher 2001:38). Hartell (2000:24) describes “analysis” as the process of separating the combined units of something (words or concepts) in order to examine and describe them. When using conceptual analysis as a method, efforts will be made to “take apart,

revisit, reconsider, study and describe” the different meanings of concepts in order to provide clear perspectives on the problem investigated.

### **6.5.3 Data collection techniques**

Data collection techniques refer to the specific skills and actions that are actualized in order to gain information on the problem that is investigated. Several practical skills are required for collecting data in scientific research (McMillan & Schumacher 2001:39). The most important consideration in selecting a reliable sample of literature for this study was to ensure that it was directly, or as closely possible, related to reality and the factors that influence the vulnerability of the adolescent (especially the young girl) with regard to HIV/AIDS infection.

The following techniques will be utilized in this study:

#### **6.5.3.1 Analysis of primary sources**

In this study attention will be given to the analysis of primary sources. “Primary sources” refer to original documentation or the remains thereof. Documentation will be reports from persons that participated in events, relevant to this study, or were eyewitnesses to such events. “Remains” refers to sources that were intentionally preserved to supply information, for example, minutes, articles and correspondence in newspapers and magazines, etcetera.

#### **6.5.3.2 Analysis of secondary sources**

The secondary sources used in this study will consist of reports from people that were not eyewitness to, or part of, an event – but only reported what the person, that was physically part of an event, said or wrote. Textbooks, encyclopaedias, dissertations and theses are considered as secondary sources

## **6.6 Objectivity of the study**

According to McMillian & Schumacher (2001:11) objectivity in research refers to data collection and procedures of analysis that make reasonable interpretations possible. Scientific research, especially on sensitive issues such as HIV/AIDS, gender, and sexuality requires precious self-control from the researcher. In this study the researcher regarded objectivity as of greater a scope than the researcher being dispassionate or unbiased in the collection and interpretation of the facts, or the researcher not tailoring personal conceptions to fit preconceived notions or preferences. Research integrity necessitated the researcher to overcome personal and prejudicial attitudes, personal preconceptions and value judgements, and not to be subject to traditional or “received systems of thought”.

Care was also taken to pursue the seemingly strong ideas and apparent discoveries as well as considering the inexplicable or complex ones according to the significance it has had in answering the primary question of this study.

## **7. DELIMITATION OF THE STUDY**

This study is undertaken from a pedagogical perspective that views each child as a child in need, a child that is dependent on and entitled to education or a safe place to learn (Bill of Rights, Constitution of South Africa, Act 108 of 1996) and a child that is precious. The contextual factors that affect the adolescent’s risk with regard to HIV/AIDS infection and especially the young girl’s vulnerability towards HIV/AIDS infection imply that the sexuality of the adolescent is also vulnerable. Sexuality is a given human onticity (Van Rooyen & Louw 1993:15) and it therefore forms part of the total being of the girl. In this study the sexual relationships of adolescents and especially women and young girls, and the factors that influence these relationships, will receive much attention.

The adolescent years as a developmental phase will receive attention in this study, as adolescents experience many physical and psychological changes during puberty. These changes might contribute to girls being more vulnerable with regard to HIV infection and the research will investigate the manner in which they contribute to the young girls’ vulnerability with regard to HIV/AIDS infection.

According to Van Rooyen & Louw (1993:110), certain risk behaviour regarding sexual intercourse is a contributing factor toward HIV/AIDS infection. The sexual behaviour of the adolescent and especially activities that make the young girl more vulnerable with regard to HIV/AIDS infection will be described, and the reasons why they are exposed to risky sexual intercourse will be determined.

In this study attention will also be given to the adolescent as a family member. The family as the most basic social unit in society (Le Roux 1992:6) is characterised by certain parental behaviours. The child-rearing behaviour of parents with regard to warmth and dominance influences the personality of the child (Le Roux 1992:25). Therefore the influence of parents on the personality development and consequent vulnerability of the girl will be described

## **8. PLAN OF STUDY**

In the light of the fact that this study diverges into different sections it may be necessary to organize it into a schematic presentation for the sake of order (Figure 1):

In Figure 1 it becomes clear that this study diverges into five chapters. Chapter 1 is the background and orientation, Chapter 2 investigates the socio-pedagogical and physiological vulnerability of the young girl, Chapter 3, the socio-economical vulnerability of the young girl; Chapter 4 describes the impact on education, and Chapter 5 concludes the study with specific findings and recommendations from each chapter.

### **8.1 CHAPTER 1: BACKGROUND AND ORIENTATION**

This chapter presents a background and orientation with regard to the study. It entails an introduction and description of the problem regarding contextual factors that affect adolescents' risk with regard to HIV/AIDS infection, the aims of the study, the methodology of the study and a conclusion. The terms used in this study are also conceptualized.

## **8.2 CHAPTER 2: THE SOCIO-PEDAGOGICAL VULNERABILITY OF THE GIRL**

In this chapter research with regard to socio-pedagogical factors that may contribute to the vulnerability of the adolescent (and especially that of the young girl) to HIV/AIDS infection will be done. Specific attention will be given to the physiological vulnerability of the female body with regard to HIV/AIDS infection.

## **8.3 CHAPTER 3: THE SOCIAL-ECONOMICAL VULNERABILITY OF THE YOUNG GIRL**

In this chapter it will be determined how social-economical factors may contribute to the vulnerability of the adolescent (and especially that of the young girl) with regard to HIV/AIDS infection. Specific attention will be given to poverty and violence as factors that increase the vulnerability of the young girl.

## **8.4 CHAPTER 4: IMPLICATIONS FOR EDUCATION**

In this chapter the possible implications that the vulnerability of the adolescent (especially that of the young girl) may have for education (the school in particular) will be discussed.

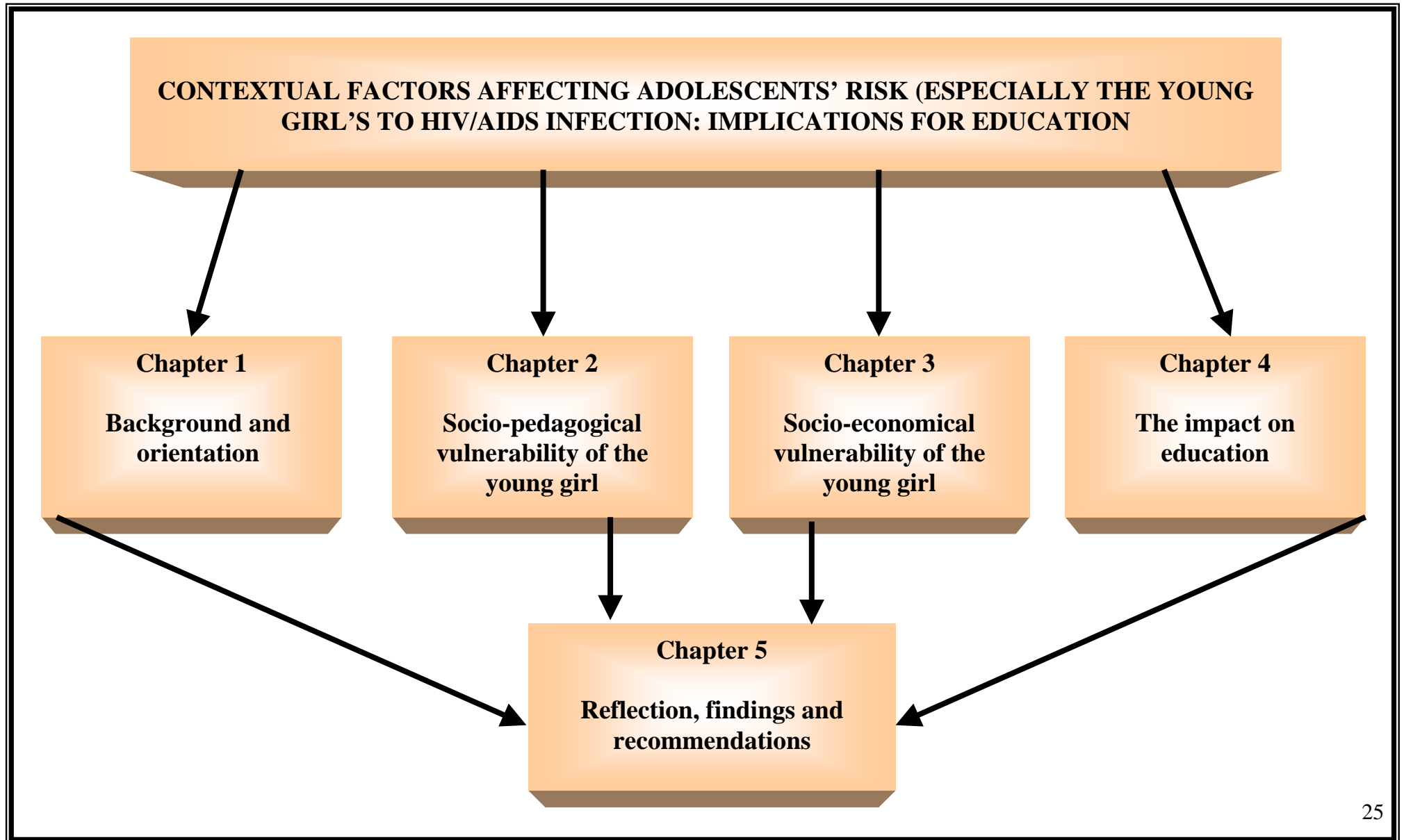
## **8.5 CHAPTER 5: REFLECTION, FINDINGS AND RECOMMENDATIONS**

In Chapter 5 a reflection, findings, and recommendations based on the entire study will be presented.

## **9. ANALYSIS OF CONCEPTS**

The title of this study is derived from the problem experienced in society and as stated in paragraph 3 of this chapter, namely: “Which contextual factors affect the adolescent’s risk (especially the young girl’s) to become HIV/AIDS infected and what are the possible implications for education?” The title will thus be: Contextual factors affecting adolescents’ risk to HIV/AIDS infection: Implications for education.

Figure 1: Schematic presentation of the plan of study



## 9.1 The concepts “vulnerable” and “risk”

### 9.1.1 Definitions according to dictionaries

a) The Reader’s Digest Universal Dictionary (1988:1648) defines “vulnerable” as:

- i) “Susceptible to injury, either physical or emotional; unprotected from danger.”
- ii) “Susceptible to physical attack; insufficiently defended.”
- iii) “Liable to censure or criticism; assailable”
- iv) “Liable to succumb to persuasion or temptation.”

It is interesting to note that the word “vulnerable” originated from the Latin word “*vulnerāre*”, which means “to wound”.

b) The Collins Cobuild English Dictionary (1998:1874) defines “vulnerable” as:

- i) “Someone who is vulnerable is weak and without protection, with the result that they are easily hurt physically and emotionally.”
- ii) “If someone is vulnerable to a particular illness, they are more likely to get it than other people.”
- iii) “If someone is vulnerable to doing something wrong, they are easily influenced to do it because they are weak, innocent, or in a difficult position.”

c) The Reader’s Digest Universal Dictionary (1988:1321) defines “risk” as:

- i) “The possibility of suffering harm or loss.”
- ii) “A factor, element, or course involving uncertain danger; a hazard.”
- iii) a synonym for “danger”.

For the purpose of this study the concepts “risk” and “vulnerable” will be used interchangeably and will refer to physical, emotional and social contextual factors that may render the adolescent (especially the young girl) vulnerable, or at risk, with regard to HIV/AIDS infection.

## 9.2 The concept “young”

- a) According to the Collins Cobuild English Dictionary (1998:1948), the concept “young” can be understood as “a person who has not lived or existed for a very long time”.
- b) The Reader’s Digest Universal Dictionary (1988:1739) describes “young” as:
- i) “Beginning in the early or underdeveloped period of life or growth”
  - ii) “Pertaining to or suggestive of youth or early life”
  - iii) “Lacking experience; immature; green”
  - iv) The plural of “young” is described as “youth” and refers to young people collectively. The typical qualities of “youth” are given as “vigour, enthusiasm, rashness, inexperience, or freshness”. “Youth” is also described as “an early period of development or existence”, the “time of life between childhood and maturity”.
  - v) Synonyms for “young” are “adolescent, teenager, puberty”.
- c) Pretorius (1988:133) describes “youth” as that category of persons that are on the way from one social position (child) to another (adult). The period is characterised by inner unrest and challenge. According to Pretorius, four distinct phases can be identified in the youth period, namely:
- i) **pre-puberty:** a phase when minor changes occur in behaviour and the first signs of secondary sexual characteristics develop as puberty starts (girls at approximately 11 years and boys at approximately 13 years).
  - ii) **The negative phase:** characterised by difficult behaviour and negative temper (girls from 12-14 years and boys from 13-15 years).



- iii) **The puberty phase:** until approximately 18 years of age.
- iv) **The adolescent phase:** until 20-21 years of age.

### 9.2.1 The concepts “adolescent” and “puberty”

A further analysis of “adolescent” and “puberty” attaches a more specific meaning to the concept “young”.

#### 9.2.1.1. The concept “adolescent”

- a) The Collins Cobuild English Dictionary (1998:24) describes adolescents as “young people who are no longer children but who have not yet become adults”.
- b) As defined in Reader’s Digest Universal Dictionary (1988:30), the concept “adolescent” refers to a person that is “undergoing adolescence”. Characteristics such as “immature in attitude and behaviour” are ascribed to the “adolescent”. The period of adolescence is “the period of physical and psychological development from onset of puberty to maturity”.
- c) The word “adolescent” is derived from Latin “*adolēscēt*”, which means “to grow up”, to “be nourished”.
- d) According to Engelbrecht et al. (1982:73), adolescence can be categorised as:
  - i) **Early adolescence** (junior secondary school years): characterised and dominated by the “growth spurt”, physical and sexual maturing.
  - ii) **Middle adolescence** (senior secondary school years): becoming psychologically independent and learning to cope with heterosexual relationships.
  - iii) **Late adolescence:** the final school years until a definite and constant personal identity is obtained. The time where adolescents commit themselves to definite social roles, value systems and aims in life.

### 9.2.1.2 The concept “puberty”

- a) “Puberty” is described as “the stage of maturation in early adolescence in which the individual becomes physiologically capable of sexual reproduction and the secondary sexual characteristics appear”. This definition correlates with the characteristics of “youth” according to Pretorius (1988:133), as mentioned in paragraph 10.2 of this chapter.
- b) The word “puberty” is derived from the Latin “*pūbertās*”, meaning “age of manhood”. It is thus the maturing years in which a boy becomes a man and a girl becomes a woman.
- c) According to Le Roux (1992:14), “puberty” is the human developmental phase which heralds adolescence and during which hormonal changes lead to physical growth and sexual maturity so that the reproduction organs start functioning and secondary sexual characteristics develop.
- d) Van Rooyen & Louw (1993:43) mention that despite sexual maturation, visible advancement towards manhood and womanhood is evident. Van Rooyen & Louw interestingly mention that puberty can also be seen as a continuation of early childhood and the safety of this continuation into puberty depends on the foundation laid in childhood.
- e) According to Van Rooyen & Louw (1993:44), the factor that specifically determines the commencement of puberty is unknown. It appears that the commencement of puberty advances by four months every ten years.

For the purpose of this study the concept “young” will refer to a child that is coming of age, thus, a girl in her youth, starting puberty, on her way to adolescence and womanhood and in the grip of physiological and psychological changes.

### 9.3 The concept “girl”

- a) The Collins Cobuild English Dictionary (1998:711) describes “girl” as:
  - i) a female child
  - ii) someone’s daughter

- iii) young woman
- iv) a man's girlfriend

b) The Reader's Digest Universal Dictionary (1988:648) defines "girl" as:

- i) a female who has not yet attained womanhood
- ii) a female child

In this study "girl" will refer to the young female who has not yet attained womanhood, in her youth on her way to adulthood.

#### **9.4 The concept "HIV/AIDS"**

##### **9.4.1 The concept "HIV"**

The concept "HIV" is an acronym for "Human Immunodeficiency Virus" (Collins Cobuild English Dictionary 1998:800). In this acronym four concepts are identified and will be discussed briefly.

a) "Human" is described in Reader's Digest Universal Dictionary as:

- i) "showing qualities characteristic of man as distinguished from machines, such as sympathy or fallibility (making errors)".
- ii) "pertaining to or being a man as distinguished from a lower animal; reasoning; moral".
- iii) "pertaining to or being a man as distinguished from a divine entity or infinite intelligence; mortal; earthly".
- iv) "a human being; a person", a member of the genus *Homo*, and especially of the species *Homo sapiens*.
- v) "a human" from the Latin "*hūmānus*", meaning "man".

b) "Immuno-" indicates "immune response" or "immunity". "Immune" means "having immunity to infection"; it relates to or confers the body's immune system. If a person is immune he is "not affected or responsive" to infection and

“protected from danger”. The person has “immunity”: an inherited, acquired, or induced resistance to a specific pathogen, especially by the production of antibodies or by inoculation (Reader’s Digest Universal Dictionary 1988:770).

- c) “deficiency” refers to “the quality or condition of being deficient”; “a lack; a shortage; an insufficiency”. “Deficient” is used to refer to “insufficiency or incompleteness, and is basically a quantitative term” (Reader’s Digest Universal Dictionary 1988:409).

The use of “deficiency” with regard to “immuno” thus implies that the immune system of the human body is lacking in quality as the antibodies are lacking in quantity and causing the immune system to be deficient in protecting the body against illness and infection.

- d) “Virus” is derived from the Latin “*vīrus*”, meaning “poison, slime”. A “virus” is described as “any of various submicroscopic pathogens consisting essentially of a core of a single nucleic acid surrounded by a protein coat, having the ability to replicate only inside a living cell.”

It is interesting to note that the terms “germ” and “virus” are not interchangeable and must be carefully used. “Germ” is a non-scientific term relating to microorganisms that are invisible to the unaided human eye, and refer to disease producing bodies. “Virus” is the technical term for any of a group of extremely small agents capable of producing diseases in human, animal and plant life.

“HIV” reduces people’s resistance to illness by destroying the immune system in humans (Van Rooyen & Louw 1993:109) and can cause “AIDS”. If someone is “HIV positive”, they are infected with HIV, and may develop “AIDS”. If someone is “HIV negative”, they have been tested for the virus and are not infected.

#### **9.4.2 The concept “AIDS”**

“AIDS” is the acronym for “*Acquired Immune Deficiency Syndrome*”. The concepts will be discussed briefly:

- a) “Acquired” is described in Reader’s Digest Universal Dictionary (1988:24) as “to gain possession of” and “to get, especially by one’s own efforts or qualities”. The description of “an acquired characteristic” is very significant as it is “a nonhereditary change in an organ caused by use or disuse or by environmental factors”.

In Collins Cobuild English Dictionary (1998:17) the use of “acquired” is stated as “you buy, or obtain something for yourself, or someone gives it to you”. It is important to note that “acquired” means “not inborn, passed from person to person, including from mother to baby” (World Health Organisation 1992:21).

- b) “Immune” refers to the immune system of the human body. The “immune system” defends the body and creates “resistance to a disease” and to be “not affected by or responsive to” disease.
- c) “Deficiency”, as already mentioned, refers to the “insufficient” or ineffective condition or quality of the immune system to protect the body from disease.
- d) “Syndrome” is from the Greek “*sundromē*”, meaning “running together”, a concurrence (of symptoms).

The Reader’s Digest Universal Dictionary (1988:1535) describes a “syndrome” as:

- i) “a group of signs and symptoms that collectively indicate or characterise a disease, psychological disorder, or other abnormal condition”.
- ii) “a set of signs or symptoms indicating the existence of an undesirable condition, problem, or quality”.

## 9.5 The concept “infection”

- a) The Reader’s Digest Universal Dictionary (1988:788) describes “infection” as:
- i) “Invasion of the body by pathogenic (illness causing) micro-organisms”.

- ii) “The pathological state resulting from such invasion, characterised by inflammation and tissue damage due to the action of toxins produced by the micro-organisms.
- iii) A disease is “infectious” when it tends to spread or affect others easily.
- iv) A synonym for “infection” is “contagious”, also referring to disease transmission by direct or indirect contact.

In this study HIV/AIDS is regarded as “infectious”, because it is a pathological disease caused by invasion of the body by micro-organisms (viruses). The disease spreads easily and is transmitted by direct contact with HIV contaminated blood or tissue.

The relationship between HIV and AIDS becomes clear. The HI virus causes the human immune system to become deficient in protecting the body against diseases over time. When the HI virus has caused enough damage to the immune system, infections and cancers develop. These infections and cancers make the person ill and the condition is referred to as the “syndrome” AIDS.

## **10. SUMMARY**

In this chapter attention is given to statistics with regard to the HIV/AIDS epidemic that is evident in the lives of our youth. The background that led to the identification of the problem regarding the vulnerability of the young girl is described. A historical background regarding HIV/AIDS, symptoms of HIV/AIDS, transmission of HIV/AIDS, myths regarding HIV/AIDS and the prevention of HIV/AIDS are discussed. The research question of the study is formulated and primary and secondary aims of the study are indicated. The methodology that outlines and focuses the study, namely a qualitative approach with the appropriate techniques to successfully complete the study and solve the problem is described. The plan of the study is drafted by means of describing the different chapters that will be forming the body of the dissertation in an attempt to solve the identified problem. Terminology with regard to the title and the study is conceptualized.

## CHAPTER 2

### THE SOCIO-PEDAGOGICAL VULNERABILITY OF THE YOUNG GIRL

#### 1. THE AIM OF THE CHAPTER

The aim of this chapter is to investigate factors in the situation of the young girl, in an attempt to determine which factors contribute to her vulnerability to become HIV infected.

To effectively investigate and describe the situation of the young girl, it may be necessary to focus on the following factors in this study:

- The child-rearing style of the parents.
- The vulnerability of the modern nuclear family.
- The deterioration of the modern nuclear family.
- Gender inequalities.
- The physiological uniqueness of the young girl.

#### 2. INTRODUCTION

The young child as part of a family is under the direct influence of the child-rearing style that is realized within the family. In each family the parents' educational behaviour, as the young child consciously or unconsciously experiences it, has a significant influence on the development of his or her personality (Pretorius 1992:25). Each family is unique and even the education of different children within the same family is not similar. The personality of the young child, that develops under the influence of the child-rearing style of the parents, may make the child more vulnerable to become HIV infected.

The modern family finds itself in a society characterised by rapid technological, industrial, economical and social changes (Hartell 2000:39). These changes, which often have a negative influence on the family, can disturb the educational climate in many families. Pretorius (1998:63) states that there are numerous factors, such as poverty, community unrest and unemployment hampering modern family life. The modern family is subjected to changes that impede and complicate the role and responsibilities of parents in such a way that the parents neglect their educational responsibility or transfer it to others (Van Rooyen & Louw 1994:3).

The consequence of complex and dynamic changes in society is that it becomes more difficult to adequately educate children. The child experiences childhood in a changing world as traumatic, since the world and society tend to be hostile toward children and this hostility may threaten the child's development towards adulthood (Le Roux & Smit 1992:83-84).

Packard (1983:3-9) identifies the following family and societal influences that threaten the child's development towards adulthood:

- ❑ an increase in the number of children whose parents are divorcing
- ❑ numerous family situations are characterised by single parent families
- ❑ children experience loneliness because of inadequate communication in the family
- ❑ the family situation is characterised by a lack of intimate contact and intervention in parenting
- ❑ parents often regard their children as a handicap to their freedom and to achieving fulfilment in their occupations
- ❑ parents are often not child-orientated and are uncertain about their parenting roles
- ❑ instances of child abuse and neglect are on the increase.

Hartell (2000:40) confirms that a variety of pathological factors within the family, such as child abuse and divorce, impede on effective education within the family and lead to poor examples of responsible living set by parents. These factors lead to greater vulnerability of the modern family and distort the vision of a happy marriage and family life for the child.

In the midst of influences from the family and society, the child on his or her way to adulthood also travels the journey as a physiological human being. The changes that occur during puberty have an influence on the child as a total being. The developing child experiences general feelings of uncertainty, emotional changes and strong urges (Van Rooyen & Louw 1994:5) that impact on his or her development toward adulthood. A discussion follows that focuses on the family, child-rearing style in the family and social and biological factors that may influence the vulnerability of the young child.



### 3. BASIC FORMS OF PARENTING

The Collins Cobuild Dictionary (1998:1372) explains the concept “child rearing” as bringing children up until they are old enough to look after themselves. If you say that someone was reared in a particular way, you describe how he or she was brought up. The Reader’s Digest Universal Dictionary (1988:1278) describes “rear” as “to care for a child or children during the early stages of life, bring up”. The word “rear” is derived from Middle English “*reren*”, which means “to lift up, raise”.

According to Le Roux (1992:12), the concept “child-rearing style” refers to the behaviour, attitude, disciplinary approach or way of communication that educators (parents) use or demonstrate in their relationships with children. Pretorius (1998:63) adds that “child-rearing style” or “educational-behaviour-pattern” or “parenting” is the mode of education that parents use in the normal and daily education of the child within the family situation to attain a certain aim or ideal with the education of the child.

Pretorius (1998:33) states that the child-rearing style of the parent has a significant and powerful impact on the personality development of the child. The personality of the child determines his/her behaviour and the social adaptation that the child has to realize in different situations.

For the purpose of this study, “child-rearing style” or “parenting” will refer to the behaviour of parents as primary educators in the family and the influence their behaviour has on the development of the child, and the possible subsequent vulnerability of the child because of the child-rearing style that the parents realize.

The Dutch pedagogue, Angenent, places the fundamental patterns of child rearing in clear synoptic perspective with the design of child-rearing models and structures. These fundamental patterns are applicable to normal, day-to-day child rearing within the family situation, and two basic dimensions of child rearing are distinguished, namely the warmth dimension and the dominance dimension (Angenent 1985:75):

□ **The warmth dimension in parenting**

The warmth dimension in parenting refers to the horizontal, emotional distance between parent and child, to the extent to which a warm and loving atmosphere prevails in the child's upbringing. Pretorius (1992:27) differentiates between a warm parent who has a good relationship with the child, and the cold parent who does not respond emotionally to the child.

**Figure 2: The warmth dimension in child rearing**

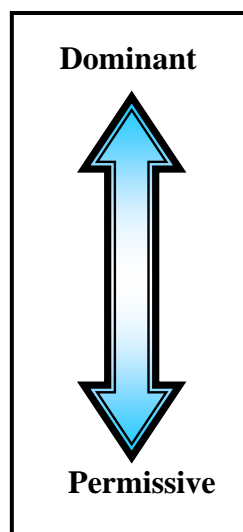


Source: Angenent (1985: 86)

□ **The dominance dimension in child rearing**

Dominance in parenting refers to the vertical distance between the parent and the child. This aspect has to do with the distinct degree in which a parent either tries to dominate and force a child in a certain direction, without allowing much freedom for self-development, and the indulgent parent who gives the child too much freedom (Pretorius 1992:29).

**Figure 3: The dominance dimension in child rearing**

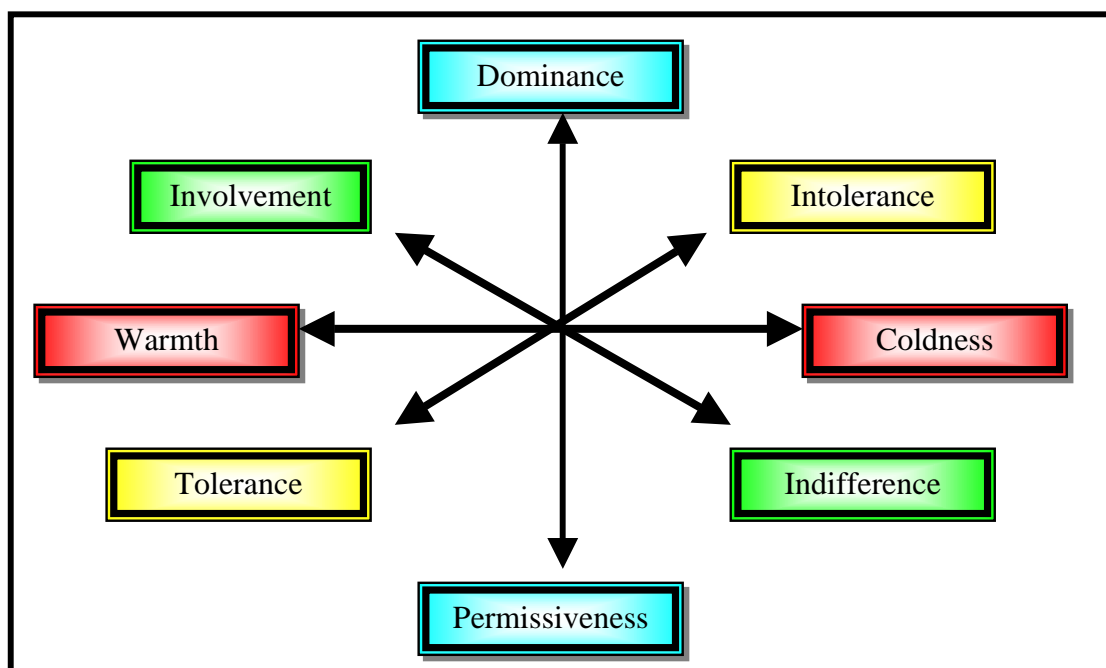


Source: Angenent (1985: 86)

The relationship between these two basic dimensions of parenting can be illustrated by a two-dimensional child-rearing model (Figure 4). The basic concepts of warmth and dominance form the principal axes of the model, with antipoles warmth/coldness and dominance/ permissiveness. The two secondary axes in the model have to do with combinations of the main axes. The “tolerance/intolerance” axis refers to democracy in child rearing and differentiates between the parent who displays a genuinely meant permissiveness and the parent who coldly limits the child’s possibilities. The “involvement/ indifference” axis refers to the parent’s participation in child rearing and contrasts warm, protective strictness with cold, unresponsiveness and apathy (Pretorius 1998:62). According to Pretorius (1998:62), eight child-rearing styles or basic forms of parenting can be distinguished on the basis of this model, namely:

- ❑ warm parenting
- ❑ dominant parenting
- ❑ tolerant, democratic parenting
- ❑ involved parenting
- ❑ cold parenting
- ❑ permissive parenting
- ❑ intolerant, autocratic parenting
- ❑ indifferent parenting

**Figure 4: The two-dimensional child-rearing model of Angenent**



Source: Angenent (1985:86)

A brief discussion will follow to differentiate between the eight basic forms of parenting and the child-rearing behaviour that the parent realizes, as well as the possible predisposition that the girl may experience because of the child-rearing style of her parents.

### 3.1 Warm parenting

The concept “warmth” is defined as “psychological warmth; spontaneous willingness to understand, accept and help another person without being possessive” (Pretorius 1992:28). The Reader’s Digest Universal Dictionary (1988:1690) defines “warmth” as “excitement or intensity, as of love or passion; ardour; zeal”. It is interesting to note that the word “ardour” is derived from the Latin “*ardēre*”, meaning “to burn”, a “fervent enthusiasm or devotion” and the word “zeal” is from the Greek “*zēlos*”, that means “enthusiastic and diligent devotion in pursuit of a cause, ideal, or goal”.

For the purposes of this study, “warm parenting” will refer to a parent who is lovingly and willingly involved in raising his or her child. The “warm” parent may be the parent who enthusiastically raises his or her daughter with the aim of her being less vulnerable to situations that may place her in danger with regard to HIV infection.

#### 3.1.1 Characteristics of warm parenting

Pretorius (1988:28) describes the following characteristics of warm parenting:

- good I-You relationships and communication between the parent and the child.
- acceptance of the child with all his or her shortcomings and failings.
- mutual trust between parent and child.
- the parent is emotionally involved in the child’s daily activities.
- the parent loves and adores the child and is concerned for the child’s well-being.
- the parent encourages the child to make friends and bring them home.
- punishment is appropriate and on reasonable grounds.
- reward and communication are central to warm upbringing. Corporal punishment is the exception rather than the rule.

Child rearing cannot be separated from family life. Warmth is encountered within a harmonious family where tension and conflict are limited (Pretorius 1988:28). The family where warmth as rearing style prevails is usually an “open family” where the family members have good contact with the “outside world”. A good marital relationship forms the basis for this favourable family situation, and the parents fulfil their task of guidance and nurturing to the best of their abilities, while realizing an optimal family life.

### **3.1.2 Effects of warm parenting**

Positive parental involvement and support of the child lead to intensive, positive communication. The child feels secure and safe in the family because the parent accepts the child as an individual and this acceptance assures the child that he or she is someone with his or her own personality (Pretorius 1988:43). The child thus has positive self-awareness and a positive self-concept, therefore the child accepts himself or herself with all his or her failures and shortcomings. The child experiences little uncertainty or anxiety, assured with the knowledge that dependable parents are always available. The child is assertive in new and unfamiliar circumstances and can take a stand.

The above characteristics that the girl may attain when she is reared with warmth in the family may make her less vulnerable when she experiences problems during puberty and adolescence. The girl may be able to accept her body as it is changing to that of a woman. She will have “someone” when she experiences uncertainty and anxiety during puberty because her parents communicate positively with her (Van Rooyen & Louw 1993:47). A girl who knows that she has parents that support her and with whom she can spontaneously communicate, may be able to handle herself more assertively in unfamiliar situations and not be predisposed to risky situations in which she is sexually exploited and more vulnerable to HIV infection (in this regard also refer to Chapter 3, paragraph 3.1- 3.3.2.3).

### **3.2 Cold parenting**

Pretorius (1992:44) describes “cold parenting” as “limited personal communication between parent and child”. The parents do very little to support the child and parents may even reject the child. Parents, who behave cold towards the child, anger easily

and are quick to punish. Besides meaning “lacking heat”, the word “cold” is also defined as “unenthusiastic and apathetic” (Reader’s Digest Universal Dictionary 1988:313). The use of “apathetic” as a synonym for “cold” is interesting because “apathetic” is a blend of “apathy” and “pathetic”. The word “apathy” is from the Greek “*apathēs*”, meaning “without feeling”. The word “pathetic” is from the Greek word “*pathētos*”, meaning “liable to suffer”, thus, “without feeling and liable to suffer”.

For the purposes of this study, “cold parenting” will be regarded as an unfavourable relationship between the parent and the child in which the child is liable to suffer emotional and physical harm, because of limited personal communication between the parent and the child. It will be argued that cold parenting may make the child more vulnerable with regard to HIV infection.

### **3.2.1 Characteristics of cold parenting**

According to Pretorius (1992:29), cold parenting is characterised by the following:

- ❑ parents with a superficial, indifferent, cold, negative and hostile attitude towards the child.
- ❑ the parent does not accept the child.
- ❑ an emotional distance between parent and child.
- ❑ the parent negates the child.
- ❑ no relationship of trust and support.
- ❑ the parent devotes very little time and effort to the child. The child is seen as a burden.
- ❑ the parent withdraws from his parental and domestic duties. The parent goes his own way.
- ❑ the parent often punishes. Corporal punishment is no exception, arbitrary and inconsequent.

The family life associated with cold parenting is regarded as disharmonious - there is a complete absence of a happy atmosphere in the family, with disturbed I-You relationships and poor communication between family members.

### **3.2.2 Effects of cold parenting**

The child that is coldly reared, experiences inadequate communication with his parents and receives limited attention from them. The child is left to “make do” from a very young age (Pretorius 1992:44). The consequence is that the child develops a superficial independence, which is more pretence than reality. The child that is deprived of attention and affection from parents is “hungry for affection”. They are afraid of being left out and are extremely eager to please others and to do things for others. They will buy affection at any cost.

In view of the above opinions, the girl who is raised by “cold” parents may be more vulnerable to influences that may harm her and predispose her to HIV/AIDS infection. When the girl reaches puberty and experiences a “great need for someone” (Van Rooyen & Louw 1993:47), she may reach out to people that might misguide her and take advantage of her extreme eager to please others. This may lead to sexual abuse of the young girl, as her efforts to please others can be interpreted by sexual offenders as “sexual enticing behaviour” (Le Roux 1992:152). The girl who experiences cold parenting may be alone and feel forgotten, with no one to whom she can communicate her fears and anxieties. As a result, she may keep concerns about her changing body and feelings to herself, brood over them, and eventually turn molehills into mountains.

The emotional distance between the parent and the young girl causes a lack of intimacy and the young girl may search for love in sexual intercourse as “pretence love” or “instant love” (Le Roux 1992:90) to serve as a substitute for parental love. This predisposes the girl to be more vulnerable to high-risk sexual behaviour and possible HIV/AIDS infection.

### **3.3 Dominant parenting**

Dominance in parenting means “excessive control, correcting and oppression” (Pretorius 1998:66). The Collins Cobuild English Dictionary (1998:491) supports this definition by describing dominance of a person as “the fact that the person is more powerful, successful, influential or prominent than other people”.

For the purposes of this study, dominance in parenting will refer to the powerful and influential relationship between the parent and the child in which the parent exercises

excessive control over the child by forcing the child into a certain direction, without allowing much freedom for self-development.

### **3.3.1 Characteristics of dominant parenting**

The following characteristics of dominant parenting can be identified (Pretorius 1992:29): The parent

- ❑ is very possessive towards the child and controls the child in all his or her activities
- ❑ excessively corrects all the child's activities and this amounts to a "chain reaction of corrections"
- ❑ tries to impose his views on the child and makes excessive demands on the child while restricting the child rigidly
- ❑ is excessively concerned with the child's health and rapid development
- ❑ expects the child to perform as a model of top achievement and obey numerous strict instructions
- ❑ wants the child to obey at once without argument and becomes very angry when the child is disobedient.

The closed, patriarchal family life that is associated with dominant parenting is usually not influenced by external factors. The parents are the central figures in the family. The father as head of the family is "lord and master", and maintains discipline. The children grow up in social isolation because of the closeness of the family or extended family (Pretorius 1992:30). One of the possible consequences of a child's isolation from society, under the influence of dominant parenting, may be that violent behaviour such as incest and other forms of sexual abuse are not discovered.

### **3.3.2 Effects of dominant parenting**

Pretorius (1992: 45) states that the child who is reared in an exclusively dominant family situation does not experience sufficient freedom and suitable opportunities to experiment and develop self-discipline and responsibility for the self. Dominant parenting will inhibit the child and limit his or her experiences. The individuality of the child in a dominant family will not develop to its full potential, as the parent tries to enforce his or her views on the child and this restriction leaves the child with little



room to develop a unique identity. The child is used to rigid rules and may conform easily to the prevailing norms and customs. This blind conformation can render the child vulnerable because the adolescent does not want to be different from his or her peers during puberty and easily conforms to the demands of the peer group (Van Rooyen & Louw 1993:47). The girl may conform to the norms and values of her peer group that may influence her to engage in risky sexual behaviour that predisposes her to HIV/AIDS infection. Pretorius (1992:45) states that a child growing up under extreme dominance “does not learn to develop himself and to stand on his own feet”. According to Pretorius (1988:59), an imbalance regarding the rearing of the child may develop when the emphasising of control and the setting of demands take place at the expense of communication and cherishing.

The girl may also withdraw from the oppression of her extremely dominant upbringing and rebel against all rules and regulations and find little purpose and direction in her own life (Pretorius 1992:45). This behaviour may also render the girl vulnerable during adolescence, as the girl experiences a great need for “someone” to communicate and understand the changing emotions and physical difficulties that she endures during puberty. According to Van Rooyen & Louw (1994:48), puberty is a time when a young girl starts to distance herself from prescriptions and restrictions with regard to behaviour. The girl in a dominant family upbringing may be extremely vulnerable to risky sexual behaviour when she tries to free herself from the conformist and conservative ideal which has constantly been forced upon her, and engages in risky sexual activities such as anal sex that make her vulnerable to HIV/AIDS infection (in this regard also refer to paragraph 7.1.2.6 of this chapter).

The dominant child-rearing style (parenting) may contribute to the vulnerability of the young girl to HIV infection when it is considered that the young girl has a “great need for someone” during puberty (Van Rooyen & Louw 1994:47) and that effective communication with someone who gives emotional support is much needed. The dominant child-rearing style may render the girl even more vulnerable, as the parent only sets limits and demands without realizing effective communication through which the girl can experiment by voicing her wishes and setting her own demands. The needs and wishes of the young girl are not considered and this inconsideration can lead to feelings of inadequacy, inferiority and shame at a time when she needs the cherishing acceptance of loving parents. This may also result in the girl becoming rebellious towards authority, provocative, negative and hostile, and consequently she

might try to find other means of feeling accepted and loved by engaging in risky sexual practices that increase her vulnerability to becoming HIV/AIDS infected (Botha 1992: 25).

### **3.4 Permissive parenting**

Permissive parenting is the opposite of dominant parenting (Pretorius 1992:30). The permissive parent follows a “laissez-faire” attitude in his or her relationship with the child; there is the minimum control and the child is left to be. The Reader’s Digest Universal Dictionary (1988:1152) defines permissive as “ ... lenient, tolerant or liberal, especially when based on or reflecting a belief that there should be as few restraints as possible in matters of sexual morality.”

Pretorius (1998:65) describes the permissive child-rearing style as non-reprimanding and excessively acceptable towards the child’s impulses, wishes and behaviour. Permissive child rearing sets minimal demands to the child’s responsibility while the child is free to regulate his own activities. Parental control is avoided and the child enjoys excessive participation in making decisions in view of the parent’s failure to distance himself from the child and incapability to say “no” to the child. The parent focuses on what the child “wants” and not on what “ought to be”, while the parent tries to avoid conflict with the child and consequently gives way to the child’s fancies. The main characteristic of the permissive child-rearing style is the excessive flexibility of the parent.

#### **3.4.1 Characteristics of permissive parenting**

Bester (1985:29) describes the following characteristics of permissive parenting:

- ❑ the child is allowed a lot of freedom and virtually no boundaries are set
- ❑ no means of punishment are utilized except for approval as measure to regulate the child’s behaviour
- ❑ the person in authority is only a pawn in the hands of the child
- ❑ no decision is taken for the child; the child must follow her own route
- ❑ the person in authority is not involved or concerned with the child
- ❑ the child is overloaded with materialistic possessions.

### 3.4.2 Effects of permissive parenting

According to Pretorius (1998:65), the following effects may be expected when an exclusively permissive child-rearing style is maintained: The child

- ❑ experiences the feeling that nobody loves and cares for him
- ❑ experiences feelings of uncertainty and insecurity
- ❑ blames the parents when things go wrong for him
- ❑ feels that the person in authority has let him down by not providing the necessary guidance and warnings in time
- ❑ usually has little respect for people with authority
- ❑ tends to be very selfish and has little appreciation for what is done for him.

The permissive style of child rearing may increase the vulnerability of the young girl. Van Rooyen & Louw (1993:6) argue that the teenager has an imperative need for guidance. The girl, as teenager, is open and ready for discussion and guidance with regard to herself and when she does not receive love and care as a result of a permissive child-rearing style, careless behaviour may occur, such as teenage prostitution that renders the girl vulnerable to HIV/AIDS infection (Oprah Winfrey, 5 December 2003). The teenager, and therefore the girl, has a need for someone to lead her and she is willing to be led. The lack of guidance and understanding within the permissive family may result in teenagers looking for answers elsewhere, where “false prophets” are ready to give guidance. When a girl is subjected to permissive child rearing, the feelings of insecurity and uncertainty that she experiences during puberty (Van Rooyen & Louw 1993:6) may be intensified. She may feel that her permissive parents are not involved in her life as they let her go free to make her own decisions. In an attempt to seek confirmation and security she may be more vulnerable to wrong influences and might not turn to her parents when things go wrong, as she experiences that they do not love and care for her. The permissively reared girl may have doubt in and distance herself from her parents, authority and accepted norms of behaviour, leaving her more vulnerable to unfavourable influences such as teenage prostitution and a higher susceptibility to HIV/AIDS infection.

### 3.5 Tolerant, democratic parenting

Tolerant, democratic parenting is a combination of warmth and permissiveness, with characteristics of both warm and permissive parenting (Pretorius 1998:66). The parent in this parenting style is also called the accepting and understanding parent. The Reader's Digest Universal Dictionary (1988:1586) explains "tolerant" as "inclined to tolerate the beliefs or behaviour of others".

#### 3.5.1 Characteristics of tolerant, democratic parenting

Pretorius (1998:66) identifies the following characteristics of tolerant, democratic parenting: The parent

- ❑ accepts the child as an equal
- ❑ aims at establishing camaraderie between him and the child
- ❑ displays a lot of flexibility without fear of losing his position of power as an educator
- ❑ aims toward the well-being, self-actualisation and high self-concept of the child
- ❑ is very involved with the child, but it is not an involvement that feeds dependency
- ❑ creates opportunities for the child to form a well-motivated and responsible viewpoint.

#### 3.5.2 Effects of tolerant, democratic parenting

The most important effects of the tolerant, democratic parenting on the child may be that the child is predisposed to prosocial behaviour and the creation of a trusting relationship that forms the basis for entering into social relationships (Pretorius 1998:68). The child is equipped to deal with complex patterns of behaviour as the democratic parent creates opportunities for the child's socialisation, which *inter alia* involves social skills and adaptability, as well as a prosocial attitude.

As a result of a tolerant, democratic parenting style, where the child reveals mature judgement and good problem solving behaviour, less vulnerability with regard to risky sexual behaviour and the consequent HIV/AIDS infection, may manifest. As

mentioned in paragraph 3.1.4.2, the adolescent has an urgent need for guidance and communication (Van Rooyen & Louw 1994:6). By means of tolerant, democratic parenting, where intimate communication is realized together with unconditional acceptance of the child's thoughts, the girl may be more prudent not to follow a lifestyle that increases her vulnerability to HIV/AIDS infection.

### **3.6 Intolerant, autocratic parenting**

According to Pretorius (1998:68), intolerant, autocratic parenting features characteristics of both cold and dominant parenting. The intolerant, autocratic parent is very commanding and always makes many demands on the child. The word "intolerant" refers to "not tolerant of different characteristics or habits in others; bigoted; irritable; short-tempered" (Reader's Digest Universal Dictionary 1988:804).

#### **3.6.1 Characteristics of intolerant, autocratic parenting**

Characteristics of intolerant, autocratic parenting, according to Pretorius (1998:68), are the following: The parent

- ❑ demands absolute obedience from the child and regards it as a virtue. The child may not acquire the ability to think for himself or herself and the child's ability to make autonomous, responsible decisions is hampered.
- ❑ applies forcible, disciplinary rules in order to inhibit the child's will whenever the child's conduct is in conflict with what the parent considers to be acceptable.
- ❑ believes his word should be accepted without questioning.
- ❑ does not realize opportunities for real educational communication with the child.
- ❑ realizes negative communication that is deprived of all feeling and that harms the child's emotional life and his feeling of self-worth.
- ❑ values the maintenance of his authority, and suppresses any efforts the child may make to challenge his authority.

### **3.6.2 Effects of intolerant, autocratic parenting**

According to Angenent (1985:106), a child who is exposed to an intolerant parenting style is hostile, aggressive, bossy, rebellious and consequently socially unstable. Because the child's behaviour is forced by his autocratic parents, adequate self-actualisation may be impossible. Steyn et al. (1989:388) add that the child in an autocratic parenting style is characterised by an immature dependence on other people. This extreme child-rearing behaviour may predispose the young girl to become extremely dependent on other people in society, for example the girl that is involved with a "sugar-daddy" in whom she sees the fulfilment of her needs - consequently increasing her vulnerability to HIV/AIDS infection. The girl's inability to take autonomous, responsible decisions may predispose her to take unnecessary risks with regard to sexual activity and consequently increase her vulnerability to HIV/AIDS infection. The girl may not have the ability and confidence to question rules and form her own opinion on the behaviour of others, but easily conform to the expectations of others. This readiness to accept and conform to the expectations of others, coupled with a low self-esteem, may leave the girl more vulnerable to sexual exploitation and risky sexual behaviour, which predisposes her to HIV/AIDS infection.

### **3.7 Involved parenting**

Involved parenting means that dominance, limitations and control go hand in hand with warmth and love (Pretorius 1998:69). The Reader's Digest Universal Dictionary (1988:808) refers to the word involved as "to occupy or engross completely; to absorb". The parent has a good relationship with the child and wants to safeguard him from mistakes, even though it may be at the cost of the child's autonomy and underestimation of his potential to develop. Involved parenting that is characterised by extreme dominance and an exaggerated fear that something will happen to the child often results in overprotection and infantilising of the child (Angenent 1985: 106).

#### **3.7.1 Characteristics of involved parenting**

Pretorius (1998:69) identifies the following characteristics of involved parenting: The parent

- ❑ shares experiences with the child and pays attention to, and is interested in the child's activities
- ❑ tries to protect the child from harm and mistakes
- ❑ may display excessive physical pampering (mothering) and might not set boundaries for physical contact
- ❑ wants to “possess” the child for too long and does not take into account that the child needs and wants to develop and emancipate.

### **3.7.2 Effects of involved parenting**

Pretorius (1998:70) states that involved parenting may imply suffocating parenting, which impedes the child's development and achievement of responsible independence. The parent interferes too much with the child and forces himself on the child, which results in communication without distance. Because of the parent's “over-protectiveness”, the child may remain dependent and cannot actualize his potential while displaying little self-confidence and a low self-concept. The girl that is reared by an involved parent may have little self-confidence and a low self-concept, that can impede her ability to act assertively with regard to sexual relationships and other social situations such as peer pressure to experiment with sex or drugs, which in turn can contribute to her vulnerability to HIV/AIDS infection.

The excessive physical pampering and lack of boundaries for physical contact may predispose the girl to sexual exploitation and sexual abuse, as she may find it acceptable to be touched and pampered by adults. The girl may not question unacceptable physical contact and be predisposed to sexually exploitive situations in which she may be raped and become vulnerable to HIV/AIDS infection (in this regard also refer to Chapter 3, paragraph 3.2-3.3.2.4 of this study).

### **3.8 Indifferent parenting**

The Reader's Digest Universal Dictionary (1988:784) explains “indifferent” as “having no particular interest or concern; apathetic.” The parent shows signs of both cold and permissive parenting (Pretorius 1998:70). Pellegrini (1987:149) describes this parenting style as minimal time and effort spent with the child, while the child is kept at a distance.

### **3.8.1 Characteristics of indifferent parenting**

The following are characteristics of indifferent parenting that may be identified (Pretorius 1998:71): The parent

- ❑ shows no interest in the child and therefore ignores and neglects the child
- ❑ does not satisfy the child's primary needs for love and support, while disregarding the child's need for authority and guidance
- ❑ displays an emotional distance towards the child and removes himself totally from the child and his actions, thus giving the child absolute freedom
- ❑ unhesitatingly uses withdrawal of love as disciplinary tactic or punishment.

### **3.8.2 Effects of indifferent parenting**

Pellegrini (1987:149) states that unresponsive-undemanding parents often abuse and neglect the child, as the child's basic all-important needs for love and care are not fulfilled. The consequence may be that an indifferently reared child may be inclined to aggression, disobedience and other antisocial behaviour because of the inadequate socialising that impedes his development (Pretorius 1998:71). This cold, permissive parenting may lead to feelings of inferiority and a negative self-concept of the child.

The girl who is reared indifferently may, because of her negative self-concept, inadequate social skills and feelings of inferiority, be extremely predisposed to sexually exploitive situations and risky sexual behaviour that make her vulnerable with regard to HIV/AIDS infection. Superficial interest, love and support from strangers, may become substitutes for the warmth and acceptance that she does not receive from her parents, for example: the many young girls that voluntarily accept older men as their sexual partners (sugar daddy) and consequently increase their vulnerability with regard to HIV/AIDS infection.



Figure 5: Schematic presentation of educational styles’ possible predisposition to HIV infection

Parent style	Warmth	Coldness	Dominant	Permissive	Tolerant, democratic	Intolerant, autocratic	Involved	Indifferent
<b>CHARACTERISTICS</b>	<ul style="list-style-type: none"> <li>-Parent is warm and loving towards child.</li> <li>-Accepts child with failures and shortcomings.</li> </ul>	<ul style="list-style-type: none"> <li>-Parent is cold and hostile towards child.</li> <li>-Parent rejects child.</li> <li>-Antipole of warm parenting.</li> </ul>	<ul style="list-style-type: none"> <li>-Excessive control, correcting and oppression.</li> <li>-Parent forces child into a certain direction.</li> <li>-Restraining parenting.</li> </ul>	<ul style="list-style-type: none"> <li>-“Laissez-fair” attitude of parent.</li> <li>-Minimum parental control and child is left to be.</li> <li>-Non-reprimanding parent with minimal demands.</li> </ul>	<ul style="list-style-type: none"> <li>-Combination of warmth and permissivity.</li> <li>-Accepting and understanding parent.</li> <li>-Camaraderie between parent and child.</li> </ul>	<ul style="list-style-type: none"> <li>-Combination of cold and dominant parenting.</li> <li>-Parent is very demanding.</li> </ul>	<ul style="list-style-type: none"> <li>-Limitations and control go hand in hand with warmth and love.</li> <li>-Parent wants to safeguard the child from mistakes but underestimates development.</li> </ul>	<ul style="list-style-type: none"> <li>-Combination of cold and permissive parenting.</li> <li>-Parent is not interested in child and neglects the child.</li> <li>-Primary needs are not taken into account.</li> </ul>
<b>CHILD REARING</b>	<ul style="list-style-type: none"> <li>- Good relationships and communication.</li> <li>- Mutual trust.</li> <li>- Parent emotionally involved in child’s activities.</li> <li>- Appropriate punishment.</li> </ul>	<ul style="list-style-type: none"> <li>-Unfavourable relationships and communication.</li> <li>-Insensitive towards child’s needs.</li> <li>-Emotional distance between parent and child.</li> <li>-Punishment cruel or inappropriate.</li> </ul>	<ul style="list-style-type: none"> <li>-Parent constantly corrects the child.</li> <li>-Parent imposes his views on child and restricts child.</li> <li>-Parent excessively concerned with child’s health and rapid development.</li> <li>-Parent uses strict discipline.</li> </ul>	<ul style="list-style-type: none"> <li>-Child has a lot of freedom and no boundaries.</li> <li>-No means of punishment.</li> <li>-Parent is uninvolved or unconcerned with the child.</li> <li>-Child is overloaded with materialistic possessions.</li> </ul>	<ul style="list-style-type: none"> <li>-Parent accepts child as an equal.</li> <li>-Parent displays flexibility.</li> <li>-Parent aims at well-being and self-actualisation of child.</li> <li>-Parent is involved but encourages independence.</li> <li>-Parent uses commands and sanctions only when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>-Parent demands absolute obedience.</li> <li>-Parent exploits disciplinary rules and inhibits child’s will.</li> <li>-Limited opportunities for educational communication.</li> <li>-Parent maintains his authority and suppresses the child.</li> </ul>	<ul style="list-style-type: none"> <li>-Parent pays attention to and is interested in the child.</li> <li>-Parent protects child from mistakes.</li> <li>-Parent may display physical pampering.</li> <li>-Parent wants to possess child for too long.</li> <li>-Parent inhibits child’s emancipation.</li> <li>-Communication without distance.</li> </ul>	<ul style="list-style-type: none"> <li>-The parent does not show love and interest in the child.</li> <li>-Emotional distance between parent and child.</li> <li>-Parent uses withdrawal of love as disciplinary tactic.</li> <li>-Negating or ignoring parenting style.</li> <li>-Parent does not offer guidance and support that the child needs.</li> </ul>
<b>EFFECT ON CHILD</b>	<ul style="list-style-type: none"> <li>- Intensive, positive communication.</li> <li>- Experiences safety and security.</li> <li>- Positive self-awareness and self-concept.</li> </ul>	<ul style="list-style-type: none"> <li>-Inadequate communication leads to inadequate socialization.</li> <li>-Child develops superficial independence.</li> <li>-Child develops low self-concept.</li> <li>-Child hungry for attention and aims to please others.</li> </ul>	<ul style="list-style-type: none"> <li>-Child has insufficient freedom and inappropriate opportunities to experiment.</li> <li>-Child may have undeveloped social responsibility.</li> <li>-Low self-concept and conforms easily to norms and customs.</li> </ul>	<ul style="list-style-type: none"> <li>-Child feels unloved and uncared for.</li> <li>-Child feels insecure and uncertain.</li> <li>-Child has little respect for others.</li> <li>-Child may look for security and love through other means.</li> </ul>	<ul style="list-style-type: none"> <li>-Child displays pro-social behaviour.</li> <li>-Child can establish and maintain social relationships.</li> <li>-Child develops a positive self-concept and is adequately socialized.</li> </ul>	<ul style="list-style-type: none"> <li>-Child may become hostile, aggressive, rebellious and socially unstable.</li> <li>-Child may develop an immature dependence on others that may predispose her to risky sexual situations.</li> </ul>	<ul style="list-style-type: none"> <li>-Child’s development of independence may be impeded.</li> <li>-Inadequate self-actualisation of child.</li> <li>-Child displays little self-confidence and low self-concept.</li> <li>-Child may be socially less assertive.</li> </ul>	<ul style="list-style-type: none"> <li>-Child’s basic needs for love and care are not fulfilled.</li> <li>-Child inclined to aggression, disobedience and antisocial behaviour.</li> <li>-Leads to feelings of inferiority and negative self-concept.</li> <li>-Looks for substitute love and acceptance.</li> </ul>

#### **4. THE VULNERABILITY OF THE MODERN NUCLEAR FAMILY**

With regard to the above-mentioned styles of child rearing which have been discussed, it appears that the girl may be vulnerable to HIV infection because of the specific child-rearing style of her parents. In view of the fact that child rearing usually takes place within a family, it may be necessary to further investigate the type of family in which the girl is raised. The traditional structure and function of the family has changed considerably, this changed family structure within modern society may contribute to the vulnerability of the young girl to HIV infection. The following discussion focuses on the meaning of “family” and the changes that have occurred within the family, which may contribute to the vulnerability of the young girl to HIV infection.

##### **4.1 The concept “family”**

Pistorius (1983:51) states that it is within the family that the child starts his journey to adulthood and to himself. Pretorius (1998:41) endorses this view by stating that the word “family” means “party of travellers”. The typical family consists of a father, mother and a child or children, and they realize intimate interaction and group activities known as family life. This view is supported by the Reader’s Digest Universal Dictionary (1988:553) that describes “family” as “the most instinctive, fundamental social or mating group in man or animal” and “the union of a man and a woman, especially through marriage, and their offspring; parents and children”.

The family is seen as the primary (first) life-situation of the child and the family offers many years of natural care. The family is not only the first educational situation that the child experiences, but also the most powerful. During the child’s first three years, which are regarded as the crucial years in the personality development of the child, the child is virtually exclusively in contact with his or her family members and unconsciously follows the example set by the parents. This unconscious acceptance of values leads to the forming of life-long habits and attitudes during the earliest childhood that become more evident with time (Pistorius 1983:52).

Of all the life-situations, the family situation has the innermost and most enduring influence on the child (Pistorius 1983:53). The family introduces the child to his or her human environment in particular, as the child learns within the family what is

socially acceptable and unacceptable in terms of behaviour, attitudes, and views concerning his fellow man (Pretorius 1998:41). In this regard, the way in which parents live together is of the utmost importance, as parents consciously or unconsciously convey their social attitudes, views, preferences and censures to the child. The behaviour patterns, attitudes, and views that the girl may acquire in her family may be of such a nature that they predispose her to follow a life-style that makes her vulnerable to HIV infection.

Pistorius (1983:53) confirms this assumption by stating that within a healthy family situation, the child develops a sense of direction that will prevent him or her from future muddle, but in an unhealthy and deficient family situation, the child may be irrecoverably harmed.

#### **4.2 Types of families in contemporary society**

In the literature, a number of definitions are given of the phenomenon “family”. Le Roux (1992:6) describes the family in more detail and indicates specific characteristics of the family, for example that the family is the smallest, most basic social unit in society and the family members are related by blood relationship, marriage or adoption. Le Roux (1992:6) further elicits that the composition of the family can vary from a childless couple or single parent family to a couple with their own children and/or adopted children.

An interesting judicial perspective on the family in Western countries recognizes the family as a social institution based on an organised and legitimate unit of a father, mother and child (Pretorius 1998:41). According to Verster, Theron & Van Zyl (1989:51), the judicial perspective on the family recognises the family as “... an important building block of the organised society. International conventions, such as the United Nation’s Convention on Children’s Rights and the South African Constitution, recognize the child’s right to security, family care and parental care within the family.”

An extensive definition of the family according to Hartell (2000:32) describes the family as the smallest social unit in society that is united by blood relationship, marriage or adoption (legislative or non-legislative in the case of adoption, for example when needy children are placed in temporary or permanent care). The

composition of a family can vary from an extended family, a childless couple, single parent family or a couple with several own, adopted children, to alone-children (for example when parents have passed away because of illness, violence or an accident). The family usually resides under the same roof.

It is easy to refer to “the family”, but from the above definitions, it becomes clear that no two families are the same and different types of families may be found in our contemporary society. J. A. Ponsioen (cf. Pretorius 1986:50) distinguishes between the following six family types:

#### **4.2.1 The patriarchal family**

This type of family can still be found in rural areas where the husband and father is the absolute lord and master. The family is a productive unit, and remains entirely locked in itself.

Pistorius (1983:54) states that the one-sided and often autocratic behaviour of the father can for example hamper the emancipation of other family members. This is confirmed by Pretorius (1998:50), who states that, because of the emphasis on authority, the patriarchal family can offer stability, control and security, but the over-protection of the child against the outside world can obstruct the child’s adequate socialization and gradual social integration. In this regard, Nieuwoudt (1985:17) identifies the hyper-authoritarian parent as one of the possible causes of child abuse, where the parent forces a child to do and act exactly as the parent expects him to act.

This is supported by Pretorius (1998:51), who also mentions the strong possibility of autocratic, inflexible and one-sided communication within the patriarchal family.

#### **4.2.2 The open family within a closed circle, town or neighbourhood**

This type of family is found in a closed town environment and in the slums of cities, where members of the community monitor one another in terms of proper behaviour. The town or neighbourhood therefore still partially fulfils the function of the extended family. Pistorius (1983:56) states that this family still provides cherished safety and security to the child because of the protective openness.

Pretorius (1998:51) states that the child in this family may experience inadequate social orientation, as the family in the closed circle often resents the wider society and does not offer the child enough opportunities for social exploration, emancipation, experience and choice of position, nor for the acquisition of social norms. Without adequate experience with regard to the wider society and sufficient knowledge of social norms, the child may be exposed to harmful social behaviour such as teenage alcohol abuse, drug abuse and risky sexual behaviour. These harmful social behaviour patterns amongst the youth are proven factors contributing to the spread of HIV (Van Rooyen & Louw 1993:115).

#### **4.2.3 The closed family**

This family is found among all classes and the emphasis is on own entertainment and getting away from the noise of everyday life. The family is the heart of religion and traditional morality. Pistorius (1983:55) states that the closed family tries to isolate itself from the rest of society in an attempt to avoid the influence that society can have on the value orientation of the family, and authority within this type of family weighs more than freedom.

Over-accentuation of the family's isolation from society prevents the child from encountering a wide range of people outside the family in whose example other possibilities might be discovered; the child's socialisation may be hampered (Pistorius 1983:55). In the same regard as the open family in a closed circle, town or neighbourhood (refer to paragraph 4.2.2), the closed family does not offer enough opportunities for social exploration, emancipation, experience and choice of position, nor for the acquisition of social norms. As an alternative and to escape from this closed family, the child may choose the barred society and reject his or her identification with his or her parents (Pistorius 1983:56). The child may then identify with and engage in harmful practices such as drug abuse and promiscuous behaviour that can place him or her in a vulnerable position to HIV infection.

#### **4.2.4 The pseudo-family**

This family is not what it appears to be. There is intense tension between husband and wife or between parents and children with conflict in respect of acceptable norms, and

only the pretence of a normal family is upheld. Pistorius (1983:57) mentions that the parents in this family try to maintain authority, but usually with no success. The parents feel that they have no control over the children and sometimes employ excessive means to try to reinstate their authority. Pretorius (1998:51) states that in family types such as the pseudo-family, where the essentials of identity acquisition such as fundamental trust, real educational communication and identification are lacking, there is a strong possibility that the youth will at some stage experience an identity crisis.

This identity crisis may be intensified by the fact that within the pseudo-family there exists a discrepancy between the norms of the parents and that of society (Pistorius 1983:57). The child in this family usually tries to maintain the peace with pseudo-obedience to the parents while he secretly tries to participate in societal activities. The child may then fall prey to negative peer group pressure and social influences such as child pornography and child prostitution that, because of their promiscuous nature, may place the child in a vulnerable position with regard to HIV infection.

#### **4.2.5 The hostel family**

In this family everyone goes his own way and co-existence is inadequate. There is no family life and family members live outside the home with no intimacy towards other family members. At home, usually a mother or daughter is working her fingers to the bone. Pretorius (1998:50) doubts whether positive interpersonal relationships and learning to co-exist can successfully be actualised within a hostel family.

With the absence of educational communication, a family life that is located outside the home and everyone that goes his own way, the family is severely affected by society's influences (Pretorius 1998:51). The negative sexual influence of pop music on the teenager, for example, may influence the teenager's views, values and conduct (Le Roux & Smit 1992:102-103). Lyrics like "Girl, I want your body. Girl, I need your body. Won't you come home with me?" by Michael Jackson (popular pop music artist), is an example of the conflicting norms and values with which the mass media confront young people.

According to Le Roux & Smit (1992:91), the decline of intimate family relationships spells isolation and estrangement for the teenager, which result in feelings of

loneliness. The teenager may deal with these feelings of loneliness or protest by conforming to the peer group; this may have a negative influence on the child. The child is searching for intimate relationships and may be sexually exploited, commit to drug or alcohol abuse or other harmful practices that can lead to HIV infection.

#### **4.2.6 The open family in an open society**

This family integrates new social facts and demands, but still lives a full, optimal family life. There is openness towards society and the family is part of various institutions. The husband and wife are equals with shared chores. Pretorius (1998:51) states that openness, optimal family life, acknowledgement, understanding and encountering others, and co-existence and joint action in the open family create the possibility for real, intimate educational communication, which may influence education favourably. Pistorius (1983:57) adds that the success of this family is evident when the child is adequately equipped to enter the bewildering society with its contradictory possibilities.

Figure 6: Schematic presentation of family types

FAMILY TYPE	Patriarchal	Open family in closed circle, town or neighbourhood	Closed family	Pseudo-family	Hostel Family	Open family in an open society	Dissocialising family
<b>CHARACTERISTICS</b>	-Still found in rural areas. -Father is absolute lord and master.	-Found in closed town environment, and slums of cities. -Closed community monitors behaviour and resents larger society.	-Found in all classes of society. -Family isolates itself from society, avoids influences from society. -Values authority more than freedom.	-Found in all classes of society. -Family not what it appears to be. -Relationships are tension-loaded and pretence of normal family is displayed.	-Found in all classes of society. -Co-existence is inadequate while everyone goes his own way. -No intimacy in family relationships.	-Integrates new social demands and facts but still has a full optimal family life. -Part of various institutions within society.	-Ideal breeding ground for misbehaviour. -Family types: <ul style="list-style-type: none"> <li>• Neglected</li> <li>• Meek</li> <li>• Inflexible</li> <li>• Modern, big city</li> <li>• Disharmonious</li> <li>• Child-headed</li> </ul>
<b>CHILD REARING</b>	-Autocratic, one-sided communication. -Offers stability, security to child.	-Inadequate social orientation and guidance.	-Inadequate social orientation and guidance.	-Parents have no control and employ excessive means to reinstate authority. -Communication is tense and negative.	-Inadequate educational communication. -Permissive attitude towards discipline.	-Realizes intimate educational communication. - -Parental guidance towards social integration.	-Chaotic relationships. -Hardly any discipline. -Inadequate internalization of norms. -Communication is tense and negative.
<b>EFFECT ON CHILD</b>	-Overprotection can obstruct adequate socialising and social integration.	-Insufficient knowledge of social norms, social exploration, emancipation.	-Insufficient knowledge of social norms, social exploration, emancipation.	-Child experiences an identity crisis because of inadequate guidance in social orientation.	-Society has great influence on child. -Identity crisis because of inadequate guidance toward social orientation.	-Adequately equipped to enter society. -Optimal mobility in society and ability to deal with changes in society.	-Inadequate social integration. -Inadequate interpersonal relationships. -Societal factors affect education negatively.



#### **4.2.7 The dissocialising family**

Pretorius (1998:49) presents an interesting typology of the “dissocialising family”. This family is the ideal breeding ground for misbehaviour, and the following types are identified:

##### **4.2.7.1 The neglected family**

Within this family, there is insufficient care with respect to living conditions, personal hygiene, clothing and the preparation of meals. There is evidence of a serious lack in order and organisation that results in a chaotic family life and especially in disordered relationships between the family members, with frequent temper outbursts. Pretorius (1998:51) points out that communication within this family is severely neglected in the sense that it is negative, obstructive, disagreeing and lacks mutual understanding.

The child within this family may feel severely neglected by his or her family, because of the lack of intimate communication and relationships and this may predispose the child to look for “easy” relationships in society that can offer comfort and communication. These “easy” relationships may, however, lead to sexual exploitation of the girl that increases her vulnerability to HIV/AIDS infection (Oprah Winfrey, 5 December 2003).

##### **4.2.7.2 The meek family**

The household of this family may be orderly but personal hygiene and habit forming may be dubious. The children are protected against the outside world, causing inadequate social integration. The critical phases in the child’s life are the transition to school with the duties and demands of independence, and learning to let go of the family during puberty and adolescence.

The child in this family may be vulnerable to negative societal influences such as drug abuse, promiscuous behaviour and sexual exploitation, as the overprotection of the child against the outside world negates the child’s opportunities for social exploration, emancipation, experience and acquisition of social norms. The girl that is socially inexperienced with inadequate knowledge of social norms and proper social

behaviour, may be vulnerable to sexual exploitation by opportunistic exploiters, such as promises for modelling contracts, or “pimps” that often mislead her into child prostitution, and consequently expose her to HIV/AIDS infection (Oprah Winfrey, 5 December 2003).

#### **4.2.7.3 The inflexible family**

To the outside world, this family may appear to be virtuous and is indeed very orderly. Everyone knows his duty and fixed principles to regulate behaviour are followed. There is the danger of scheme education, with no opportunity for individual development, because the family has a patriarchal and old-fashioned character. Pretorius (1998:51) states that the child in this family can develop inadequate socially communicative mobility. In view of this fact, the child may not be equipped with adequate social skills to conduct him- or herself in an assertive manner and therefore the girl in this family may not have social skills to negotiate safe sexual behaviour in a relationship with a dominant partner who sets inflexible sexual demands. The girl in this family may be vulnerable to HIV infection.

#### **4.2.7.4 The modern, big-city family**

This family is the unavoidable victim of the changes in modern social circumstances. The family hands over its functions to the community without disapproval. Work and labour have no positive meaning and everyone seeks his or her own recreation. The family has no character – the so-called open family in the negative sense. No attempts are made to consciously direct education through the addition of norms. The modern, big-city family bears a resemblance to the hostel family as described in paragraph 4.2.5 above.

Children in this family are especially open to society’s influences, such as drug abuse and promiscuous behaviour that may lead to risky sexual behaviour and place the girl in a vulnerable position with regard to HIV infection (Oprah Winfrey, 5 December 2003).

#### **4.2.7.5 The disharmonious family**

Family relationships within the disharmonious family are characterised by open or hidden conflict, and personal discord is the order of the day. The family members are restlessly seeking balance, and are in constant conflict with themselves; this may lead to unforeseen temper outbursts (Pretorius 1998:50). These temper outbursts, strife, conflict and unrest may lead to inadequate educational communication, where the transfer of values and norms is inadequate and unacceptable. The child within this family may lack adequate social orientation because of the ill acquisition of social norms and may intuitively accept sexual abuse (such as incest) or other harmful social practices (such as female genital mutilation) as normal social behaviour and in turn be more vulnerable to HIV/AIDS infection.

#### **4.2.7.6 The child-headed family**

The child-headed family is a contemporary phenomenon within society and the emergence of this family type is *inter alia* ascribed to the effect that HIV/AIDS has on the nuclear family (Edwards 2002:75). In the child-headed family, children are forced to act as parents and to care for their parents and/or siblings. This is referred to as the “parentification process” and is associated with social isolation. The young child in the family assumes the role of his or her parents with regard to household responsibilities and caring for the ill and/or other members remaining in the family. The challenging responsibilities that the child bears deprives him/her of the care and support that he or she would normally receive in a family (Edwards 2002: 76).

It is usually accepted that the girl in a child-headed family will take responsibility for caring within this family type and many of these burdened girls are removed from schooling at an early age and may resort to prostitution in order to provide for the family’s material needs. This inevitably increases the girl’s vulnerability to HIV/AIDS infection, as it is coupled with the myth that sexual intercourse with a virgin can cure HIV/AIDS, and that young people are “safe” to have sex with (in this regard refer to Chapter 1, paragraph 2.2.4 and Chapter 3, paragraph 3.3.2 of this study).

### **4.3 The modern nuclear family**

It appears from the literature that the nuclear family (a social unit in society consisting of a married couple and their children) has become extremely vulnerable, so much so that the family fails to satisfy the needs of family members (Hartell 2000:44). Factors such as disharmonious marital relationships, marital restrictions on the woman because of her occupational role, inadequate attention for the child and an increase in extra-marital relationships cast doubt on the existing family structure (Le Roux & Smit 1992:104). In order to gain a better understanding of the functional erosion and vulnerability of the nuclear family, and how this may further impact on the vulnerability of the girl in the family to HIV/AIDS infection, it may be necessary to investigate the origin of the nuclear family.

To be able to place the nuclear family in perspective, a short historical overview will be given with regard to the radical changes that occurred within family life and society. Firstly, the extended family life will be discussed, followed by a brief description of the structural changes that took place within the family.

#### **4.3.1 The extended family**

The extended family consisted of several smaller families that were the main form of societal living and the basic economic unit in which the functions of the family were executed. The household comprised of different generations living together to form a primary community with prescriptive relationship patterns, rights, duties and responsibilities. The nuclear families (man, wife and their own children) formed part of the extended family and were influenced by the decisions of the larger group in which the patriarch was the fundamental authority. This contributed to the security of the nuclear family and the individual (Pretorius 1988:59, Hartell 2000:42).

The extended family was the main unit of labour and nearly all, if not all, the family members were involved with the family labour. The communal economy of the extended family provided family members with economical security. The members of the extended family supported one another during economical difficulties. Families experienced less tension regarding poverty and economic pressure than the modern nuclear family (Pretorius 1988:55, Hartell 2000:42).

The extended family offered emotional security to the individual (Pretorius 1988:59). The individual was protected from loneliness because of his or her continuous contact with other family members. When a family member experienced a personal crisis, he or she could depend upon the emotional support and assistance of family members to help him or her to cope with the crisis. The extended family especially offered emotional support and security to the children in the family (Hartell 2000:42).

The matrimonial relationship and parent-child relationships of the smaller family were subjected to influence and control of the extended family, thus creating extensive social control. Several adults cared for the welfare and discipline of the children, causing the parents to be “under supervision” of the extended family, so that the parents did not lose track and become dysfunctional regarding their child-rearing function (Hartell 2000:43, Chinkanda 1994:173,174).

According to Steyn (1977:388-393), the extended family was characterised by economical, emotional, social, and role security, together with pedagogical security and a stable family life; the extended family experienced ideal circumstances for guiding the child towards responsible adulthood.

#### **4.3.2 Structural change of the extended family**

The Industrial Revolution brought industrial labour and urbanisation that changed the general structure of the pre-industrial family extensively (Hartell 2000:43).

The industrial revolution created a new labour dispensation that entailed that the individual no longer laboured within the extended family, but followed his own career on the grounds of his capabilities, achievements and specialisation. The family life of the nuclear family was disconnected from the extended family because the parent started to pursue his career within the wider society. The parents started to work outside the family and thus less time was spent on communal family activities, resulting in educational deprivation and neglect (Steyn & Breedts 1978:57-58, Pretorius 1988:52-53, Chinkanda 1994:180). The spread and abuse of child labour increased and children as young as five or six were sent to work in factories to supplement the income of the family (Verster, Theron and Van Zyl 1989:132).

Chinkanda (1994:180) indicates further that more functions of the family that were fulfilled within the extended family moved to structures outside the family. The consequence of this is that the needs of the family that were attended to within the extended family now had to be fulfilled outside the family. This process of detachment for the sake of work outside the family led to intensive changes in family relationships, family dynamics, family traditions and family functions (Pretorius 1998:50-60).

The parent (as the basic unit of labour) together with the nuclear family had to move to big industrial cities for the sake of job opportunities. This separated the nuclear family from the extended family, resulting in geographical isolation of families. The nuclear family became structurally separated and isolated from the wide relational system in which the nuclear family was bedded. The nuclear family started to function as a separate unit and consequently became vulnerable (Pretorius 1988:53, Hartell 2000:44).

The aspects of the nuclear family's vulnerability will be discussed based on perspectives of Steyn (1991:25), Pretorius (1998:58-60) and Hartell (2000:44-49).

### **4.3.3 Vulnerability of the nuclear family**

According to literature (Pretorius 1998:58-60), the modern nuclear family has become vulnerable with regard to various aspects and can therefore not cope with the demands of the contemporary society. The economical, social, pedagogic, role differentiation and communication vulnerability of the nuclear family and the possible contribution thereof to the girl's vulnerability with regard to HIV/AIDS infection will be discussed.

#### **4.3.3.1 Economical vulnerability**

The contemporary nuclear family is economically vulnerable, because during times of need the family is dependent on its own resources for economical support (Pretorius 1998:53). The greatest difficulty of the structurally isolated nuclear family, according to Steyn, Van Wyk & Le Roux (1989:115), is the fact that there may be a greater

possibility of economical insecurity. In this situation, the family is responsible for its own source of revenue; the nuclear family is dependent on one or two people for fulfilling the economical needs of the family. In times of unemployment, illness or death, there is no extended family to give support and the nuclear family might fall into economical distress. The low level of income (salaries) of especially black parents (Hartell 2000:45), unemployment, long illness, death and the fact that financial support is not easily obtained, makes the nuclear family even more vulnerable with regard to economical sustainability.

In this regard, the young girl may be vulnerable to HIV infection, as it may be expected that the girl within the family has to contribute to the financial welfare of the family. The girl may then resort to risky or harmful sexual behaviour such as prostitution or drug dealing in order to support her family. The girl may also be “sold” to older men in order for her parents and family to secure an income. According to UNAIDS (1999b:2), the main reason for girls entering the sex industry is to satisfy their parents’ urgent need for money, material goods and the survival of the family. Many parents may decide to sell their daughters and earn quick money to provide for the family’s immediate needs. With weaker family ties and often less family support, girls have become common targets for recruitment into sex work, through either force or deception (in this regard also refer to paragraph 4.2.6.7 of this chapter).

#### **4.3.3.2 Social vulnerability**

In the isolated nuclear families the social control, as mentioned in paragraph 4.3.1 above, was done by the extended family. This function of social control disappeared and this has caused the nuclear family to become unstable. Members of the nuclear family are now only dependent on one another for support when they experience relational difficulties, as the extended family is not available to render support. Some of the activities of the nuclear family are not “visible” to other members of the family, consequently family members cannot supervise one another’s behaviour and thus not exercise control over other family members (Hartell 2000:45). Relationships within the nuclear family are very private, because of the isolation from the extended family. This implies that relationships in the nuclear family, whether positive or negative, may for the most part remain a private family issue that does not concern friends or family members from outside the nuclear family.

According to Hartell (2000:46), the typical city family functions as an isolated entity that is influenceable and vulnerable as it may lack a support system of family members and a circle of close friends. Pretorius (1998:57) is of the opinion that the smaller, isolated family no longer has any social control, and the family has become unstable and extremely vulnerable. The family members only depend on each other, and when they experience relationship problems, they do not have relatives to turn to. The child may experience that he or she is an object within the family that is traded for sexual intercourse in order to satisfy the needs of the parents and family (Beeld 2003a:6). The girl may be more vulnerable to HIV/AIDS infection when she has little social support from other family members and if she is socially regarded as an object that can be used to satisfy her parents' or other family members' sexual needs.

#### **4.3.3.3 Emotional vulnerability**

According to Hartell (2000:46), the industrialised society causes emotional congestion in the family. The immense pressure on the family members brings about problems within the family that threaten the family's stability and cause emotional tension and stress. The relationships within the family are characterised by intense emotionality and the individual may experience the need to get away from the family and to unburden him-or herself. With regard to this emotional problem, Pretorius (1998:57) explains that the family in society remains the only place where there is room for the individual to unload his or her emotions. This may cause the tension of the outside world to be absorbed by the family and threaten the family's stability. This may lead to sexual violence against women and children with the consequent increased possibility for HIV/AIDS infection (in this regard refer to Chapter 3, paragraphs 3.1-3.3.3 of this study).

The members of the nuclear family, in the absence of the extended family, depend more intensely on one another for emotional gratification and affective support. Parents are inclined to overprotect their children and keep children dependent on the parents for too long (Pretorius 1989:60). Consequently, the child takes longer to develop and emancipate from his parental home, and when the child does not adequately detach himself, it may threaten personality development. In some families, where parents are absent for long periods because of employment, there may



be a lack of emotional support of the children. In these families, there are frail family relationships and inadequate parental control (Peacock 1994:139). Nortje (1993:29) indicates that the absence of the parents may have a negative influence on the maturation and social adaptation of the child, as the child needs both the parents to accomplish a balanced adulthood. The girl is then socially vulnerable, as inadequate social adaptation and the need for emotional support during adolescence may contribute to the girl's relentless search for emotional gratification within obscure social sub-cultures like prostitution, which in turn increases her vulnerability to HIV/AIDS infection (Oprah Winfrey, 5 December 2003).

#### **4.3.3.4 Pedagogical vulnerability**

Pretorius (1998:57) states that the educational milieu of the nuclear family is disturbed because of increased pressure from outside the family. Verster, Theron and Van Zyl (1989:133) mention that "Twentieth-century man has apparently been sacrificed to the times; the tempo, tensions and threats of this century have invaded the intimate world of the family, creating a disturbed family climate which forms an ideal breeding ground for the pedagogic neglect of the child".

The complexity of modern society and the increasing demands that are set to the parent bring about that parents experience problems with the rearing and education of their children. Factors such as career demands and marital problems keep parents away from their homes, because relationship problems are avoided by spending time elsewhere. The absence of the parent results in the child relying on peers and the media for role models and decreasing reliance on parental models (Hartell 2000:47).

The absent parent is dependent on resources outside the family to assist in the rearing of the children in the family. The educational role of the parent fades and influences from outside the family, that are not always positive, may create a pedagogically vulnerable situation, as the parent may not be able to control the influences from society (Nortje 1993:33). According to Chinkanda (1994:180), it is especially the children of parents who must travel long distances between their homes and places of employment and hardly ever see their children, that may be faced with negative social influences. The problematic family situation does not contribute to the child's image of a stable family situation for his own future. The social and emotional vulnerability

of the family, together with the nuclear family's instability, contributes to the pedagogic vulnerability of the family (Pretorius 1998:60, Hartell 2000:47). Within this milieu, sexuality education that should be the primary responsibility of parents may not be realized and the girl may become less assertive and disempowered with regard to her own sexuality, and consequently predisposed to risky sexual practices such as prostitution and the coupled possibility to become HIV/AIDS infected.

#### **4.3.3.5 Vulnerability regarding role differentiation**

The contemporary nuclear family also appears to be vulnerable with regard to role differentiation. According to Pretorius (1998:60), the socialisation of the boy may be hampered when the father is continuously absent because of occupational demands. The lack of the father as role model may also cause insecurity and feelings of uncertainty within the child. The increasing absence of the father's authority may also cause the development of the child's conscience, responsibility, morality and attainment of independence to be neglected (Pretorius 1998:60, Hartell 2000:48).

Women also appear to experience uncertainty with regard to the roles they have to fulfil. Crucial factors here are the emancipation of the mother, her entrance into the marketplace and the decrease in the number of children. The dual role that the mother must fulfil as career woman and homemaker may lead to fatigue, conflict and stress that hamper the marriage and healthy family life (Nortje 1993:34,36).

The fact that the mother experiences role uncertainty may have far-reaching implications for the girl in the family, especially when the mother is not an inspiring and attractive female role model. The result is that the mother as well as the girl may experience problems with regard to role differentiation (Nortje 1993:36). The girl may be predisposed to harmful practices such as teenage prostitution, and the consequent vulnerability to HIV/AIDS infection in her striving to find her role as a woman in a contemporary society that portrays women as sexual objects (Oprah Winfrey, 5 December 2003).

The woman's entrance into the marketplace has resulted in a change with regard to the role of the father (man), and this appears to cause tension. The father is expected to change his behaviour patterns and attitudes and to fulfil more household chores.

The father must become more of a “home companion”, while his wife is still the expected homemaker – the role of the father may be inferior to the role of the mother in the household and lead to unconvincing examples of masculinity which are portrayed to the children in the family (Nortje 1993:36).

The dual responsibility of the mother and the occupational demands and absence of the father cause tension between the spouses, less time for one another and for family members, and eventually educational neglect (Hartell 2000:48; Pretorius 1988:54). The changes with regard to fulfilment of parental roles and thus as role models consequently confuses the child and may add to the problematic adaptation of the child in society and in marriage (Pretorius 1998:60-61). Inadequate social skills may weaken the girl’s ability to identify with sexually responsible behaviour and predispose the girl to risky sexual behaviour such as teenage sexual experimentation, and even prostitution, with consequent vulnerability to HIV/AIDS infection (Oprah Winfrey, 5 December 2003).

#### **4.3.3.6 Communicative vulnerability**

Louw (1990:22) argues that there is a decline in family relations as a result of career orientated attitudes and the coupled personal and career interests of first world families. Le Roux & Smit (1992:84-86) mention that the time parents spend with their children is declining because both parents are working. In many families, not enough time is spent together and thus inadequate communication between family members is realized. According to Pretorius (1988:127), numerous children receive more communication from radio and television than from their parents. Le Roux & Smit (1992:102) are of the opinion that the family increasingly finds itself in a “television addiction syndrome” which is characterised by shallow discussions of television programmes. This may result in the child becoming lonely without the family noticing it. The child’s views, attitudes and conduct are exposed to the influence of the conflicting norms and values of the mass media (Le Roux & Smit 1992:103) which may have a negative influence on the child’s norms and perceptions with regard to sexuality.

According to Hartell (2000:49), poor communication between parent and child may lead to tension, frustration and anxiety that the child experiences. Confusion,

loneliness, feelings of insecurity, a negative view of life and negative attitudes may be the results of the impersonal and inadequate interaction between the child and parent. The girl may wander in the streets in search of intimate communication with someone who may be interested in providing her with security and personal attention. This may predispose the girl to sexual exploitation and violence, such as rape, or even prostitution (Oprah Winfrey, 5 December 2003), and consequently increase the girl's vulnerability to HIV/AIDS infection.

The young girl (as part of the contemporary family) may be vulnerable to HIV/AIDS infection because of the vulnerability of the nuclear family. The family may experience economical, emotional, social, role differentiation, and pedagogical and communicative vulnerability. According to Pretorius (1998:61), the vulnerability of the family may lead to the inadequate fulfilling of sociopedagogical essences, namely:

- ❑ Inadequate education and co-existence as a result of a vulnerable, unstable, unsupportive family
- ❑ Difficult socialisation, emancipation and distancing by the young person
- ❑ Inadequate educational communication due to social and emotional vulnerability, threatened family stability and the probability of too strong emotional ties (communication without distance)
- ❑ The influence of a changed societal structure, which hampers education
- ❑ Difficult social orientation, for example drastic social emancipation, role uncertainty, living in plurality (among many people), social lability (instability), contact inflation.

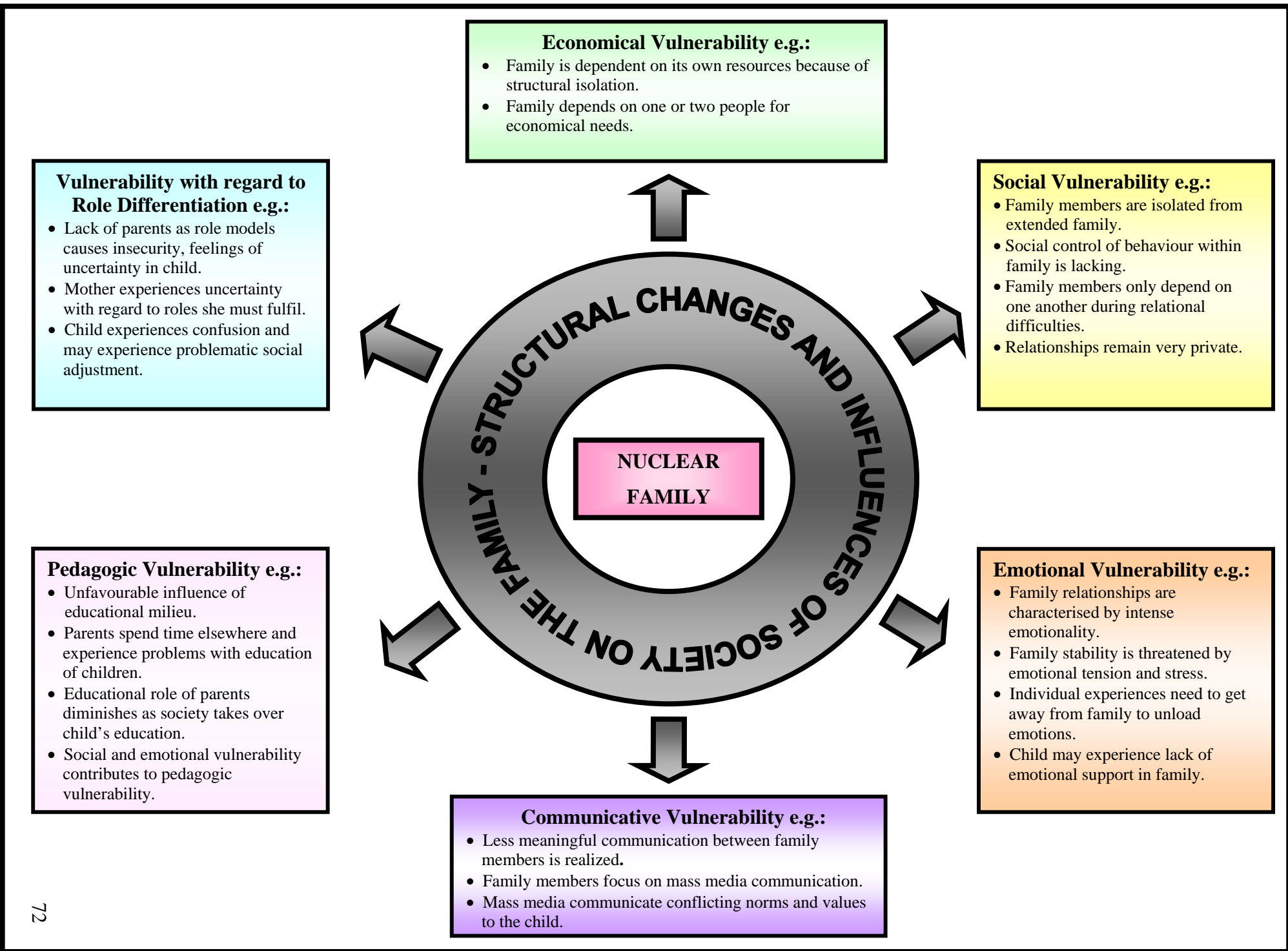


Figure 7: Schematic presentation of the vulnerability of the family

## **5. THE DETERIORATION OF THE NUCLEAR FAMILY**

### **5.1 The concept “deterioration”**

The Reader’s Digest Universal Dictionary (1988:425) describes “deteriorate” as “to decline or grow worse in quality, condition, or value”. This implies that something becomes worse in some way. Hartell (2000:51) also refers to “deterioration” as the negative change that occurs within the family, a detachment from traditions and a distancing from norms and values. “Deterioration” further refers to the decay or decline of norms and values in the family.

For the purposes of this study, “deterioration” will refer to the negative change that occurs within the family with regard to the decay or decline of norms and values in the family.

### **5.2 Manifestations of deterioration in the family**

Deterioration in the family implies that the family as the cradle for the child and the springboard for his future cannot adequately prepare the child for his future life (Hartell 2000:51). The deterioration of the family may manifest some of the following characteristics:

#### **5.2.1 Influence of a liberal philosophy of life**

According to Pretorius (1998:58), the youth and adults in the modern society are continuously confronted, conditioned and influenced by liberal influences. The communication media bring this liberal culture and philosophy of life into the home with the accompanying permissiveness and equalizing influence on young and old. Some parents may adopt a laissez faire attitude with regard to their children because it appears that some liberal parents believe in “freedom” and “natural” child rearing. The child may become more vulnerable with regard to negative societal influences, as some families do not provide a happy family life as frame of reference.

It appears that the liberal influence and permissive attitude of parents do not contribute to the child’s preparation for his future maturity and own future family life. Permissive upbringing can be attributed to parental inability to set boundaries for the

child. The parents' courage fails them and they allow the child to make his or her own choices. Children that are reared too permissively, experience problems with regard to their socialization. They tend to grow up as selfish and egocentric people, with little respect and consideration for other people. They tend to be demanding and impatient when things do not go their way and some are underachievers, because there have been limited demands on or expectations of them from a young age (Pretorius 1992:46). The child may regard sexuality with the same liberal attitude, feel free to experiment, and practise irresponsible sexual behaviour, such as early sexual debut or sex with more than one person, and consequently increase their vulnerability to HIV/AIDS infection. In South Africa, a recent youth survey revealed that nearly half of the boys and a third of the girls between the ages of 16 and 24 had had sexual intercourse, with 14,4% being sexually experienced before they went to high school (Pretoria News 2003: 11).

### **5.2.2 Incorrect disciplining**

According to Hartell (2000:52), a spirit of equality and camaraderie prevails between parent and child in the contemporary family. Parents and children have equal status and become friends. The parent, as bearer of authority and example of normative living by which the child is guided towards responsible adulthood, has taken an accommodative and lenient attitude with regard to the child.

The exclusiveness of traditional family values has made way for a liberal time-spirit with poor moral standards and an ill sense of responsibility (Hartell 2000:52). Parents are no longer figures of authority and do not know how to maintain authority, they find it difficult to control and discipline their children and to neutralise the liberal influence from outside the family. Makweya (1998:68) adds that in different cultures many families appear to experience an exchange of authority. It appears that authority is invested within the child while the parent is submissive to the child's authority. The parent as role model, embodiment of responsible adulthood and example of norms and values has disappeared for the child, with the result of derailment and the loss of security experienced by the child (Pretorius 1998:61).

Consequently the derailed and insecure child with no discipline and selfcontrol may fall victim to social sub-cultures such as drug abuse or prostitution that increase his or her vulnerability to HIV/AIDS infection (Oprah Winfrey, 5 December 2003).

### **5.2.3 The influence of friendships and hero-worshipping**

The child has a need for someone to identify with and whose exemplary normative lifestyle can serve as a guide for the child (Hartell 2000:53). This identification model serves an important role in the personality development of the young child. When the role model has a liberal and immoral attitude towards life, the child's personality development can be influenced negatively.

According to Hartell (2000:53), children often identify with pop singers, movie stars or sport heroes who are brought into the child's life through the media. The personal detail of the heroes' lifestyle is made known to the child so that the child can copy this down to the finest detail. If the media for example personify someone with a liberal and immoral life style into the life-world of the child and emphasize sexuality and aggressiveness, it may influence the child and prohibit the development of responsible and normative adulthood (Pretorius 1998:59).

The liberal role model that is portrayed by the media may influence the values of the young girl. The young girl as adolescent on her way to adulthood has an intense need for someone to guide her through difficult times of uncertainty (Van Rooyen & Louw 1993:46). The young girl may be more vulnerable to HIV infection if the role model that the media portray leads a liberal and promiscuous life.

### **5.2.4 Use of leisure time**

According to Pretorius (1998:60), it appears that contemporary youth prefer spending their leisure time passively rather than actively. Hartell (2000:53) views this as time wasting and harmful for the personality development of the youth. The career-orientated parents have little time to teach their children the value of effective and appropriate use of leisure time. Children accept the aimless spending of leisure time as normal and may develop into parents with a permissive attitude towards leisure time spending of their children (Pretorius 1998:62). A recent study of South African Youth Risk Behaviour confirms this passive nature of contemporary youth and indicates that 37,5% of school children are not actively involved in any physical activities and 17% are overweight. A quarter of the participants in the study indicate



that they watch television or play computer games for three or more hours a day (Pretoria News 2003: 11).

Pretorius (1988:184) states that the absence of guidance towards purposeful leisure time spending may lead to the youth declining into idleness, boredom and loneliness. Some youths may participate in undesirable activities such as drug abuse and sexual experimentation under the strong influence of peer group pressure. The young girl with inadequate guidance towards positive spending of leisure time may then be tempted to spend her leisure time under the influence of negative societal factors that may place her in situations such as sexual experimentation in which she becomes more vulnerable to HIV infection.

## **6. GENDER INEQUALITIES**

### **6.1 The concept “gender”**

Readers' Digest Universal Dictionary (1988:636) describes the concept “gender” as “classification of sex” and “the sex of a person”. “Gender” thus refers to the fact that a person or animal is male or female. According to Meintjies & Marks (1996:35), “gender” also refers to the identities, roles and relationships of women and men that are formed by culture and society. Although some differences between men and women are biological (women can bear children, men cannot; men are often physically stronger than women), most differences are determined by society. Van Rooyen & Ngwenya (1997:1) describe “gender” as the difference between being male or female, either congenital or as the result of acquired behaviour. According to UNAIDS (1998:2), “gender” means to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships in society.

For the purpose of this study, the concept “gender” will refer to being male or female. The focus will especially be on the female gender and the qualities of being female that render the young girl vulnerable with regard to HIV infection.

### **6.2 The concept “inequality”**

Readers' Digest Universal Dictionary (1988:787) describes “inequality” as “lack of equality, as of opportunity, distribution of wealth, or the like”. The Collins Cobuild

English Dictionary (1998:861) explains “inequality” as “the difference in social status, wealth, or opportunity between people or groups”.

For the purposes of this study, the concept “inequality” will be used with regard to the concept “gender”, and “gender inequality” will refer to uneven social status, wealth and opportunities of the female gender and how this inequality may render the young girl as an “unequal to male” more vulnerable with regard to HIV infection.

According to UNAIDS (2001a: 21), girls and women in the majority of countries face a particular risk of HIV infection because of the correlation between their economic disposition and social status that may increase their vulnerability to HIV/AIDS infection. These realities disempower girls and women, hampering their abilities to make healthy choices or negotiate safer sex practices. Economic and social indicators such as literacy, income, and education emphasize girls’ and women’s unequal status: UNAIDS (2001a:21) reports that:

- ❑ women and girls constitute two-thirds of the global 876 million illiterates
- ❑ on average, a woman will receive 30-40% less compensation than a man for the same work done
- ❑ globally there are 90 young women in secondary school for every 100 young men.

### **6.3 Gender differences**

According to Van Rooyen & Ngwenya (1997:1), gender differences are indisputable. It is not always possible to determine what differences are already present at birth and what are acquired through the rearing of the child as male or female, therefore the authors make cautious reference to differentiate between congenital (natural) and acquired differences. According to UNAIDS (1998:3), “...gender is socially defined. Our understanding of what it means to be a girl or a woman develops over a lifetime; we are not born knowing what is expected of our sex – we learn it in our families and communities. Thus, these meanings will vary by culture, by community, by family, and by relationship, with each generation and over time.”

### **6.3.1 Congenital or natural differences**

Of all the many physical differences between the male and female gender the most obvious and important biological differences are the male and female sex organs. The primary determinant for the distinct development of boys and girls is found in the body. Van Rooyen & Ngwenya (1997:2) mention that sex hormones influence the way the human body develops and functions. In the womb, the size and the shape of certain parts of the brain develop differently in male and female babies. Despite the fact that boys usually weigh more and are taller at birth, have a faster metabolism after puberty and apparently have greater vitality, speed and muscle power, it is found that the bodies of the two genders differ substantially regarding the secretion of hormones.

Hormonal differences between men and women are located in the hypothalamus, the part of the brain that regulates hormone flow. The hypothalamus keeps the hormones in males more or less in balance, but produces more extreme hormonal fluctuations in the course of a woman's 28-day menstrual cycle (Van Rooyen & Ngwenya 1997:2). The hormonal shifts cause the mood swings of women, which have been mistaken for mental instability and even madness in less enlightened times. Reid & Bailey (1992:4) state that the hormonal fluctuations of the menstrual cycle influence the production of vaginal and cervical secretions. Secretion is most prolific at mid-menstrual cycle and so, at other times in the cycle of young women whose mucous secretion is not fully developed, secretion and lubrication of the vaginal area may be inadequate for sexual intercourse to take place without the danger of damaging the mucous membrane of the vaginal wall. This could also be true of young women whose menstrual cycle is irregular.

### **6.3.2 Acquired behaviour and the role of education**

Particular behaviour characteristics can be taught and become customary, as parents tend to treat their sons and daughters differently (Van Rooyen & Ngwenya 1997:3). A girl is expected to be soft and shy and parents encourage behaviour like this, while boys are expected to be assertive or even aggressive. Such behaviour is brought about by, among others, the following:

- parental encouragement and parental role modelling

- ❑ rewards for acquisition of certain behaviour
- ❑ sex education patterns
- ❑ imitating the father or mother or other male/female figures
- ❑ expectations of others.

It is supposed that boys and girls are taught to be different in the parental home, by society, at school and even at initiation school (Van Rooyen & Ngwenya 1997:4). Parents play an important, determining role in this regard. It has been found that children of the same gender differ completely from each other with regard to their sexuality, if their parents treat them in different ways. According to Meintjies & Marks (1996:35), the roles of men and women are shaped in the family by fathers, husbands or tribal chiefs, who often control the family and children in the family. The authority men have in the family, with support from state, religion and society, may create the basis for patriarchy. Connell (1995:82) argues that all men share in the “patriarchal dividend” through which men gain honour, prestige, the right to command, and material advantage over women.

During childhood and adolescence, girls are often kept close to their mothers while boys are permitted to spend more time outside the home. This gives the boys more freedom but also greater exposure to other boys and men who may encourage them to see women as sex objects that may be dominated by men (UNAIDS 2000:5). It may be in this context that boys also learn behaviours such as substance use and rejection of condoms. Boys are encouraged to imitate older boys and men, and discouraged from imitating girls and women. Boys, who view fathers and other young men being violent towards women, or treating women as sex objects, may end up believing this is normal and acceptable behaviour for men. Research suggests that when fathers and other male family members display a positive role, boys develop a more flexible vision of manhood and are more respectful in their relationships with girls.

### **6.3.3 Traditional gender roles**

Gender differences and the inequalities associated with them can be explained in a variety of ways.

### 6.3.3.1 Culture and gender

According to Rivers & Aggleton (1999:3), it is widely accepted that gender roles are not “natural” but are culturally produced. Chinkanda (1992:229) states that women fall victim to men’s abuse because of women’s traditional role and status in society that perceives women as the weaker sex and in some cases relegate women to the same status as children.

Van Rooyen & Ngwenya (1997:4) state that under favourable pedagogic conditions, both boys and girls become conscious of their sex at a very early age and will have reasonable knowledge of what their gender involves. This phenomenon is primarily due to cultural demands (Van Rooyen & Ngwenya 1997:4).

The simplest way to understand culture is to think of it as “way of life” (Meintjies & Marks 1996:32). Culture gives meaning to life and is made up of beliefs, morals, traditions and social and historical inheritance. Culture is determined by history, religion, organisations and the family of which a boy or girl is part. Culture thus shapes how one thinks about the world and about oneself, and involves the way a person develops and organizes aspects of his social life. Culture also determines who has power and status in a society. Meintjies & Marks (1996:33) give a good example of this culture, namely the first question after a birth: “Is it a boy or a girl?” The sex of a boy or a girl determines how they are reared in a certain culture. In some African countries, boys are more valued by the community than girls are. Boys are seen as potential leaders and protectors of their families and communities – an attitude which dates back to the time when men were hunters and warriors, while girls are valued as potential mothers.

Meintjies & Marks (1996:36) also argue that in our society, masculinity, or what it means to be a man, is sometimes associated with having access to women. The need to emphasize male control can lead to women being forced to have sexual intercourse (rape). Culture has been used to justify this behaviour. Some men argue that African culture gives men the right to abduct women and that women should submit to this. The fact that sexual intercourse without the approval of both partners equals to rape, is sometimes conveniently disregarded. According to Meintjies & Marks (1996:36), the most vulnerable women are young girls and mentally disabled women and girls, who are subjected to sexual harassment and forced sex by male relatives, their teachers,

their boyfriends and fellow activists (in this regard refer to Chapter 3, paragraph 3.3). UNAIDS (2001b: 27) also mentions the customary practice in some cultures of young or virginal women who have to marry older, more sexually experienced men as a cultural factor that may increase young women's vulnerability with regard to HIV/AIDS infection.

Mothers often reinforce traditional ideas about manhood by showing that they do not expect sons to do household chores or express their emotions (UNAIDS 2000:5). Boys are encouraged to imitate older boys and men, and discouraged from imitating girls and women. Relatives, teachers and other adults may worry more about the sexual behaviour of girls, leaving boys to learn about sexuality on their own. Boys may be discouraged from talking about their bodies and issues such as puberty and masturbation. This can start lifelong difficulties for men with regard to talking about sex and learning the facts rather than believing the many myths that surround the subject, and therefore continue to substantiate girls' and women's sexual subordination and consequential vulnerability with regard to HIV/AIDS infection.

#### **6.3.3.2 Education and gender**

Because some African and Western cultures appreciate women only as potential mothers and wives, young girls are not often given equal access to education. Girls are brought up to believe that they will get married and that their husbands will expect of them to fulfil a wifely role, both sexually and in terms of domestic work (Meintjies & Marks 1996:34). Girls in some cultures have little opportunities to follow their own desires and develop their own identities, because society is usually intolerant and hostile towards girls and women who choose independence from marriage and family life. The institution of marriage (including polygamous marriage, in which a man has more than one wife) grants men control over women and children (Meintjies & Marks 1996:35).

Unmarried and independent women are sometimes viewed with suspicion and hostility and run the risk of being seen as "unnatural" and rejected as "unfeminine". Unmarried women are given less status in society than married women. Some girls may then leave school and rush into early marriages or sexual relationships in order to obtain "social status" and consequently be vulnerable to HIV/AIDS infection. UNAIDS (2001b: 23) states that the goal of producing children is "directly

incompatible with safer sex practices” and girls and women who aim at becoming pregnant may have no real options to protect themselves against HIV/AIDS infection.

In some societies, girls may find it difficult to gain information and correct knowledge with regard to reproductive health and HIV/AIDS prevention, due to societal expectations that they are not supposed to be sexually active (UNAIDS 2001a: 24). In some countries like Brazil, Mauritius and Thailand young women appear to be cautious to obtain information on sexual health for fear of appearing sexually active (Rivers & Aggleton 1999: 15). However, even where access to correct information is probable and available, young women do not often have the power to demand condom use by their partners.

### **6.3.3.3 Sexuality and gender**

Male and female sexuality are usually viewed differently (Meintjies & Marks 1996:35). Social myths suggest that men are sexually virile, vigorous and active, while women are passive and receptive with regard to sexual intercourse. Another belief in some African cultures is that women should be less sexually active than men are. Women and girls get the message that “nice girls” do not seek or initiate sex, and should not enjoy it too much. A study of boys’ and girls’ sexuality in Zimbabwe indicates that, while boys are expected to initiate sexual encounters, girls are not (UNAIDS 2001b: 23). Women are not expected to initiate sexual encounters and within any sexual encounter, women should only provide sexual pleasure to the man. When the social and cultural norms within a society sustain the man’s right to determine the type and timing of sex, girls and women may be disempowered to negotiate safer sex practices such as condom use, and consequently be vulnerable with regard to HIV/AIDS infection (UNAIDS 2001b: 24).

Pregnancy outside of marriage is condemned, as pregnancy obviously indicates sexual activity. At the same time, it is often believed that only fertile women deserve marriage, so some girls feel pressured to prove their womanhood by becoming pregnant at an early age and consequently sacrifice their reproductive health and increase their vulnerability to HIV/AIDS infection (UNAIDS 2001b: 23).

The cultural double standard (Meintjies & Marks 1996:36) means that women are sometimes abused and violated sexually and they are often denied pleasure and

enjoyment during “legitimate” sexual intercourse. Women are expected to behave reservedly even in the most intimate situations. This makes many women feel repressed and unable to assert themselves in their sexual relationships and consequently women are often unable to ensure that safe sex practices like condom use take place, and therefore increase their vulnerability to HIV/AIDS infection. UNAIDS (2001b: 24) states that for men the gender stereotype is sexual aggression and this implies that a number of sexual partners must be pursued and the man should be “in control” of sexual interactions. Other stereotypical characteristics of men include dominance, physical strength, virility and risk-taking. The social pressure to illustrate a man’s skills with regard to these characteristics can sometimes motivate young men to embark and insist on risky sex practices such as gang rape, that may increase their own and the young girl’s vulnerability with regard to HIV/AIDS infection.

In order to avoid the problems that come from failing to conform to dominant gender stereotypes, women and girls may risk the dangers associated with conformity (Rivers & Aggleton 1999:4). Men may find that conforming to stereotypical versions of masculinity place them and their partners at heightened risk to HIV infection. In many cultures, women are expected to preserve their virginity until marriage, while young men are encouraged to gain sexual experience. Having had many sexual relationships may make a man popular and important in the eyes of his peers (Rivers & Aggleton 1999:4) while women, in most societies, are expected to be virgins until they marry (Meintjies & Marks 1996:35). Those women who do not preserve their virginity are seen as “whores” or “sluts”, while men are expected to prove their virility by “sowing their wild oats” – having plenty of casual sex.

According to Rivers & Aggleton (1999:5), in the majority of countries there are strong pressures on young unmarried women to retain their virginity. However, the social pressure to remain a virgin can contribute in a number of ways to the risks of sexually transmitted infections (STIs) and HIV in young women. In some social contexts, young women engage in risky sexual practices, such as anal sex, as a means of protecting their virginity, and consequently this increases their vulnerability with regard to HIV/AIDS infection (Beeld 2003b: 5).

Male sexuality is perceived by some men and women as unrestrained and unrestrainable, and in some parts of the world having a sexually transmitted infection



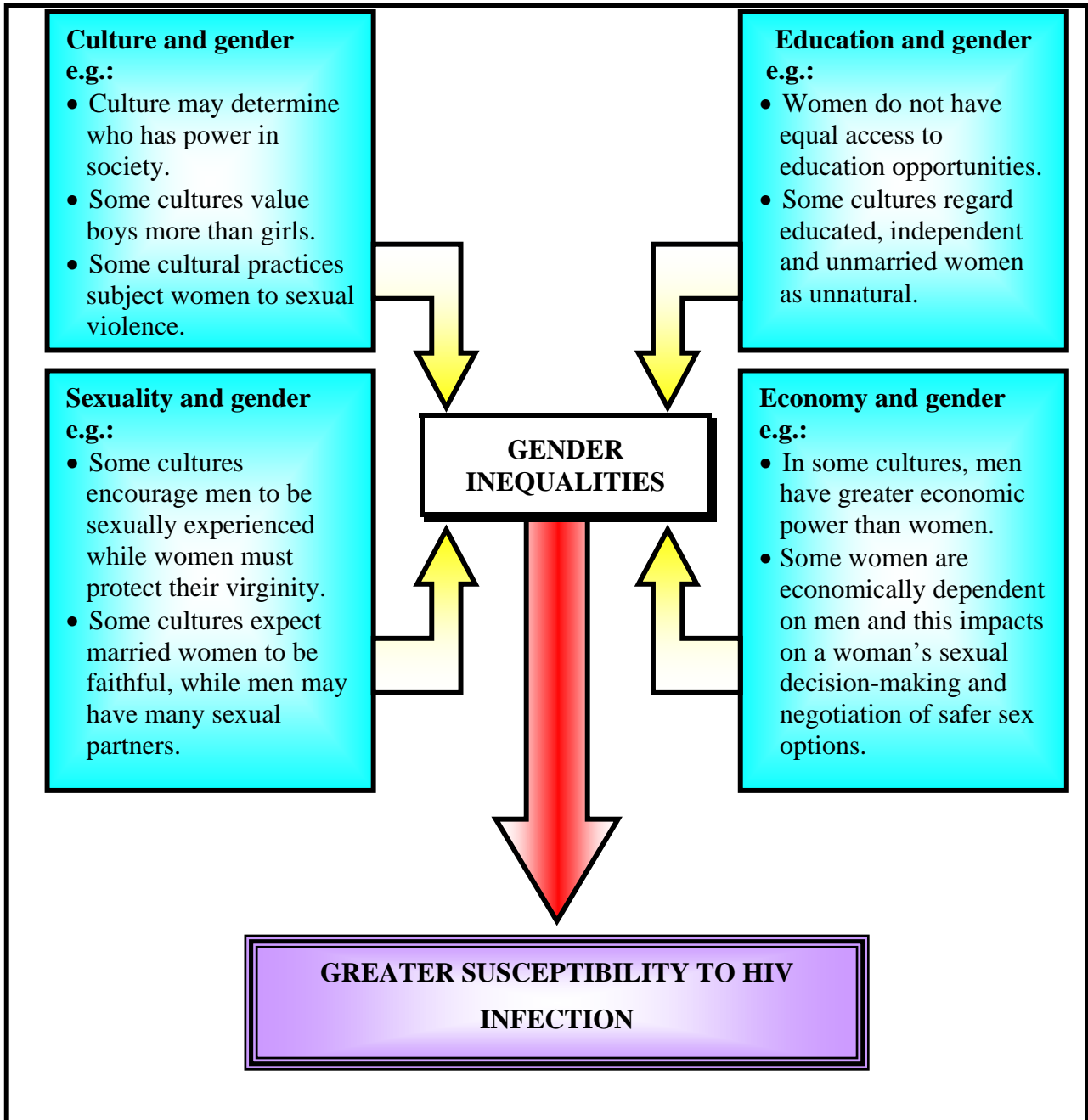
(STI) is considered an achievement that confirms masculinity (UNAIDS 2000:12). UNAIDS (2001b:6) confirms this argument by stating that in many cultures women are expected and sometimes forced to be sexually faithful to a husband or male partner while the male is permitted or even encouraged to also have sex with other women. This implies that men are more likely than women to have extramarital sex partners, or more than one sex partner; this increases their own and their partners' risk of contracting HIV/AIDS. The young girl may be extremely vulnerable to HIV/AIDS infection because her lack of knowledge and sexual inexperience are highly valued by older and sometimes HIV infected men, while the young boy's fear for stigmatisation if he cannot demonstrate having a wide sexual experience, also places the girl in high sexual demand.

#### **6.3.3.4 Economy and gender**

According to UNAIDS (2000:4), women are made more vulnerable to HIV infection by men's greater economic and social power, and by unequal gender relations. Women are economically dependent on men and this constrains women's ability to make decisions about safer sex. Men usually decide when and with whom to have sex and whether they will use condoms. This leaves women with little or no control over their exposure to HIV infection (in this regard also refer to paragraph 6.3.3.3 above).

Rivers & Aggleton (1999:4) also suggest that sexual decision-making is usually controlled by men. In many cultures, coercive or forced sex and sexual violence are common. Girls and women are often coerced into sex and some young women may obey their boyfriends' wishes because they believe that girls are "meant" to be compliant and subservient, especially when the sexual favours are paid for. Gordon & Crehan (1997:4) report that globally at least 10-15% of all women indicate that they are forced to have sex and that considerable proportions of the victims of sexual assault are less than 15 years old. Girls are often pressured by boys to have sex as a proof of love and obedience (Rivers & Aggleton 1999:5). This conflicting pressure may cause girls to have little influence over sexual decision-making or the use of contraception such as condoms, leaving girls sexually disempowered and vulnerable to HIV/AIDS infection.

**Figure 8: Schematic presentation of gender inequalities and susceptibility to HIV infection.**



The traditional gender roles that the young girl is exposed to in society appear to increase her vulnerability with regard to HIV/AIDS infection. The double standards and stereotypical gender inequalities that a girl experiences with regard to her sexuality and role as female in society may render her vulnerable to HIV/AIDS infection. The gender norms (Rivers & Aggleton 1999:6) dictate that girls and women remain inadequately informed about sex and reproduction, while young men are expected to be more knowledgeable as an indication of their sexual experience.

## 7. THE PHYSIOLOGICAL VULNERABILITY OF THE YOUNG GIRL

Apart from the social and gender vulnerability of women and girls to HIV infection, the mere reality of female physiology may render the girl more vulnerable to HIV infection. It is therefore necessary to look into the unique characteristics and functions of the female body that may contribute to the vulnerability of the girl to HIV infection.

The unique physiology and anatomy of the female body and certain genital conditions that women and girls experience, may render them more vulnerable to HIV infection than their male counterparts. According to UNAIDS (1999a:1), the HIV infection rates among teenage girls are often much higher than in teenage boys; the reason lies, *inter alia*, in girls' increased biological vulnerability. Compared with that of males, the female reproductive tract is more susceptible to infection with HIV and other STIs, particularly in younger girls because the cervix is not fully developed and the skin is more likely to rip or tear during sexual intercourse, thus increasing the risk of HIV/AIDS infection (UNAIDS 2001a: 3). Increasing the biological vulnerability of girls are complex and unhealthy societal expectations that disempower girls and young women to have less control over their lives and bodies than their male counterparts do.

Reid & Bailey (1992:1) also state that it is more likely for a women to be infected with HIV/AIDS than a man, possibly at all ages and most definitely when they are in their teens and early twenties and after menopause. There appears to be a biological, immunological and/or virological susceptibility in women, which changes with age and which may make them more vulnerable to HIV/AIDS infection.

### 7.1 Women's sexual anatomy

Despite the fact that gender roles and the interrelated social inequalities that are associated with being of the female gender may increase women's and especially young girls' vulnerability to HIV/AIDS infection, it appears that the female gender is physiologically also more vulnerable to HIV/AIDS infection than their male counterparts. In order to gain the best possible understanding of female physiology and the corresponding vulnerability to HIV infection that it entails, it is important to understand the anatomy of the female genitals and to be familiar with the functioning thereof.

### **7.1.1 Functions of the female reproductive system**

The human reproductive organs become active at puberty and during this developmental stage the body also begins to mature physically (Fine & Alter 1996:262). The pituitary gland in the brain sends messages to the sex glands to produce greater levels of sex hormones. The sex hormones allow the sex organs and sexual feelings to develop. In females, the main sex hormone is oestrogen, secreted by the ovaries (in males it is testosterone, secreted by the testes).

According to Van Rooyen & Louw (1993:51), the hormone oestrogen is responsible for the initial and continuous growth of the breasts until the breasts reach the size that is genetically determined. The size of a woman's breasts is not an indication of her ability to breast-feed a baby or her capacity for sexual enjoyment (Fine & Alter 1996:262). Van Rooyen & Louw (1993:51) mention that the Western media equate large breasts with sexuality and womanhood. This may lead to the woman with smaller breasts feeling less feminine and attractive.

According to Van Rooyen & Louw (1994:34), the function of the female reproductive system is threefold, namely:

- to produce the female sex hormones responsible for the development and maintenance of female sex organs and sexual characteristics
- to produce mature eggs in the ovaries
- to accommodate, protect and feed the fertilised egg during pregnancy and until the baby is born.

### **7.1.2 The external female genitals**

The external genital organs are called the vulva (Van Rooyen & Louw 1993:34). The word "vulva" is the Latin for "covering". The vulva consists of:

- the labia majora (or outer lips)
- the labia minora (or inner lips)
- the clitoris
- the hymen.

### **7.1.2.1 The labia majora**

The labia majora (or outer lips) is the Latin for “greater lips”. The labia majora are the two rounded folds of tissue that cover the openings of the vagina and urethra. The folds of tissue contain fatty tissue and blood. During sexual maturation, secondary hair growth develops that covers the labia majora to some extent. The inside of the labia majora has two glands that secrete a liquid around the opening of the vagina.

### **7.1.2.2 The labia minora**

The labia minora (Latin for “lesser lips”) are two smaller folds of hairless skin that cover the clitoris. The labia minora are located on the inside of the labia majora.

### **7.1.2.3 The clitoris**

The word “clitoris” is derived from the Greek “*kleitoris*” that means “little hill”. In Latin the word “clitoris” means, “that which is covered”. The clitoris is a small bud of tissue that is located about 25 mm above where the labia minora meet (Fine & Alter 1996:263). It is supplied by nerves, which make it one of the most sexually sensitive parts of the female body. The clitoris consists of a shaft and a rounded head that is covered with folds of skin. During sexual arousal, the clitoris swells and becomes erect in the same way that a man’s penis does.

### **7.1.2.4 The hymen**

According to The Reader’s Digest Universal Dictionary (1988:757) the word “hymen” is derived from Greek “*humēn*” that means “membrane”. It is interesting that in Greek Mythology, Hymen is the “god of marriage”. The hymen is a thin membrane that partly or completely covers the opening of the vagina. The hymen usually tears during the first sexual intercourse (Van Rooyen & Louw 1993:35).

### **7.1.2.5 Tearing of the hymen**

According to Van Rooyen & Louw (1993:35), the hymen tears during the first sexual intercourse. The hymen sometimes stretches or tears with certain sport activities. Once the hymen has torn, it never closes again and in extraordinary cases, the girl is

born without a hymen. Usually the hymen tears easily, but in some cases the hymen must be torn by a surgical procedure. Sometimes the hymen is a solid membrane with no opening (“hymen intacta”). This rare condition among young girls causes blood to accumulate behind the membrane after the first menstruation. The condition is treated by cutting the membrane.

#### **7.1.2.6 Virginit**

Van Rooyen & Louw (1993:35) state that in some cultures virginity is a symbolic concept that refers to a girl or woman that has not engaged in sexual intercourse. When the hymen tears during sexual intercourse, the girl or woman is no longer regarded as a virgin. As virginity is not seated in the hymen itself, but refers to a woman that has not engaged in pre-marital sexual intercourse, the girl or woman that has lost her virginity due to injury, is still regarded as a virgin.

In the majority of countries, young unmarried women are pressured to retain their virginity (Rivers & Aggleton 1999:5). However, the social pressure to remain a virgin can contribute in a number of ways to the risk of contracting a sexually transmitted infection (STI) and HIV. Some young women and men may engage in risky sexual practices, such as anal or oral sex, as a means of preserving their virginity.

Van Rooyen & Louw (1993:35) argue that some girls experience the loss of their virginity as a very emotional moment. The feelings that the girl experiences, are engraved deep into the heart of the young girl and this can consciously or subconsciously colour the girl’s future sexual experiences. The responsibility of the boy with regard to the young girl must be emphasized.

### **7.1.3 The internal female genital organs**

#### **7.1.3.1 The vagina**

According to The Reader’s Digest Universal Dictionary (1988:1655), the word vagina is derived from the Latin “*vāgīna*” that means “sheath”. The vagina (Fine & Alter 1996:263) is a tubular canal, more or less 10 cm in length, which runs from the outside opening to the cervix (the mouth of the womb) and as a muscular organ, the

vagina stretches to accommodate the male's penis or the baby. The vaginal walls consist of tissue that is usually collapsed together. The muscular tissue within the walls of the vagina is full-blooded with multiple small glands that continuously secrete a layer of white or clear cleansing fluid or mucus, causing the vagina to be self-cleansing. Some women, according to Fine & Alter (1996:264), seldom produce any fluid, while others produce quite a large amount and women often notice extra vaginal mucus around the time they ovulate.

A women's vagina is a unique and delicate organ, and fluids released from glands of the vagina, the womb and cervix, constantly clean the vagina (Moore & Zimbizi 1996:424). A normal discharge is not discoloured, does not smell or cause itching.

Reid & Bailey (1992:3) mention that mucus in the female genital tract has four relevant roles: The mucus

- acts as a physical barrier, separating semen and other material from the vaginal and cervical walls
- lubricates and protects the surface of the vagina from abrasion during intercourse
- flushes the cervix and vagina in the same way that mucus flushes the respiratory tract, removing foreign material
- has an immune function, that is, mucous contains cells of a separate immune system, that function to activate the immune responses of the cells in the vaginal and cervical surfaces.

The proper functioning and presence of an intact mucous membrane may then make the young girl less vulnerable to HIV infection. If mucous production in young women is less proficient it will have a less protective role. There will be less of a barrier to viral penetration and it will provide less assistance in minimizing irritation and tearing of the genital membranes and so facilitate viral entry. According to Reid & Bailey (1992:4), it is known that the hormonal fluctuations of the menstrual cycle influence the production of vaginal and cervical secretions. Secretions are most prolific at mid-menstrual cycle and so, at other times of the cycle of young women whose mucous secretion is not fully developed, may be inadequate. This could also be true of young women whose menstrual cycle is irregular.

The young girl is more vulnerable to infections during the menstrual cycle when mucous production is low and the girl consequently has less natural protection against infections.

### **7.1.3.2 The cervix**

The cervix is part of the womb or uterus (Fine & Alter 1996:264). The cervix is the end which protrudes into the vagina, and which by opening or dilating allows the baby out at birth. It has an opening, which feels, and looks like a dimple, and which usually becomes wider and more “slit-like” after women have had children.

It has been assumed that the cervix is the most likely site for initial HIV infection in women (Reid & Bailey 1992:3). Any erosion of the cervix or damage to it would increase the likelihood of virus entry. There is evidence that more young sexually active women contract human papilloma virus and herpes simplex infections and that human papilloma virus infection of the cervix is a major cause for cellular changes, which lead to cervical ectopy and cervical cancer. Reid & Bailey (1992:4) further report that since 1950 incidences of cervical cancer were higher in young women who began sexual activity or married before the age of 17.

### **7.1.3.3 The uterus or womb**

The womb or uterus is a muscular organ. It is pear shaped and about the size of a clenched fist. It is about 10 cm in length and above the vagina (Fine & Alter 1996:264). The lining of the womb (the endometrium) responds to hormones secreted by the ovaries. Every month it prepares for the possible implantation of a fertilised egg (ovum). When conception does not take place, hormone levels drop and the lining “peels” off. This shedding of the lining of the womb in the form of blood is known as menstruation. The outer muscular wall of the womb is able to enlarge a lot during pregnancy – up to six babies can be accommodated in the womb and the muscles also help with delivering the baby during birth.

### **7.1.3.4 The fallopian tubes**

The fallopian tubes extend from each side of the upper end of the womb (Fine & Alter 1996:264). The fallopian tubes are about 10 cm long, and end in finger-like



projections near the ovaries. The fallopian tubes pick up the egg or eggs that the ovary produces every month. The egg is then transported down through the tube towards the womb. While in the tube, the egg is fertilised if there is sperm present. The fertilised egg is then moved into the womb, where it lodges and begins to grow into the foetus. If the egg is not fertilised, it is simply passed out of the body during menstruation.

Van Rooyen & Louw (1993:39) mention two complications with regard to the fallopian tubes:

- Salpingitis is the inflammation of the fallopian tubes that damages the finger-like projections and causes blockage or abscess forming that may lead to infertility.
- The fertilised egg may not move into the womb and lodge itself to the epithelial tissue in the fallopian tube, causing an “ectopic pregnancy” with horrific consequences.

### **7.1.3.5 The ovaries**

According to Reader’s Digest Universal Dictionary (1988:1101), the word “ovary” is deduced from the Latin “*ōvum*” meaning “egg”. Fine & Alter (1996:264) state that the ovaries are situated near each of the fallopian tubes and are almond-shaped. The ovaries release eggs during the process called ovulation in the reproductive years of the female, and produce hormones. Van Rooyen & Louw (1993:36) mention that at the time of birth countless small round follicles, each containing an undeveloped egg, are present. Unlike with men, the total number of ova are present at birth and decreases thereafter. By the time of puberty, the number of ova decreases to around 300 to 400 that may mature and be released by the ovaries. Usually only one ovum is released by the ovaries during the menstrual cycle.

## **7.2 Genital conditions**

According to McNamara (1991:1), certain genital conditions facilitate the transmission of the HI virus in girls and women.

The epithelial mucosa (mucus membrane) is the female's normal protection against infection. If the epithelial mucosa is not intact, the susceptibility to sexually transmitted infections (STIs) and HIV infection is increased. McNamara (1991:2) states the following:

- The intact epithelial mucosa in the vagina alone may not be sufficient protection against HIV infection during sexual intercourse.
- The use of condoms is important even in the absence of a sexually transmitted infection or other genital condition.
- Improved genital health can decrease, but not eliminate, susceptibility to HIV infection.

McNamara (1991:2) is of the opinion that the preservation of the intact surface of the female genital tract may be a defence against heterosexual transmission of HIV. If the vaginal epithelial mucosa, which is the female's biological barrier against infection, is not intact when the male deposits infectious semen, susceptibility to HIV transmission may be significantly increased. STIs are one source of damage to the biological barrier of women and the association between STIs and HIV infection is well documented (Wasserheit 1990:1).

According to Reid & Bailey (1992:3), a young woman's genital tract is not mature at the time she begins to menstruate. The mucous membrane changes from being a thin single layer of cells to a thick multi-layer wall. This transition is often not completed until the late teens or early twenties. It is conceivable therefore that the intact but immature genital tract surface in a young woman is less efficient as a barrier to HIV infection than the mature tract of older women.

### **7.2.1 Sexually transmitted infections**

Moore & Zimbizi (1996:419) describe sexually transmitted infections (STIs) as "vuilsiekte", "drop" or venereal disease (VD). STIs occur when germs are spread from one person to another through sexual contact, causing infection of the genitals, reproductive tract and sometimes the whole body. Van Rooyen & Louw (1993:104) state the direct relationship between sexual promiscuity and the spread of STIs.

According to Van Rooyen & Louw (1993:108), HIV/AIDS is one of more than 50 different STIs.

The interrelationship between HIV/AIDS and STIs has been well documented internationally. If either the HIV infected or uninfected sexual partner has an STI, especially an STI that causes open sores or lesions on the penis or vagina, the risk of HIV transmission to the uninfected partner greatly increases, because:

- open, bleeding sores or lesions on the skin or mucous of the uninfected partner facilitate HIV to easily enter the body of the uninfected
- open, bleeding sores or lesions on the skin or mucous of the infected partner increase the amount of HIV that is “shed” during sexual intercourse
- partners with a STI usually have more of the immune cells that HIV attaches to near their penises or vaginas (UNAIDS 2001b: 3).

It is widely accepted that one of the reasons for AIDS spreading so rapidly in Africa is because of the high rate of STIs (Flood, Hoosain & Primo 1997:45). The presence of an untreated STI, in both men and women, momentarily enhances the risk of transmitting and contracting HIV through unprotected intercourse (Edwards 2002:60).

STIs are “communicable” diseases, which means that they are passed from one person to another and a person can only be infected by someone who is already infected with the disease (Moore & Zimbizi 1996:419). People who have STIs will continue to infect their partners until they get medical treatment that cures the STI. Moore & Zimbizi (1996:420) state that most STIs can be cured if they are treated early, while untreated STIs can lead to complications such as pelvic inflammatory disease (PID), which increases the chances of tubal pregnancies, infertility and cancer of the cervix. STIs also make both men and women more vulnerable to HIV infection and AIDS. In women, STIs may cause rashes, bumps, blisters or sores on different parts of the body, especially around the genital area, inside the vagina and on the cervix. Some STIs cause unusual, discoloured or strong-smelling vaginal discharges. Others may cause itching, burning when urinating, headaches, pain in the lower back and pelvic area, and general tiredness (Moore & Zimbizi 1996:422).

McNamara (1991:2) is of the opinion that the term “sexually transmitted infections” (STIs) extends the list of traditional venereal diseases such as gonorrhoea, syphilis, chlamydial infections and granuloma (nodes or masses that are chronically infected) to cover more than 20 organisms and syndromes, including chlamydia, genital herpes, and human papillomovirus infections (warts). The major primary manifestations of sexually transmitted infections throughout the world include urethritis (urinary tract infection) in men, cervicitis and vaginitis in women and genital ulcers, genital warts and enteric infections in both men and women. Women can experience abnormal vaginal discharge, a burning feeling with urination, abnormal vaginal bleeding and genital pain or itching, with infections of the lower reproductive tract.

According to McNamara (1991:2), genital ulcers caused by syphilis, chancroid and herpes facilitate penetration of HIV through disruption of epithelial mucosa or through the increased local concentration of lymphocytes that are target cells for HIV. The organisms that cause STIs need a warm, moist area to survive and multiply, which makes the genitals an ideal area. All the organs in the body that have a mucous membrane (mucosa) can be infected with a venereal disease for example the mouth, eyes, anus and genitals (Van Rooyen & Louw 1993:108). During a World Health Organization (WHO) expert committee meeting in 1989, it was concurred that it is biologically plausible for all STI pathogens that cause genital ulcers or inflammation to be a factor in increased infectiousness or susceptibility to HIV (WHO 1989:272-275).

#### **7.2.1.1 Vulnerability of women and girls to STIs**

Moore & Zimbizi (1996:420) and UNAIDS (2001b:12) give the following reasons for the vulnerability of women and girls to STI infection:

- Women have internal sexual organs that are not easily visible and examinable and women receive their partners inside their bodies during sexual intercourse. The woman is usually the receptive partner during sexual intercourse and she receives a part of her partner’s body (his penis, tongue or fingers) into some part of her body like the vagina, mouth or anus. This means that the man’s body fluids and semen are held within the women’s body, exposing her to greater chance of infection.

- STIs can be “silent” in women. There are no obvious symptoms and it is sometimes only discovered that a woman has had a STI when she develops complications such as pelvic inflammatory disease or finds out that she is infertile. Not all women have access to private health care, regular gynaecological examinations where STIs can be identified and antenatal clinics where tests for syphilis can be done. The result of this is that women are undercounted in sexually transmitted infection data in all countries (McNamara 1991:3) because services that they can or will use are not available.
  
- There is a stigma attached to STIs. Women are ashamed to ask for help because STIs are seen as shameful and dirty. It was widely believed that STIs only affected promiscuous people (promiscuity refers to “casual association with many sexual partners” and “lacking standards of selection; indiscriminate” [Reader’s Digest Universal Dictionary 1988:1232]), sex workers and men who have sex with men. It is known now that anyone who has sexual intercourse with an infected person can get an STI. This means an unfaithful husband can infect his wife who is faithful to her husband. Men, women and children who are raped can also be infected. Treatment of STIs in separate clinics worsens the problem, as going to such a clinic for help is making a public gesture. Women find it difficult to expose themselves in this way because of the sexual double standards of society, which imply that promiscuous behaviour is fine for men, but shocking in women.
  
- Women find it difficult to be assertive about refusing sex or insisting on safer sex because of the low social status of women in some cultures. When women ask their partners to make use of condoms, they may encounter anger and even violence, thus increasing the woman’s risk to infection. Women whose partners have sex outside of their relationships are particularly at risk. The woman’s inferior status, in some cultures, makes it difficult for her to ask her partner about his other sexual activities or to demand sexual faithfulness. This powerlessness in relationships means that women stand a greater chance to be infected with a STI.

According to Flood, Hoosain & Primo (1997:45), an estimated 50 –80 % of infected African women have had their husbands as their only sexual partners. South African women are particularly vulnerable to this situation, given the rate of male migration from rural areas to industrial centres. According to UNAIDS (2001b:2), some men like long-distance truck drivers must sometimes migrate or be mobile for work, they become lonely and enter into casual sexual relationships while they are away from their families. It appears that young people are also vulnerable. A significant number of women are pressured into their first sexual encounter, usually by a boyfriend or family member. Under these circumstances, it is almost impossible for young women to insist on safe sex (Edwards 2002:62).

## **7.2.2 Types of sexually transmitted infections in women**

### **7.2.2.1 Vaginitis**

Vaginitis (vaginal thrush or colpitis), according to Moore & Zimbizi (1996:423), is a condition in which the vagina feels tender or sore, or itches and burns. One symptom of vaginitis is an unpleasant or itchy vaginal discharge, that can be caused by a number of germs of which some are sexually transmitted. Vaginitis can either be spread during vaginal, oral or anal sex and some men can carry vaginitis without any symptoms, while other men can get infections in the penis, prostate gland or urethra (Edwards 2002:93).

A woman's vagina is a unique and delicate organ (Moore & Zimbizi 1996:424). Fluids released from glands in the vagina, the womb and cervix, constantly keep the vaginal area clean. A normal discharge is not discoloured, does not smell or cause itching. The environment inside the vagina is normally slightly acidic for protection against infection and when this acidic balance is disturbed, for example by washing out the vagina with antiseptic, an abnormal discharge occurs. When the acidic balance of the vagina is disturbed and the vagina is not able to clean itself, vaginitis infection may appear.

Trichomoniasis (or trich) is a vaginitis infection that is usually transmitted sexually, and causes vaginitis accompanied by a greenish discharge. Although it is usually spread by sexual contact, people can become infected from sharing wet or dirty

towels, washcloths, bathing costumes and underwear, especially in overcrowded conditions.

Candida (commonly called thrush) is a yeast or fungus that lives in the warm, damp and dark parts of a woman's body, such as the mouth, the rectum and the vagina (Moore & Zimbizi 1996:424). Thrush is usually caused when the delicate balance of the vagina is disturbed and the fungus begins to grow uncontrollably. This causes intense itching and burning, and can result in a very thick white or yellow curd-like discharge.

Bacterial vaginitis is also an infection that may be triggered by many different conditions. It is usually not sexually transmitted, but may cause pain during sexual intercourse and is accompanied by a foamy discharge that smells unpleasant.

According to Moore & Zimbizi (1996:425), vaginal infections can spread to other parts of the reproductive system and result in secondary infections such as pelvic inflammatory disease. They can also irritate the walls of the vagina, making it more vulnerable to the transmission of HIV.

#### **7.2.2.2 Gonorrhoea and chlamydia**

Gonorrhoea (sometimes called drop) and chlamydia are the two main STIs that infect the cervix with symptoms that usually go unnoticed. The following signs may present themselves as symptoms of these infections (Moore & Zimbizi 1996:426): Symptoms such as:

- ❑ an unusual thick yellow or white discharge from the vagina
- ❑ a burning sensation when urinating
- ❑ light bleeding when the woman does not menstruate
- ❑ pain before and during menstruation
- ❑ a sore throat that does not seem to be caused by a cold or flu and may be the result of germs attained during oral sex.

Both these infections can spread to the womb and ovaries, causing complications such as pelvic inflammatory disease resulting in possible sterility and death. They also create health problems during pregnancy and childbirth. A baby whose mother has

gonorrhoea can get eye infection during childbirth that may cause blindness (Van Rooyen & Louw 1993:108). The infection may irritate the walls of the vagina and cervix and increase the susceptibility to become infected by HIV.

### **7.2.2.3 Syphilis and chancroid**

According to Van Rooyen & Louw (1993:108), syphilis is caused by a microorganism that cannot survive outside the human body. The untreated infection spreads through the body and may cause severe health problems. The infection has several stages (Moore & Zimbizi 1996:428) and each stage results in more damage to the body and health.

Syphilis usually starts with a small, painless sore close to the area of sexual contact, for example the vulva or in the vagina (Moore & Zimbizi 1996:428). Van Rooyen & Louw (1993:108) agree that the microorganism penetrates the body through the skin or mucous membrane, usually where there is a microscopic injury caused by sexual intercourse or other intimate contact. The organs that usually are affected include the penis, vagina, anus or lips that were in contact with the sores or secretion of an infected person.

The second stage or secondary syphilis is characterised by a rash that might appear six weeks to six months after the initial infection (Moore & Zimbizi 1996:428). The rash is accompanied by flu-like symptoms such as fever, sore throat, swollen glands, headaches and aching joints. The symptoms come and go and might disappear (Van Rooyen & Louw 1993:108). The person might think that she is healed, but remain infected, and she can spread the infection to others.

The disease has entered a latent stage when it seems that the symptoms have disappeared. According to Van Rooyen & Louw (1993:108), warts develop in the moist areas of the scrotum, vagina or anus. These symptoms also disappear while the pathogens are multiplying in the body. This stage can last for many years before the final stage of infection develops.

In the final stage, syphilis causes serious damage to the body (Moore & Zimbizi 1996:428). The heart, brain, central nervous system, skin and eyes can all be affected, with results such as insanity and blindness, and eventually death may occur.



#### **7.2.2.4 Genital herpes**

Van Rooyen & Louw (1993:109) mention that herpes is an incurable virus infection that has increased, especially in America. The increase of 300 000 infections per year might be the result of the sexual revolution that encouraged young people to have as much sexual contact as possible because they could not be easily impregnated while using contraceptives.

Moore & Zimbizi (1996:429) describe herpes as very contagious. The herpes virus enters the body through the skin, mouth or genital area, causing herpes. Touching, kissing and sexual intercourse with an infected person spread the virus.

In women, genital herpes can be found on the inner thighs, vulva, vagina and cervix. The anus, rectum and buttocks can also be affected. The most common symptom of herpes is small, patchy skin rash, which turns into tiny blisters and becomes very painful (Moore & Zimbizi 1996:429). When the blisters burst open, they turn into open sores that heal very slowly and after healing the disease may return from time to time. The virus can also attack the mucous lining of the mouth. Van Rooyen & Louw (1993:109) warn that deep kissing with herpes infected persons can be dangerous.

Considering the evidence, it appears that the young girl may be rendered vulnerable to STI and HIV infection through her body because of the delicate anatomy of the female body. The mucous membrane that acts as a natural barrier may not provide enough protection against STI and HIV infection under certain circumstances (in this regard please refer to paragraph 7.2.3 to 7.2.3.3). The female's genital organs such as the vulva, vagina, cervix and womb that are lined with a protective mucous membrane, is a much larger surface area that may be susceptible to HIV infection compared to only the penile head of the male that is covered with a mucous membrane and equally susceptible to HIV infection.

#### **7.2.3 Genital trauma**

STIs are a major but not the only source of damage to the female genital tract. Other sources of infection or trauma that could damage the mucous (epithelial) barrier may include female genital mutilation, childbearing, insertion of objects into the vagina and trauma during sexual intercourse (McNamara 1991:3).

### 7.2.3.1 Female genital mutilation

According to McNamara (1991:3), a possible contributing factor to a high HIV infection rate amongst women and girls is female genital mutilation (FGM). Fine & Alter (1996:273) mention that FGM is also referred to as female “circumcision”. This term is actually misleading as it implies that no real damage is done, but it usually involves either partial or total removal of the clitoris (clitoridectomy). It is reported that female circumcision is performed on 6000 African women per day (SABC September 2002, 7:00 morning news). There appear to be three types of operations performed on young girls. The “mildest” form of circumcision, according to McNamara (1991:4), is when only the tip of the clitoris is removed. The “intermediate” type of circumcision is when the whole clitoris and often the nearby parts including the labia minora are removed. The gravest form of FGM is infibulation, also called “pharaonic” circumcision, when the clitoris, labia minora and parts of the labia majora are removed and the two sides of the vulva are fastened together, leaving a small opening for urination and menstruation.

Consequences of infibulation, such as inflammation of the genital area, partial closure of the vaginal lips, abnormal anatomy or friable scar tissue are conditions that may increase susceptibility to HIV infection (McNamara 1991:4). The “circumcision” ceremony is carried out by people with no medical or anatomical knowledge, with the result that seven out of every 100 girls bleed to death (Fine & Alter 1996:273). Many girls contract infections, including HIV, because they are circumcised in a group with the same instrument. These infections can lead to death or infertility, as some girls as young as seven years old are circumcised.

The long-term consequences (McNamara 1991:3) of infibulation are chronic urinary tract infections, incomplete healing and excessive scar tissue that can cause vaginal obstruction. During childbirth, the infibulated section has to be cut open for passage of the infant. This can be severely traumatic with possible rupture of the vagina (Gordon 1991:3). Fine & Alter (1996:273) state that the lack of knowledge on the part of the people who perform the circumcisions leads to severe scarring and damage in which even the bladder may be tampered with.

### 7.2.3.2 Dry sexual intercourse

Fine & Alter (1996:272) mention that the myth, that sexual intercourse is better and purer with a woman whose vagina is dry, is both inaccurate and potentially dangerous. The myth about dry sex is perpetuated by the cultural belief that a wet vagina indicates that a woman sleeps around and has many sexual partners. The men see wetness as a sign that their sexual partners are having sexual intercourse with other lovers, while in fact the woman is responding naturally to sexual arousal.

When a woman tries to please her partner by making the vagina drier with all kinds of substances, she can do herself serious harm. Sexual intercourse for the woman becomes painful and the risk of infection and transmission of diseases, including HIV infection, is much higher (Fine & Alter 1996:272). McNamara (1992:4) confirms that herbs, traditional preparations and foreign objects inserted into the vagina can cause inflammation, abrasions and infections, and so increase susceptibility to STI and HIV infection. These practices are performed to dry and tighten the vaginal passage, in the belief that it increases the male partner's pleasure during sexual intercourse (UNAIDS 2001:8). It is reported that women in some cultures use substances such as methylated spirits or vinegar, iced water, ice cubes, zam-buk cream, snuff, alum powder or 'muti' prepared by traditional healers to dry out the vagina. This disturbs the delicate bacterial balance of the vagina. When a dry vagina is penetrated, it can cause tears that can be very painful and will make the women more susceptible to STI and HIV infection. Dry sex may cause bleeding and consequently provide a direct passageway for HIV to enter the bloodstream (UNAIDS 2001a: 28).

Non-consensual, hurried or frequent sexual intercourse may also inhibit mucous production and the relaxation of the vaginal muscles, both of which would increase the likelihood of genital trauma (Reid & Bailey 1992:4). A lack of control over the circumstances in which sexual intercourse occurs may increase the frequency of sexual intercourse and lower the age at which sexual activity begins.

The young girl's vulnerability with regard to HIV/AIDS infection is increased when she is exposed to factors such as:

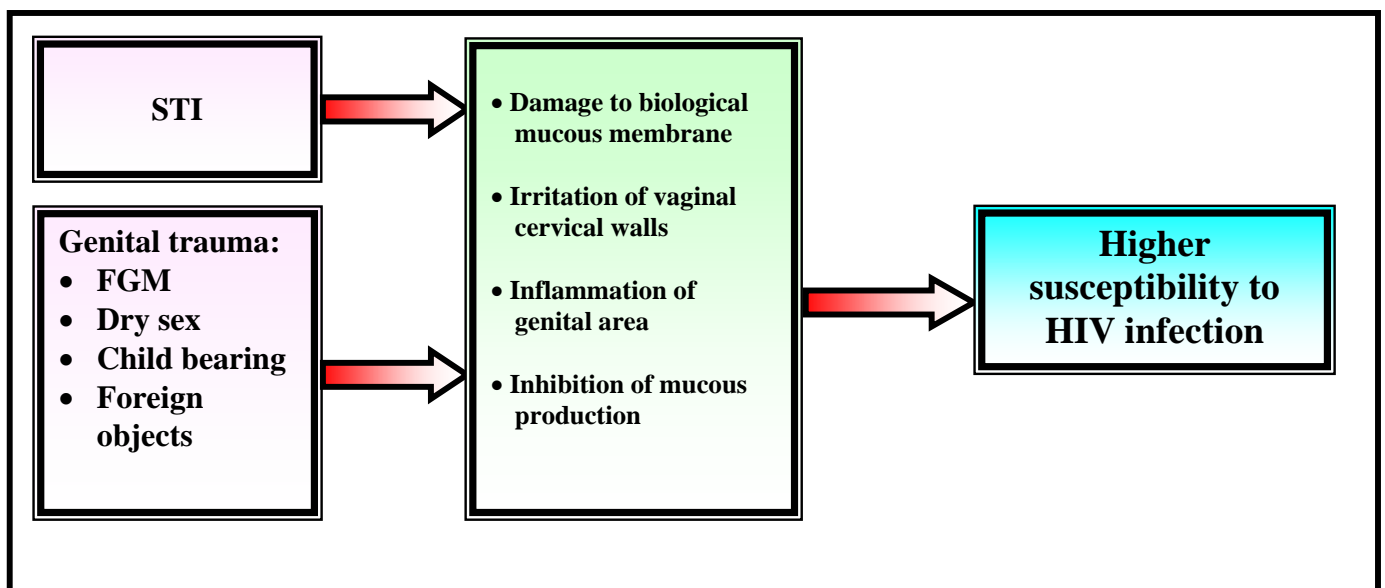
- STI infection
- exposure to sexual activity at a young age

- genital trauma because of hurried sexual activity that damages the mucous membrane
- sexual activity at an early age when the mucous membrane is not yet fully developed.

### 7.2.3.3 Foreign objects used by women

Globally, women in some cultures are known to insert objects into the vagina as medication, for contraception, to induce abortion or with the intention to increase the male partner's pleasure during sexual intercourse (McNamara 1991:4). Women reported to using one or more of the following objects to tighten the vagina: herbs, aluminum hydroxide, cloth or stones. Stones were found to have an irritating and erosive effect on the vaginal mucosa and that they facilitate entry of HIV.

**Figure 9: Schematic presentation of susceptibility to HIV infection caused by STIs and Genital trauma**



In Mexico, for example, women inserted items such as herbs, pills, soap and lime into the vagina as medication or to induce abortion (Shedlin & Hollerback 1981: 278). In Nigeria, leaves and seeds from certain trees (ejirin seeds and itu leaves) are ground and the juice from another tree (epin) is added to form a paste. The paste is then made into small balls and dried. The balls are inserted into the vagina and have the effect of destroying the foetus (Adebajo 1989:14). In Afghanistan, women reported intravaginal insertion of wooden spoons or sticks treated with copper sulphate to cause heavy bleeding and abortion. Egyptian women use aspirin, lemon juice, black

pepper and plant stems (Sukkary-Stolba 1985:78). In other countries bamboo leaves, grass, the midrib of the coconut palm, water pumped under high pressure, hangers, knitting needles, umbrellas and soft drinks such as coca-cola are used as ways to induce abortion (McNamara 1992:5).

## **8. SUMMARY**

In this chapter, the aim was to further investigate the vulnerability of the young girl to HIV infection. The child-rearing style of the parent in the family has an impact on the vulnerability of the young girl. The child-rearing style that the parent realizes effects the personality of the young girl and may render her vulnerable to HIV infection.

The nuclear family of which the girl is a member seems to provide inadequate security for the rearing of a young girl in contemporary society. This renders the young girl vulnerable to influences of society and eventually also to HIV infection. The girl is exposed to disharmonious family situations. Unfavourable family situations result in the girl not developing a positive self-concept and positive perception of her own role in her future family. The girl may then choose to look for companionship and love outside her family, leaving her vulnerable to influences of contemporary society. The young girl as a member of the contemporary family may thus be vulnerable with regard to the influences of society on the family and on herself. The family experiences economical, emotional, social, role differentiation, pedagogical and communicative vulnerability.

The young girl as member of society and a specific culture within society that determine the behaviour of gender roles may also experience that gender inequalities with regard to sexual behaviour render her vulnerable with regard to HIV infection.

Physical and anatomical characteristics of the female body, such as the tender mucous membrane within the vagina that provides protection against STIs and consequently HIV infection, may be inadequate due to factors such as FGM, early exposure to sexual intercourse and genital trauma.

## CHAPTER 3

### THE SOCIO-ECONOMICAL SITUATION OF THE YOUNG GIRL

#### 1. THE AIM OF THIS CHAPTER

This chapter aims at investigating the vulnerability of the young girl to HIV/AIDS infection, with reference to socio-economical factors that impact on the young girl and may contribute to her vulnerability to become HIV infected.

To investigate and describe the socio-economical situation of the young girl, this chapter will focus on certain socio-economical aspects such as poverty, violence against women, sexual behaviour and prostitution, as well as conflict and displacement that are considered to be contributing factors that may increase the vulnerability of the young girl to HIV infection (WHO 2002:12; Cohen 1998:1-17). According to Sweat & Denison (1995: 57), the risk of HIV infection amongst young people in developing countries is intensifying in the midst of socio-cultural, political and economic factors such as poverty, migration, war and civil disturbance.

#### 2. POVERTY AND HIV/AIDS

Cohen (1998:2) states that the poor account for the largest numbers of HIV infection. UNAIDS (2002a:26) confirms that 95% of all AIDS cases emerge in developing countries and that Sub-Saharan Africa, where the per capita income is as low as \$520, has the highest prevalence rate of HIV infection.

According to Rivers & Aggleton (1998:2), young people who are socially and economically disadvantaged are at highest risk to HIV/AIDS infection because of the precarious and impoverished living conditions that they are exposed to. Cohen (1998:8) states that in Southern Africa the majority of new infections are amongst poverty stricken young people between the ages of 15 and 24 (sometimes younger). In South Africa the percentage of pregnant 15 – 19 year old girls infected with HIV rose to 13% in 1996 – double the number than that of 1994. Infection rates for girls and young women are significantly higher than they are for boys and young men of the same age. These differential rates of infection appear to be complex, partly for physiological reasons and partly for socio-economical reasons.

## **2.1 The concept “poverty”**

According to the Reader’s Digest Universal Dictionary (1988:1210), “poverty” is described as “the state or condition of being poor; lack of the means of providing material needs for comforts; the lack of something necessary or desirable; insufficiency; deficiency in amount; scantiness”. The Collins Cobuild English Dictionary (1998:1286) elaborates that “poverty” is “the state of being extremely poor”, and “poverty” refers to “any situation in which there is not enough of something or its quality is poor”.

Webster (1984:16-19) describes poverty as a relative term, a condition that can only be defined by comparing the circumstances of one group of people or an entire economy with another. The problem of defining poverty arises, since the measure one uses to compare populations will depend on a whole range of assumptions about adequate standards of living that some enjoy and some do not. According to Pretorius (1988:202), “poverty” designates a social grouping with low socio-economic and cultural levels, and scant social and economic status.

The World Bank (1975:19) defines utter poverty as a situation in which levels of income are so low that even a minimum standard of nutrition, shelter and personal life necessities cannot be maintained.

For the purposes of this study, “poverty” will be regarded as a situation where a person’s income is insufficient to provide the necessary means of livelihood. The concept of poverty with regard to the young girl will be understood as a situation in which levels of income are so low that a minimum standard of nutrition, shelter and personal life necessities cannot be maintained. A situation of poverty that increases the girl’s social vulnerability has a disempowering effect with regard to her ability to remain HIV uninfected. Poverty may predispose the girl to situations that compel her to give way to sexual intercourse during which she is unable to negotiate safe sex and therefore be vulnerable with regard to HIV infection.

## **2.2 A culture of poverty as a causal factor with regard to HIV infection**

Booyse (1989:147) states that the potential of children in a culture of poverty is inhibited by an unsupportive milieu. The danger of this situation is that children in a

culture of poverty may not be able to adapt adequately to wider society (Banks 1990:210). According to UNAIDS (2001b:26), the term “enabling environment” describes the economic, cultural, social and political circumstances that contribute to HIV/AIDS risk. Not only may an enabling environment facilitate the spread of HIV/AIDS, but a high incidence of HIV infection may also worsen the conditions of the enabling environment, creating a “vicious cycle” in which increasing numbers of people become infected.

Sullivan (1980:329) mention that “the long term poor often share common cultural characteristics and values that separate them from other groups in society and that makes it difficult for them to struggle out of poverty. A culture of poverty is linked to juvenile misconduct, child abuse, begging, and early school leaving”. Cohen (1998:2) states that the poor account for the largest numbers of those infected with HIV, although HIV infection is also present amongst the economically affluent population. Young people may also face the increased risks of HIV infection by virtue of their social position, unequal life chances, rigid and stereotypical gender roles, and poor access to education and health services.

Garbers (1980:52) presents a schematic interpretation of the poverty spiral that characterizes a culture of poverty (Figure 10). Poverty, both material and cultural, has a direct influence on the individuals in a culture of poverty. For example, they might suffer from ill-health; the mother might be undernourished during pregnancy; family planning might be inadequate or non-existent. Infant mortality is often high and families are large. Parents also have a low level of education and scant occupational status and common trends among the children are malnutrition or undernourishment, and chronic ailments owing to inadequate medical services.

Le Roux & Gildenhuis (1994:34) argue that child rearing in a culture of poverty is troubled by a lack of order in the milieu, a day-to-day or short term orientation toward time, a powerful peer-group influence, a restricted language code, primitive communication, low intellect, insecurity, poor orientation towards school, and clashes between the value orientations of the family and the school. The result is a negative academic self-concept, relatively low level of drive, an accumulated scholastic backlog, diffuse personality structure, an unmet need for expression, creativity that is alien to the school situation, social awkwardness, and discomfort in the school situation. These factors contribute to failure in school and, frequently, to early school



leaving. A poor and uncertain occupational future, in turn, contributes to poverty, and the cycle continues.

The young girl caught up in the spiral of poverty might then be more vulnerable to HIV infection. This is supported by Rivers & Aggleton (1998:4), who state that young people living in poverty, or facing the threat of poverty, may be particularly vulnerable to sexual exploitation through the need to trade or sell sex in order to survive. More than half of 141 street children recently interviewed in South Africa, for example, reported having exchanged sex for money, goods or protection (Swart-Kruger & Richter 1997: 959).

## **2.3 Manifestations of poverty and their possible relations to HIV infection**

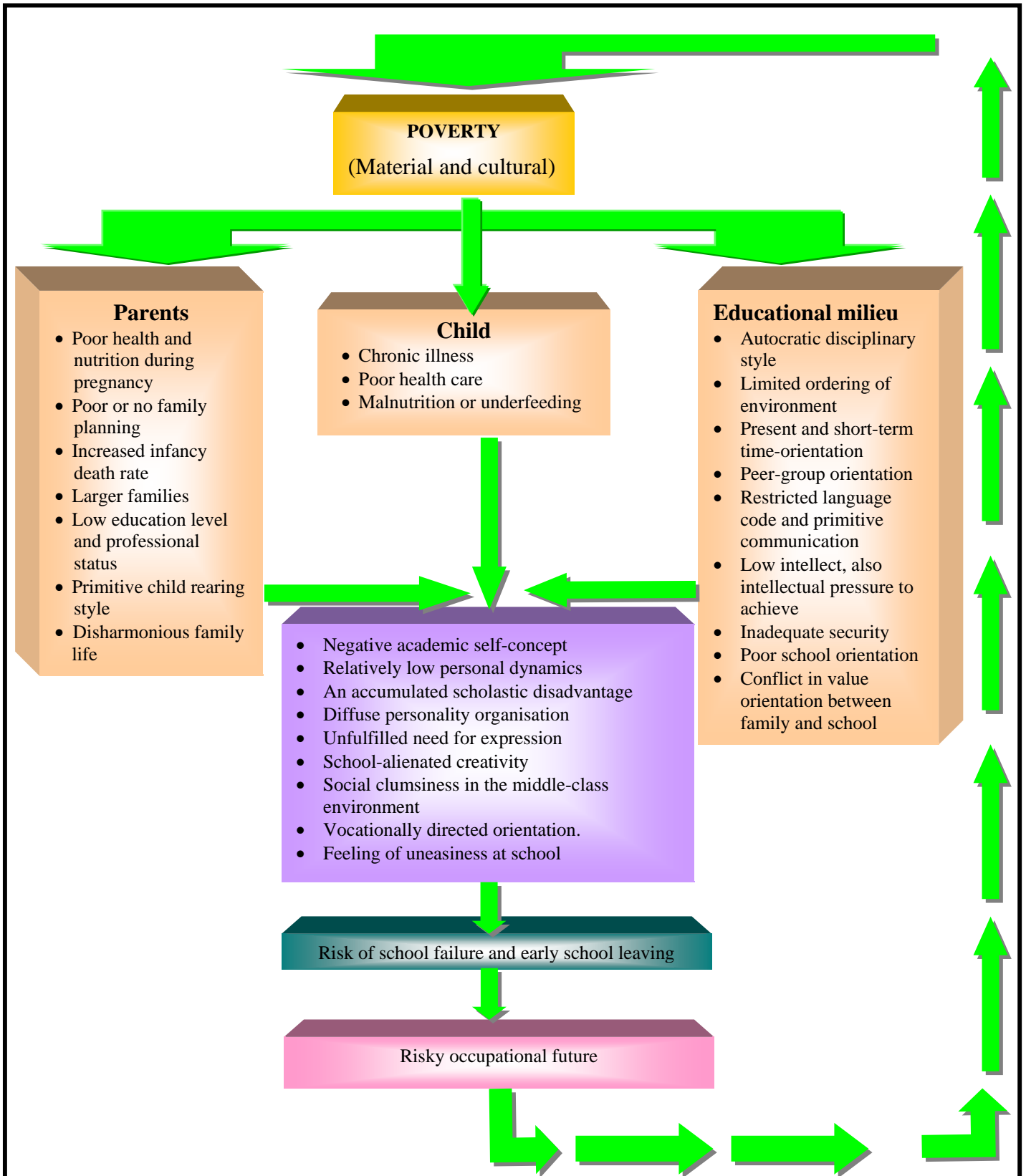
### **2.3.1 Inadequate child rearing as a manifestation of poverty**

Le Roux & Gildenhuys (1994:36) state that the child in a culture of poverty is denied the intimate association in which primary and meaningful child rearing is actualised during the process of living and sharing with others. Pretorius (1988:209) also states that it is generally accepted that parents in a culture of poverty are unable to rear their children effectively.

From birth the child depends on the care, love and rearing of parents. Children in a culture of poverty are inadequately cared for in terms of housing, clothing and personal hygiene (Figure 10). The following inappropriate child-rearing attitudes and actions of parents in a culture of poverty are distinguished (Le Roux & Gildenhuys 1994:37):

- Neglect
- Instability
- Over-correction
- Stringency
- Over-protectiveness
- Hard-heartedness
- Indulgence
- Rejection

Figure 10: The spiral of poverty



Source: Garbers 1980: 52

Inadequate child rearing (Le Roux & Gildenhuis 1994:36) manifests itself in:

- A lack of affection and personal warmth
- A positional child-rearing style
- Parents who are not child-orientated
- Disrupted family relationships
- Parents who are not socially mobile
- Limited opportunities for the child to realize her potential
- A shortage of positive role models
- The girl's own perception of her position in society is inhibited and limited; she is predisposed to an attenuated and impoverished social life; and
- An unfavourable physical, cultural and social environment that hampers the child's upbringing and development (Pretorius 1988:210-207).

Cohen (1998:3) states that despite major efforts in many African countries, access to and the quality of education, received by the poorest, still remains a major educational shortfall. The recent decade has seen a worsening of the education received by the poorest in many countries. Paterson (1996:6) states that the lack of education limits choice. In urban areas the problems facing illiterate women are enormous. Scavenging, begging and prostitution are the only means of surviving. Education teaches skill, gives confidence and provides a springboard into the modern world. And yet in Uganda, where all education has to be paid for, growing girls may be expected to stay at home and care for the children while their mothers go to work and the brothers go to school. In South Africa, 6% more girls than boys complete primary school, but 10% fewer girls complete secondary school. This may be attributed to the fact that girls of this age are expected to look after younger siblings and keep the house in order while the mother is at work (Meintjies & Marks 1996:223).

Bandura (1992:89) notes that a sense of self-efficacy is necessary for the prevention of HIV infection, since people must control their own motivation and behaviour as well as influencing the behaviour of their sexual partners. The inadequate education and consequent low sense of self-efficacy that a girl within a culture of poverty is predisposed to may render her vulnerable to HIV infection, as she might not have control over her own and her partner's sexual behaviour.

### 2.3.2 Ill-health as a manifestation of poverty

A commonly used definition of health is the one endorsed by the World Health Organisation: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (United Nations 1974:11).

Members of a culture of poverty are constantly haunted by disease. Persistent illness creates poverty, while poverty, continuing the cycle, maintains the conditions that foster diseases (Harrison 1981:289). Cohen (1998:3) agrees that the poorest have generally poor health status as the result of their poverty and their lack of access, since childhood, to those things that determine good health status. In part, this is a matter of access to formal sector health services, but it is much more a matter of environmental conditions such as poor housing, polluted water and poor nutrition.

Statistics for underdeveloped countries show that infections and parasitic and contagious diseases are the main causes of death. These illnesses include gastroenteritis, pneumonia, venereal diseases, and trachoma. Lauer (1978:280) concludes that people in the grip of poverty are more likely to contract chronic illnesses, and in the face of more health problems, they are less likely to own health insurance. And as the ultimate deprivation, they are likely to die at a younger age.

Le Roux & Gildenhuis (1994:41) state that poverty is intensified by illness. Health and the recovery of health have financial implications because adequate medicine and treatment require sufficient funds, and chronic illness means no income, while death in a family may have devastating consequences for a household’s finances because of high funeral costs (Figure 10). Cohen (1998:3) further states that these conditions apply to both male and female genders but seem to be the severest for girls and women, which may in part explain their greater susceptibility to HIV infection than males. Women receive less health care than men and the failure to treat STIs in women makes young girls more vulnerable, given the link between STIs and HIV transmission (paragraph 7.2.1 in Chapter 2). A lack of access to acceptable health services may leave infections and lesions untreated. Malnutrition in young women not only inhibits the production of adequate mucous but also slows the healing process and depresses the immune system (Reid & Bailey 1992:4).

Young women in a culture of poverty may experience constant ill-health that is difficult to recover from and this places them in a more vulnerable position to HIV infection. UNAIDS (2001a:26) states that in developing countries, 45 % of women of childbearing age are unable to take in the recommended number of calories each day. When shortage of food is a prime concern, managing HIV risk may not be a priority.

### **2.3.3 Violence as a manifestation of poverty**

The Reader's Digest Universal Dictionary (1988:1675) explains "violence" as "physical force exerted for the purpose of violating, damaging, or abusing; an act or instance of violent action or behaviour; the abusive or unjust exercise of power; an outrage; a wrong; abuse or injury to meaning, content, or intent. According to the Collins Cobuild English Dictionary (1998:1867), "violence" refers to "behaviour that is intended to hurt, injure or kill someone; when something is done or said with a lot of force and energy, often when a person is angry."

Pretorius (1988:211) states that a member of a culture of poverty may be predisposed to aggressive, violent and destructive behaviour because of a low self-concept and frustration that are frequently experienced (Figure 10). According to Pitock (1992:32), a culture of violence is typical of the section of society that has to cope with poverty.

According to the Kaiser Family Foundation (2000:10), young South Africans in low-income families are more likely to experience violence from their parents and teachers. For example, 42% of young people who live in households with an income of less than R1000 report being beaten by their mothers, compared to 24% of young people who live in households with an income of R1000 or more.

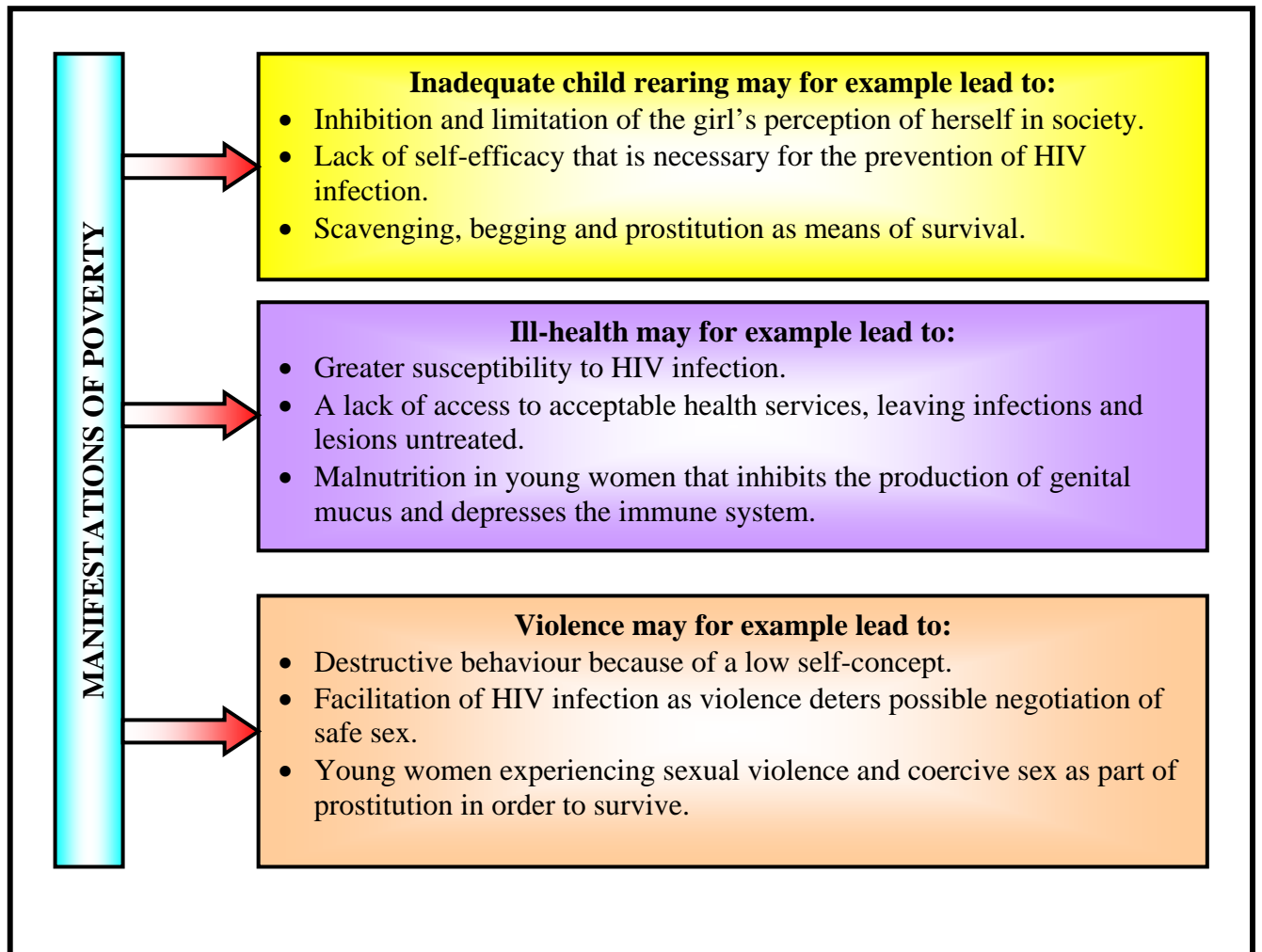
Conditions such as overcrowding, the breakdown of cultural, familial and social support systems, continued harassment by security forces, high crime rates, unrest and violence are typical of a culture of poverty (Bluen & Odesnik 1988:51). According to Le Roux & Gildenhuys (1994:47), the eruption of violence can frequently be traced to the frustration of jealous, aggrieved and embittered persons in a subculture. A culture of poverty is a breeding ground for violence. Violence is often the result of tensions due to food shortages, inadequate housing, unemployment and insecurity, and the futility of an undirected and opportunity-deprived existence that dulls the spirit.

The origins of violence are complex. According to UNAIDS (2000:9), an important factor is the sense of disempowerment that emerges from experiencing unemployment or poverty - when some men lack a meaningful role in the family or community, they may turn to violence towards women as a way of exhibiting their masculinity. A high percentage of men who are violent towards women have either been witnesses of violence or victims themselves.

Violence against women and children may also be ascribed to the gender stereotype of male sexual aggression (UNAIDS 2001b:24). This often means that the male pursues a number of sexual partners with the primary aim of being “in control” to display his male superiority and prove his embodiment of dominance, physical strength, virility, and risk-taking. The male’s aggression may also translate into situations of sexual coercion and rape, in which women and young girls are reluctant to raise the issue of condom use because of the threat of violent retaliation. Violent and coerced sex can also increase a women’s biological vulnerability to HIV/AIDS infection because of damage to membranes of the genital area (in this regard refer to Chapter 2, paragraph 7.1.3-7.1.3.5 of this study). A study of young women in South Africa indicates that 30% of the young women’s first sexual intercourse was forced; 71% reported having sex against their will, and 11% reported being raped (UNAIDS 1999a: 16).

There are some other obvious links between violence and HIV (UNAIDS 2000:9). Even when violence takes a non-sexual form such as threats, it may facilitate the spread of HIV, as such violence may prohibit the girl’s opportunity to negotiate safer sex practices. Young women who have been victims of violence are less likely to believe they can negotiate safer sex practices with a partner. This may be even worse for the young girl in a poverty situation that experiences sexual violence and sexual coercion when she has to trade sex in order to survive (Figure 11).

Figure 11: Manifestations of poverty



### 3. SEXUAL VIOLENCE AND ITS IMPACT ON YOUNG GIRLS' VULNERABILITY

#### 3.1 The concept "sexual violence"

According to Gordon & Crehan (1997:2), sexual violence describes "the deliberate use of sex as a weapon to demonstrate power over, and to inflict pain and humiliation upon another human being". It is meaningful to note that sexual violence does not have to include direct physical contact between the perpetrator and the victim: threats, humiliation and intimidation may all be considered as sexually violent when they are used with the mentioned purposes.

The term "sexual violence" is also used to describe rape by acquaintances or strangers, by authority figures (including husbands), incest, child sexual abuse, pornography, stalking, sexual harassment and homicide (Gordon & Crehan 1997:9).

The term “sexual violence” may also refer to “sexual abuse of children”. Terms such as “sexual exploitation”, “sexual molestation” and “sexual abuse of children” are all used synonymously to indicate the same form of child abuse that relates to sexual violence (Meyer & Kotzé 1992:139).

The United Nations (UN) offers the following definition with regard to sexual violence: “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (United Nations 1994:104). It encompasses, but is not limited to, “physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation (refer to Chapter 2, paragraph 7.2.3.1) and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, educational harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs”.

For the purpose of this chapter the term “sexual violence” will refer to all physical and emotional use of violence against young girls and women that results in sexual exploitation and may increase the vulnerability of young women to HIV infection.

The earliest years of a person’s life are supposed to be a time of carefree exploration, growth and support. For millions of girls around the world the reality is quite different (WHO 1997:13). Violence against the young girl includes physical, psychological and sexual abuse, commercial sexual exploitation in pornography and prostitution, and harmful practices such as son preference and female genital mutilation. These violent acts may have the result that the young girl has a low self esteem and less self respect, with consequent feelings of worthlessness. In order to compensate for this, the girl may become more willing to participate in and experiment with sexual intercourse (even expose herself to sexual violence) in order to feel accepted and worthy, and consequently be more vulnerable to HIV/AIDS infection.



According to the WHO (1998:36), sexual violence encompasses a wide variety of abuses that includes sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings and attempted rape (refer to Chapter 2, paragraph 7.2.3.3 of this study). Female genital mutilation and other harmful traditional practices such as early marriage are forms of sexual and gender based violence against women.

**Figure 12: Violence against women throughout the life cycle**

<b>PHASE</b>	<b>TYPE OF VIOLENCE</b>
<b>Pre-birth</b>	Sex-selective abortion; effects of battering during pregnancy on birth outcomes.
<b>Infancy</b>	Female infanticide; physical and psychological abuse.
<b>Girlhood</b>	Child marriage; female genital mutilation; physical, sexual and psychological abuse; incest; child prostitution and pornography.
<b>Adolescence and adulthood</b>	Dating and courtship violence, for example acid throwing and date rape; economically coerced sex, for example school girls having sex with “sugar daddies” in return for school fees; incest; sexual abuse in the workplace; rape; sexual harassment; forced prostitution and pornography; trafficking in women; partner violence; marital rape; dowry abuse and murders; partner homicide; psychological abuse; abuse of women with disabilities; forced pregnancy.
<b>Elderly</b>	Forced “suicide” or homicide of widows for economic reasons; sexual, physical and psychological abuse.

Source: WHO (1997: 3)

### 3.2 Incest as form of sexual violence

#### 3.2.1 The concept “incest”

Rosenweig (1985:52) presents the following broad definition: “incest in the most limited sense refers to sexual activity between blood relatives. Incest in the psychological sense refers to sexual activity between unmarried members of a family rather than merely the biological parents and siblings. Consequently stepfathers, uncles, cousins, even parents’ friends may be included under the rubric of potentially incestuous partners”.

The Reader's Digest Universal Dictionary (1988:777) defines "incest" as "sexual union between persons who are so closely related that their marriage is illegal or contrary to custom; the crime committed by such closely related persons who marry, cohabit, or copulate illegally. The word 'incest' is derived from the Latin word '*incestus*' meaning 'impure' and 'unchaste'.

The Collins Cobuild English Dictionary (1998:851) defines "incest" as "the crime of two members of the same family having sexual intercourse, for example a father and daughter, or a brother and sister".

Platvoet & Dubbink (1988:17) define "incest" as all forms of sexual contact between adults and children who belong to the same primary group, and from which the child feels unable to withdraw because of the physical and/or psychological dominance of the adult. The adult, to satisfy his own sexual needs, violates the relationship of trust and authority.

### **3.2.2 Occurrence of incest**

Incest, as sexual abuse occurring within the family, is most often perpetrated by a father, stepfather, grandfather, uncle, brother or other male in a position of family trust (WHO 1997:13). Incest is accomplished by physical force or by coercion and takes on the added psychological dimension of betrayal by a family member who is supposed to care for and protect the child (WHO 1997:13). Müller (1998:16) remarks that incestuous abuse may affect the child differently from that of being assaulted by a stranger, as the father or older brother is in a primary relationship and has a great deal of emotional power over the child.

According to Müller (1998:15), incestuous sexual assaults usually develop over a period of time and are often more damaging than physical violence, as the child is usually confused by bribery or trickery and even threatened by punishment and violence. Characteristics of incest include:

- variations in the ages of the victims
- complex family dynamics
- usually an adult male, the dominant father type
- often associated with low socio-economic groups

- sexual substitution
- association with aggression.

UNICEF (2001:32) states that the majority of sexual abuse cases of children are never reported to the authorities. There may be no physical signs of harm, but there is always intense shame. Even adults who are aware of the abuse, for fear of destroying the family, often maintain secrecy, and abused children are made afraid to tell about the abuse.

Children who have been sexually abused may be withdrawn, moody, anxious, depressed, self-destructive and sometimes suicidal (UNICEF 2001:33). They may also become emotionally numb, develop a low self-esteem and an abnormal perspective on sexuality, while only being able to relate to others in sexual terms. The danger of this may be that abused children become abusers themselves, or prostitutes, with consequent vulnerability to HIV/AIDS infection.

### **3.3 Rape as form of sexual violence**

#### **3.3.1 The concept “rape”**

The Reader’s Digest Universal Dictionary (1988:1272) defines “rape” as “the crime of forcing a female to submit to sexual intercourse without her consent or such a crime committed against a male; the act of seizing and carrying off by force; abduction” and “abusive or improper treatment; violation; profanation: a rape of justice; the act of plundering or despoiling a country or city, especially in war”. The word “rape” is derived from the Latin “*rapere*”, that means, “to *seize*”.

The Collins Cobuild Universal Dictionary (1998:1360) describes “rape” as “forced to have sex, usually by violence or threats of violence; the crime of forcing someone to have sex.”

Robertson (1989:4) defines rape as the deliberate, illegal sexual intercourse with a woman without her consent. Only a woman can be the victim of rape, and only a man the perpetrator. In legal terms, a woman can therefore not rape a boy, and a girl who is sexually abused by a woman, cannot be considered a victim of rape. Children under the age of 12 cannot give legal consent for sexual intercourse because of their minor

legal status, and even if the perpetrator were to pretend that the victim had consented to the intercourse, the transgression will still be regarded as rape.

Van Rooyen & Louw (1994:100) also describe rape as a crime in which the physical integrity of a woman is violated. The man unlawfully and intentionally has sexual intercourse with a woman without her consent. Penetration of the female organ by the male sex organ has to take place and ejaculation and/ or a resulting pregnancy is not considered important.

Motsei, Moore & Goosen (1996:78) define rape as when a woman is forced to have sexual intercourse against her will. It is a complete violation of a woman's human right to bodily integrity.

It is interesting to note that earlier definitions of rape implicated that only women can be victims whereas only men are the perpetrators of a rape crime. The WHO (1998:36) describes rape as sexual intercourse with another person without his/her consent. Rape is committed when the victim's resistance is overwhelmed by force or fears of other coercive means. Müller (1998:14) further defines rape as forced intercourse with a female, which also includes forced sexual assaults on young males. The rape of a young male is often associated with the physical violation of the person, as experienced with that of a young female. The defining element of rape appears to be that of lack of consent to have sexual intercourse, as Scunker-Haines (1998:47) concludes that anyone – man or women – who forces another person to have sex against his or her will, commits rape. The recently proposed Act on Sexual Offences, Section 32, perceives rape as "... any unlawful and intentional act which causes penetration to any extent whatsoever by the genital organs of a person into or beyond the anus or genital organs of another person, or any act which causes penetration to any extent whatsoever by the genital organs of another person into or beyond the anus or genital organs of the person committing the act."

### **3.3.2 Different kinds of rape**

#### **3.3.2.1 Statutory rape**

Robertson (1989:5) states that statutory rape refers to sexual intercourse between adults and children under the age of 16. A man who has intercourse with a girl

younger than 16, and a woman who has intercourse with a boy under the age of 16, fall into this category. The recently proposed Sexual Offences Act of 2003, Section 10, also states that any person who commits an indecent act, such as direct or indirect contact between the anus or genital organs, exposure or display of the genital organs or exposure or display of any pornographic material and any act which causes penetration with a child who is younger than 16 years of age, is guilty of a sexual offence.

### **3.3.2.2 Date rape**

Date rape is a common form of rape. It happens when a woman goes on a date with a man she knows, who then forces her to have sexual intercourse with him. The rapist is often a boyfriend, a good friend or an acquaintance (Motsei, Moore & Goosen 1996:81). The Collins Cobuild English Dictionary (1998:413) describes “date rape” as when a man rapes a woman after having spent the evening socially with her.

Many date rape victims’ drinks are “spiked” with drugs such as Rohypnol, Ativan, Xanax and Halcion in order to be sedated and consequently raped. The victim may experience amnesia after being drugged and never even remember being raped. These drugs belong to a class known as benzodiazepines and have a short onset time and affect memory to varying degrees (Maber 2000: 36). There are four categories of date rapists (or drug rapists), namely the opportunist who does not plan to rape a particular woman, but seizes the opportunity when he has a chance, the rapist that plans to rape a specific woman he has fancied for a long time, the serial rapist who derives pleasure out of drugging women, and the “heavy-duty porn merchant” who films drugged women.

Many women and girls do not report a suspected date rape because of the severe memory loss they experience and ambivalent feelings of guilt that make them feel responsible for what happened (Maber 2000: 37). Drug rape is also difficult to prove, and in the UK only three men have been arrested with regard to drug rape, although no one has ever been charged with the crime.

### **3.3.2.3 Gang rape**

The Collins Cobuild English Dictionary (1998:695) defines a “gang” as “a group of people, especially young people, who go around together and often deliberately cause trouble” and “ a group of criminals who work together to commit crimes”. The word “gang rape” therefore may refer to a group of young people or criminals that work together and rape young girls and women. Beeld (2002: 4) for example reported the repeated rape of a fifteen-year-old girl by five men while she and her friend were walking home at night. These gangs often target and rape teenage girls, lesbians or mentally disabled girls (Motsei, Moore & Goosen 1996:82), because they are more defenceless.

Motsei, Moore & Goosen (1996:82) mention that gang rapes are often very brutal and women or young girls have less chance of escape or resistance. These rapists want to prove their “sexual mastery” and physical strength to their friends. UNAIDS (2001b: 39) states that gang rape often occurs within war situations that are associated with increased violence against women and children. A 20-year-old Ugandan girl, for example, spent half her life in captivity since rebels abducted her at the age of 10 years. During that time she bore two children, both by officers who simultaneously raped her on a frequent basis (Green 1999: 17).

Within a gang rape situation the young girl may be exceptionally vulnerable to HIV/AIDS infection as she has no opportunity to negotiate condom use, is violently exposed to possible vaginal tearing and exposed to multiple sexual offenders.

### **3.3.2.4 Infant rape**

Infant rape is a brutal act, which appears to be increasing in frequency in South Africa (Pitcher & Bowley 2002:275). To penetrate the vagina of a small infant, the perpetrators first need to create a common channel between the vagina and the anal canal by forced insertion of an implement (Eke 2002:57). This action is similar to the most severe form of female genital mutilation introcision, in which the perineum is split with a finger, knife, or similar object, presumably to facilitate penetrative intercourse in girls as young as 5 years old who are sold into early marriage.

Infant rape of this nature can be immediately life threatening (Pitcher & Bowley 2002:274). The tearing of the perineal body, rectovaginal septum, and anterior anal muscle ring can cause infants to die from blood loss or abdominal sepsis despite medical care, especially in deprived rural communities.

There is growing support for the theory that infant rape is related to a myth that intercourse with a very young virgin infant will enable the perpetrator to rid himself of HIV/AIDS or other sexually transmitted infections (Pitcher & Bowley 2002:274). The presence of a sexually transmitted infection increases the risk of HIV infection transmission two-fold to five-fold (Van As, Withers, Du Toit & Millar 2001:421) and young girls in South Africa have been shown to be at very high risk of becoming infected after a limited number of sexual exposures, possibly because of the high prevalence of other sexually transmitted diseases.

Pitcher & Bowley (2002:274) argue that the risk of HIV transmission is likely to be very high in the case of infant rape, because physical injury is common (Van As, Withers, Du Toit & Millar 2001:1035) and, in view of the prevailing myth, because the perpetrators are probably HIV positive.

### **3.3.3 Prevalence of rape in South Africa**

Sexual abuse of girls is a worldwide problem, and a growing concern in sub-Saharan Africa. Such abuse constitutes a profound violation of human rights, and has been associated with long-term mental and physical consequences (Mccauley, Kern & Kolonder 1997:1362).

In the 1998 South African Demographic and Health Survey, 95% of the women interviewed confirmed that before the age of 15 years they had been “forced to have sexual intercourse against their will by being threatened, held down, or hurt in some way” or “persuaded to have sexual intercourse when they did not want it”. This response confirmed that the women had been raped before the age of 15 (Jewkes & Levin 2002:319). Further results from the survey confirmed that:

- ❑ 1.3 % of the women had been gang raped
- ❑ 85% of the rapes took place between the ages of 10-14 years and 15% between the ages of 5 – 9 years of age.
- ❑ in 33% of the rapes the perpetrator was a schoolteacher
- ❑ relatives accounted for 21% of the rapes
- ❑ strangers or recent acquaintances were responsible for 21% of the rapes
- ❑ boyfriends committed 10% of the rapes.

Jewkes & Levin (2002:320) confirm that the rape of girls, especially in school, is a substantial public-health problem in South Africa. The rape of girls by schoolteachers and male students not only violates the girl's body, but also violates her right to education. The risk of HIV infection is increased through sexual intercourse, as is the likelihood of unsafe sexual practices during later years.

Practices such as having multiple sex partners and participation in sex work may increase the risk of rape in adulthood (Garcia-Moreno & Watts 2000:253). Intergenerational sex also fuels the HIV epidemic by providing foci of infection within every emerging age group, leading to transmission of the virus to peers once children reach the stage of consensual sexual activity.

Many girls are forced to leave school because of pregnancies fathered by teachers and because of harassment by teachers. A girl's ability to reach her economic and social potential is thus reduced, while her possible dependency on selling sex for payment increases together with her vulnerability to HIV infection (Jewkes & Levin 2002:320).

### **3.4 Violence during conflict and refugee situations**

#### **3.4.1 Political violence**

Armed conflict and uprootedness bring their own distinct forms of violence against women and children with them (WHO 1997:11). These can include random acts of sexual assault by both enemy and "friendly forces", or mass rape as a deliberate strategy of genocide. UNAIDS (2001b: 39) states that women and girls constitute 75% of the global 18 million refugees and they are at particular risk of rape and abuse and consequently more vulnerable to HIV/AIDS infection.



The following forms of violence may manifest during conflict or refugee situations (WHO 1997:11):

- ❑ mass rape, military sexual slavery, forced prostitution, forced marriages and forced pregnancies
- ❑ multiple rapes and gang rape (with multiple perpetrators) and the rape of young girls
- ❑ sexual assault associated with violent physical assault
- ❑ reappearance of female genital mutilation, within the community under attack, as a way to reinforce cultural identity
- ❑ women forced to offer sex for survival, or in exchange for food, shelter, or “protection”.

South Africa was in a state of unofficial war since the mid-1980s (Flood, Hoosain & Primo 1997:46). This “unofficial war” was aimed at destroying apartheid and the oppression of black people. For many blacks, this meant continuous violence and disruption of their lives (Motsei, Moore & Goosen 1996:53). The implementation of apartheid over forty-five years has resulted in an economic and social crisis in South Africa that in turn has led to high rates of violent crime (Flood, Hoosain & Primo 1997:18). Statistics for homicide and serious assault have escalated dramatically. The destruction of families and stable social conditions by the enforcement of the pass laws and the forced removal of whole communities under the notorious Group Areas Act, which demarcated residential areas for the different “races”, created perfect conditions for a rise in crime. Everyone was continuously exposed to direct or indirect violence. Violence became a legitimate means of resolving conflict, which worsened violence against women and children.

The rise in violent crime coincided with the development of widespread political violence in many black communities (Flood, Hoosain & Primo 1997:19). Political violence first became a significant phenomenon in South Africa in the 1980s, at the time of the mass uprising against continued minority rule. The participants in political violence are largely men. Men also form the majority of those killed in political violence, but a number of political massacres have included killings of the elderly, women and children.

The victims of political violence include not only those killed and injured, but also the displaced (Flood, Hoosain & Primo 1997:20). The destruction of property and creation of “no-go” areas that has accompanied the political violence in South Africa has had the most severe impact on women and children. Women and children form the majority of the displaced, most visibly amongst those found in the camps for displaced people and where individuals and families have sought shelter in existing squatter camps or with relatives in the townships.

UNAIDS (1998:4) states that political situations encourage or compel many men and women to leave their homes and families in search of work and safety. Many migrant and refugee women, men girls and boys turn to sex work to support themselves and their families. The WHO (1997:11) reports that a general break down in law and order occurs during conflict and displacement situations, and this leads to an increase in all forms of violence.

The tensions of conflict, and the frustration, powerlessness and loss of traditional male roles associated with displacement may be manifested in an increased incidence of domestic violence against women and children. Alcohol abuse may also become more common and exacerbate the situation (WHO 1997:12). Flood, Hoosain & Primo (1997:21) add that one of the effects of political violence has been a reinforcement of a violent and “macho” definition of manhood in the affected communities. One of the results of the implementation of the apartheid system was the erosion of traditional systems of patriarchy that were operational within the pre-colonial societies of South Africa. African men retained their dominant role in the family while they were stripped of political power and responsibility. Violence in support of a political cause offered young militants known as “comrades” an opportunity to define themselves in an overtly macho manner, when other routes – as breadwinner and head of a household – were denied. There is evidence that women have been targeted for rape as part of political conflict (WHO 2000:22).

The underlying acceptance of violence against women, which exists within many societies, becomes more outwardly acceptable in conflict situations (WHO 1997:11). It can, therefore, be seen as a continuation of the violence that women are subjected to in peacetime. The violence situation is compounded by the polarization of gender roles, which frequently occurs during armed conflict. An image of masculinity is sometimes formed that encourages aggressive and misogynist behaviour.

The WHO (1997:11) states that some groups of women and girls are particularly vulnerable in conflict and displacement situations. These may include targeted ethnic groups, where there is an official or unofficial policy of using rape as a weapon of genocide. Unaccompanied women or children, children in foster care arrangements, lone female households and women who are held in detention and in detention-like situations, including concentration camps, are all frequent targets. To these the WHO (2000:110) adds that younger women and girls may be specifically selected for rape, being seen as less likely to be infected with HIV.

Women and girls may be idealised as the bearers of a cultural identity and their bodies perceived as a territory to be conquered (WHO 1997:11). Troops may also use rape and other forms of violence against women to compensate for men's suppressed humiliation.

### **3.4.2 Refugees and sexual violence during phases of conflict**

A substantial majority of HIV infections are sexually transmitted (WHO 1999:48). The sexual exploitation that women and girls face in refugee situations may increase their vulnerability to STI, including HIV/AIDS. STIs, including HIV/AIDS, spread fastest where there is poverty, powerlessness and social instability. The disintegration of community and family life in refugee situations leads to the break-up of stable relationships and disruption of the social norms governing sexual behaviour (WHO 1999:48).

The WHO (2000:37) states that sexual and gender-based violence can occur during all phases of a refugee situation:

- prior to flight;
- during flight;
- while in the country of asylum;
- during repatriation and integration.

The WHO (2000:5) distinguishes between four phases of conflict and displacement (Figure 12):

- Phase 1 – Pre-conflict;
- Phase 2 – Conflict;
- Phase 3 – Stabilisation;
- Phase 4 – Return and post-conflict.

#### **3.4.2.1 Phase 1: Pre-conflict**

This stage, as indicated in Figure 12, occurs before the outbreak of full-scale conflict. It is generally characterised by deteriorating economic and social circumstances, civil disturbance and growing instability (WHO 2000:5).

The wave of unrest which began in 1976, and which has reached unprecedented levels since 1984, is regarded by many to be the result of a decline in the legitimacy of the South African Government (Olivier 1992:417). It is generally accepted in the literature that the state has a monopoly of the use (of the tools) of violence such as the police, the military and legislative process, as was the case during the unrest years in South Africa. Van der Vyver (1988:7) points out that violence committed by the state is almost always the result of a lack of legitimacy of a government, constitutional dispensation or legal system.

Another factor that may contribute to violence is poverty. Olivier (1992:416) points out that political, social and economic structures can force poverty onto people, as was the case in South Africa prior to 1994. The violence lies in the fact that poverty forces people to live subhuman lives.

#### **3.4.2.2 Phase 2: Conflict**

Conflict can emerge in discontinuous phases of relative stability and intense fighting (WHO 200:5). Relative stability enables health care providers to offer a more comprehensive range of services. Intense fighting will limit the range of reproductive health services that can be offered. Flight involves the mass migration of people who have fled from their homes in search of safety, and during the journey people may suffer extreme hardship and may arrive at the place of sanctuary in very poor physical and emotional condition. During flight all women, but particularly women who are alone, are at risk of attack from bandits, pirates and smugglers. They may also be at

risk from border guards and members of security forces who demand sex in exchange for safe passage (WHO 2000:111).

During the conflict, police, military or guerrilla forces, prison officers in detention centres, and in concentration camps and rape camps, may perpetrate violence. It may sometimes occur with the support of male leaders who are willing to bargain women or girls for arms, ammunition or other benefits (WHO 2000:111). Military regimes have even developed patterns of punishment specifically designed for girls and women. Copelon (1995:123) describes how this punishment works: “For women sexual abuse, rape, and the forcing of instruments or animals into the vagina are common, as well as among the most devastating forms of torture. Forced undressing, pawing, threats of rape or being forced to perform sexual acts is also common. Torture is very frequently inflicted through means available in everyday life; the commonplace, innocuous or benign is transformed into a weapon of brutality”.

Green (1999:88) states that women are exposed to a distinctive pattern of violence in both intra-national and international conflicts. Whether ordered by the state or initiated by its agents, illegitimate detention, forced sterilization, forced pregnancies, and custodial violence, or abuse while under guard, are clearly political and often gender based. It is widely recognized that women and girls are particularly vulnerable to such violence between the time of arrest and arrival at an official detention centre, or the abuse may even occur without the victim ever being officially arrested.

As in many war and civil unrest situations in the world, this was certainly the case in apartheid South Africa, where thousands of girls and women were detained without charge, and subjected to many forms of coercion and rape as political weapons by the apartheid government (Fester 1989:248). Such treatment of women is not unique to South Africa, as Flood, Hoosain & Primo (1997:15) illustrate the endemic violence in Somalia during which gangs of armed men raped and sexually assaulted groups of women and girls. Rapes were often staged in front of family members and in conjunction with other acts of violence against husbands, parents and children. Infibulated girls (in this regard please refer to Chapter 2, paragraph 7.2.3.1) were cut open with knives before the assault, and women were forced to betray their husbands or face being raped.

The emergency phase involves the initiation of a humanitarian response to the needs of displaced and refugee populations. The purpose is to provide a secure environment to meet people's basic needs for shelter, food, water, sanitation and health care. The emergency phase is generally characterised as a period in which chaos is gradually replaced by structure and organisation in order to meet people's basic needs.

#### **3.4.2.3 Phase 3: Stabilisation**

Stabilisation occurs when the initial emergency has passed, when people have reorganised themselves into families and communities, and facilities to meet basic needs are well established. Life returns to some level of normality. Stabilisation can also be defined as having occurred when the mortality rate has fallen to less than 1-2 per 10 000 per day.

#### **3.4.2.4 Phase 4: Return and post-conflict**

Return is when refugees or internally displaced persons may return to their country or area or origin, either spontaneously or as part of a planned resettlement. Post-conflict is a period of reconstruction and of the reintegration of returnee and previous communities.

According to the WHO (1999:36), perpetrators of sexual and gender violence are often motivated by a desire for power and domination, and rape is common in situations of armed conflict. An act of forced sexual behaviour can threaten the victim's life. Like other forms of torture, it is often meant to hurt, control and humiliate, while violating a person's physical and mental integrity. In conflict situations, sexual violence may be politically motivated – when, for example, mass rape is used to dominate, or sexual torture is used as a method of interrogation (WHO 1999:37).

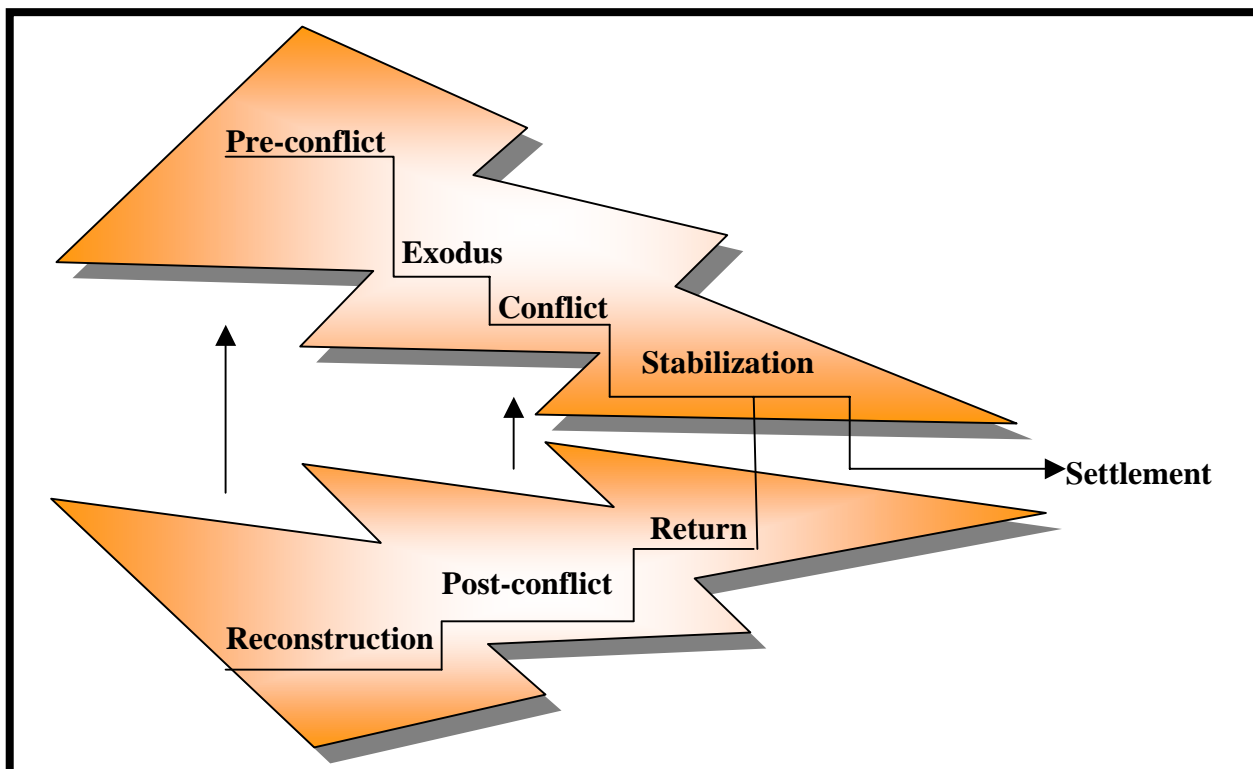
Perpetrators of sexual violence in refugee situations may include fellow refugees, members of other clans, villages, religious or ethnic groups, military personnel, relief workers and members of the host population or family members (WHO 1999:36).

The psychological strains of refugee life may aggravate aggressive behaviour towards women and girls. Male disrespect towards women may be reinforced in refugee

situations where unaccompanied women and girls may be regarded by camp guards and male refugees as common sexual property (WHO 1999:37).

The WHO (1999:38) states that women may be subjected to sexual exploitation if men are responsible for distributing goods and necessities. Women and young girls without proper personal documentation for collecting food rations or shelter material are especially vulnerable to sexual exploitation. The young girls and women may appear to be more willing to provide sexual payment, as more chances to do so exist within the refugee situation. This misguided willingness on the part of young girls and women may be fuelled by feelings of despair and a low self-esteem, due to dire circumstances within the refugee situation that leave them with “nothing else to lose”.

**Figure 13: Phases of conflict and displacement**



Source: WHO (2000:5)

### **3.4.3 The impact of violence, conflict and displacement on the health and vulnerability of the young girl**

The WHO (2000:10) states that violence, armed conflict and displacement have an intensely negative impact on the reproductive health of women, men and adolescents. The combination of poverty, loss of livelihood, disruption of services and the breakdown of social support systems destroys health.

This situation is aggravated by several factors (WHO 2000:10), such as:

- The fact that violence against civilian populations, and acts of gender-based and sexual violence against women and girls (including mass rape), are common features of war and conflict, has tremendous physical and psychological consequences for the women and girls who have been raped, for their families and for future generations.
- Women may be pressurized to give birth to replenish the population. In some cases this may coincide with women's own desire to replace children who have died or disappeared.
- There may be an increase in traditional practices, such as harmful traditional birth practices, in order to replace lost health care services, and in female genital mutilation, in an attempt to maintain cultural and religious identity.
- The spread of STI/HIV is fastest in the conditions of poverty, powerlessness and social instability that accompany conflict and displacement. In addition, mass migration may bring a population of low STI/HIV prevalence, with little knowledge of these infections and how to protect themselves, into contact with populations of high prevalence.
- The reproductive health care needs of men, adolescents and minority groups may be neglected.
- The overwhelming sense of loss (of home and family) and lack of hope for the future may affect the mental health of women, men and adolescents and can lead to an increase in risk-taking behaviours.
- Fertility rates may increase to very high levels, with women and young girls at high obstetrical risk having many pregnancies at close intervals.
- Couples may not have access to family planning services, resulting in an increase in the number of unwanted pregnancies and possibly unsafe abortions.



### 3.4.3.1 Physical consequences of violence

Women and girls who have been subjected to violence may have broken bones, knife wounds, concussion, or any of the other signs of violent assault (WHO 2000:113). For women who have been sexually assaulted, the following points may be relevant:

- Women and girls who have been sexually assaulted may have mutilation or damage to the genitals, including bruising, lacerations, tearing of the perineum and damage to the bladder, rectum and surrounding pelvic structures. Untreated wounds may be infected.
- Damage to the genitals is most severe in girls under 15, and in girls and women who have previously been subjected to female genital mutilation. In addition, these women may be forcibly cut open and are then at a much higher risk of contracting a STI or HIV.
- Other injuries associated with the use of violence during sexual assault include bruising to the arms and chest, patches of hair missing from the back of the head and bruising of the forehead.
- Women who have been sexually assaulted are at high risk of contracting a STI or HIV/AIDS, of developing pelvic inflammatory disease, and of long-term infertility. The increased mobility and changing sexual behaviours associated with conflict and displacement create ideal conditions for the spread of STIs and HIV/AIDS. Damage to the genitals increases the risk of transmission still further.
- There is a high risk of miscarriage of an existing pregnancy, or all the consequences of unsafe abortion, or pregnancy and delivery.
- The most extreme physical consequence is death, which in some situations may be very common for women and girls who are raped.

### 3.4.3.2 Unwanted and early pregnancy

Violence against girls and women may *inter alia* result in unwanted pregnancy, either through rape or by affecting a women's ability to negotiate contraceptive use. Some girls and women may be afraid to raise the issue of contraceptive use with their sexual partners, for fear of being beaten or abandoned (WHO 1997:16).

The WHO (1997:16) further states that adolescents who are abused, or have been abused as children, are much less likely to develop a sense of self-esteem and belonging than those who have not experienced abuse. Abused and violated children are more likely to neglect themselves and engage in risky behaviours such as early and unprotected sexual intercourse. A growing number of studies suggest that girls who are sexually abused during childhood are at much greater risk of unwanted pregnancy during adolescence, and consequently vulnerable with regard to HIV/AIDS infection (UNICEF 2001: 33).

## 4. SUMMARY

This chapter has examined the relationships between certain socio-economical factors such as poverty, sexual violence and violence during conflict situations, and women's vulnerability with regard to HIV/AIDS infection. The interaction between poverty as contributing factor to violence was also discussed, and it became evident that poverty as a socio-economical factor may contribute in a binary way to the vulnerability of the young girl with regard to HIV/AIDS infection.

Firstly, poverty appears to disempower the child caught up in a cycle of poverty or "enabling environment", that may lead to situations such as coercive sexual practices, in which the girl with low self-efficacy is vulnerable to HIV infection. Secondly, poverty may also contribute to violence situations such as sexual violence or political violence that is endorsed by the state, in which abuse such as sexual threats, exploitation, humiliation, rape, prostitution and torture may render the girl vulnerable to HIV infection.

In this chapter it was also apparent that the different forms of sexual violence, such as incest and rape, that many girls and women are exposed to in a male dominated socio-

economical and political environment, may predispose the young girl to uncontained social situations in which she becomes vulnerable with regard to HIV infection.

## CHAPTER 4

### IMPLICATIONS FOR EDUCATION

#### 1. INTRODUCTION

##### 1.1 Aim of this chapter

The aim of this chapter is to discuss the implications for education of certain contextual factors that may increase the adolescent's and especially the young schoolgirl's vulnerability to HIV/AIDS infection.

##### 1.2 The concept "context"

According to the Readers' Digest Universal Dictionary (1988: 343) the word "context" refers to "circumstances in which a particular event occurs, a background". The word is derived from the Latin word "*contextus*" and means, "to join together". For the purposes of this study "contextual" will refer to the circumstances in the life of the adolescent, and especially the young girl, that may increase her vulnerability to HIV/AIDS infection.

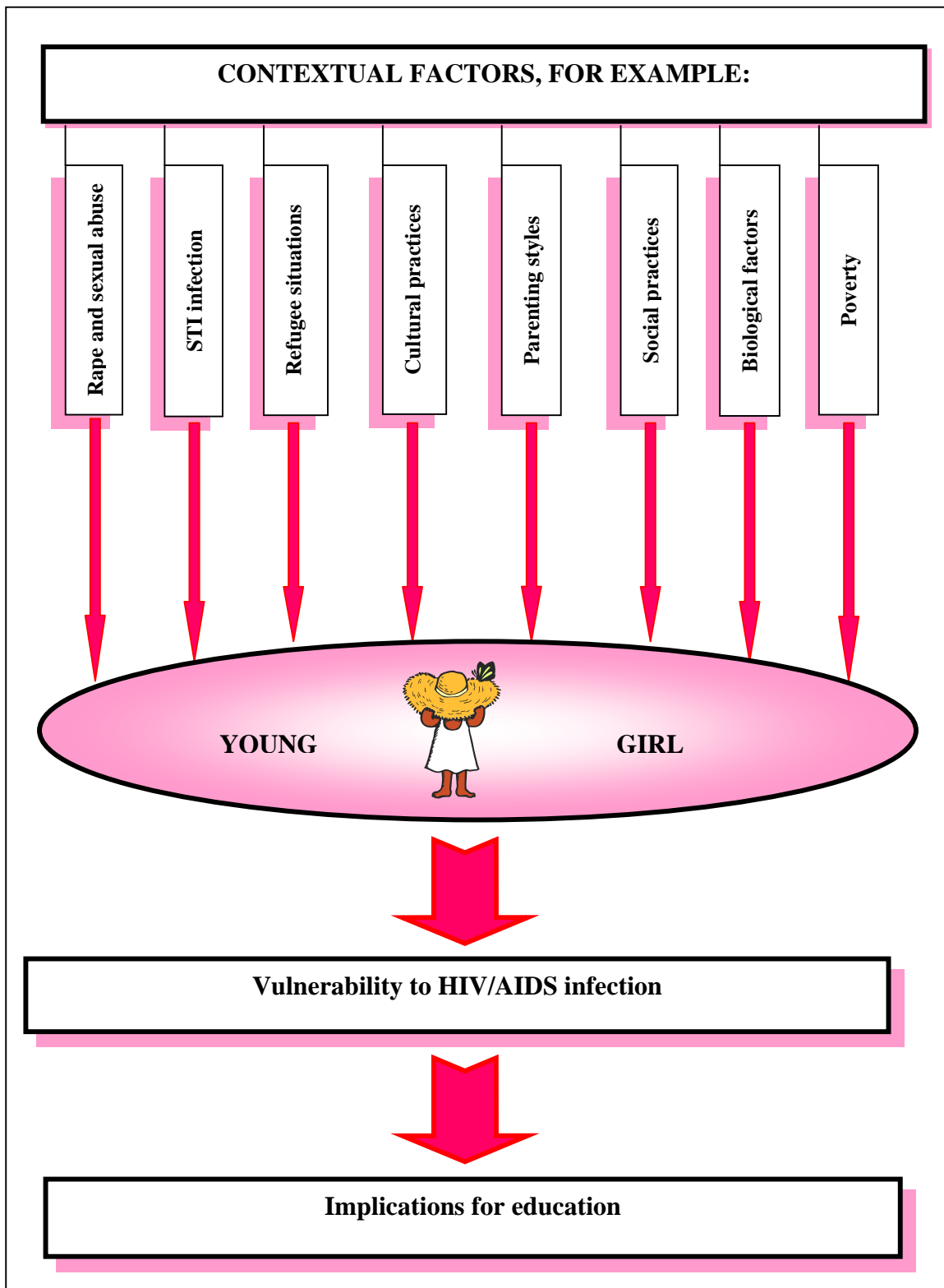
##### 1.3 Contextual factors that increase vulnerability

Contextual factors identified in the previous chapters are for example the biological susceptibility of girls to HIV/AIDS infection (Chapter 2), the social disposition of girls and women (Chapter 2), rape and sexual abuse (Chapter 3), the woman's susceptibility to STI infection (Chapter 3), refugee situations (Chapter 3), poverty (Chapter 3), certain cultural practices such as FGM (Chapter 2), and parenting styles (Chapter 2) – this appears to be the context within which girls are predisposed to HIV/AIDS infection (Figure 14). The context in which the young girl becomes more vulnerable to HIV/AIDS infection may consist of a single factor such as rape, or a compilation of factors such as biological factors or, for example, social disposition and cultural practices.

The contextual factors that increase the girl's vulnerability to HIV/AIDS infection direct an appeal to educators and all relevant stakeholders. The young girl in the midst of prevailing customary and biological contextual factors that decrease her

assertiveness has to be empowered to become less vulnerable to HIV/AIDS infection. From this discussion the following question may arise: What are the implications of HIV/AIDS for education in general (the school), and for the education of the young girl so that she could become less vulnerable?

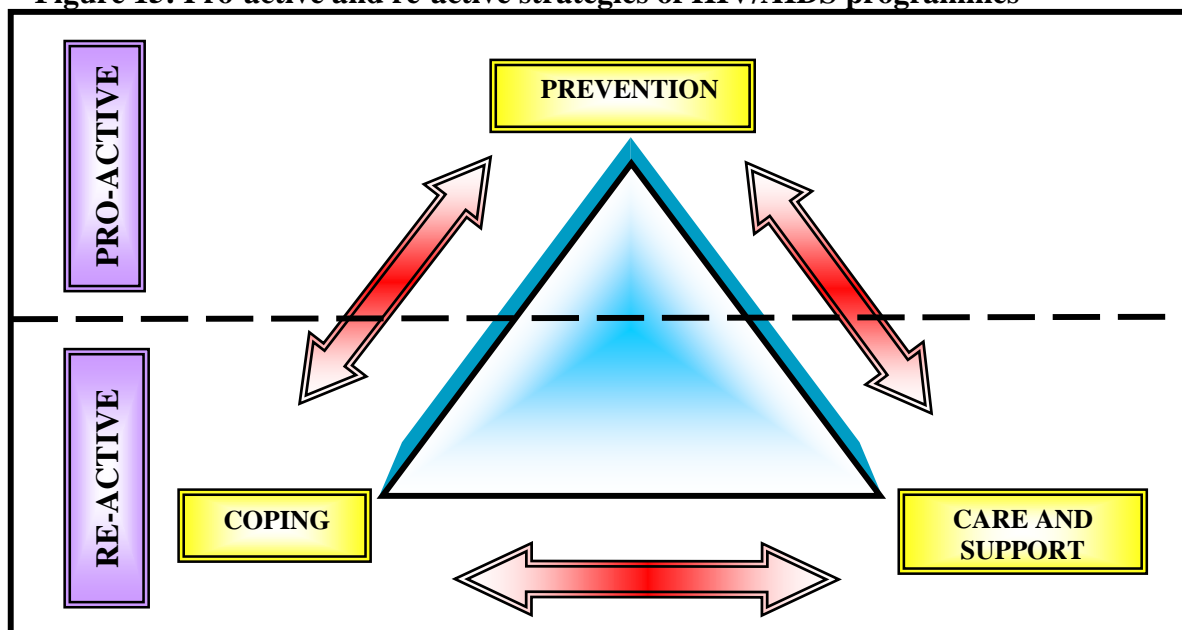
**Figure 14: Contextual factors that may increase a girl’s vulnerability to HIV/AIDS infection.**



### 1.4 Current HIV/AIDS prevention strategies

The cure for HIV/AIDS is still waiting to be discovered while life-prolonging drugs are expensive and largely unavailable in less developed countries (Lamprey, Wigley, Carr & Collymore 2002:22). Currently prevention strategies remain the fortitude of programmes to curtail the HIV/AIDS pandemic for the imminent future. Comprehensive HIV/AIDS programmes that embrace prevention, care, treatment, and support interventions that are accessible and affordable to the majority of people in need of these services, appear to be amongst the best solutions advocated by HIV/AIDS specialists. The most efficient means of fighting the HIV/AIDS pandemic, amongst other strategies, focus on behavioural change, including postponement of sexual debut, which is a challenging message to communicate to young adolescents and adults (Kelly 2000:9). The majority of strategies focus on the prevention of HIV/AIDS infection (pro-active) and the care and support of those infected and affected by HIV/AIDS (re-active). One can distinguish between pro-active and re-active strategies, but they function as a unit with interlinked programmes that support and depend on each other (Figure 15).

**Figure 15: Pro-active and re-active strategies of HIV/AIDS programmes**



**Source: Adapted from Van Rooyen & Hartell (2001: 10)**

Successful prevention efforts also include other features such as the provision of education with regard to high-risk sexual behaviour, distribution of condoms and

promotion of condom use, diagnosis and treatment of STIs, provision of voluntary counselling and testing (VCT), caring and coping mechanisms, and reduction of the stigma attached to HIV/AIDS (Lampthey, Wigley, Carr & Collymore 2002:23).

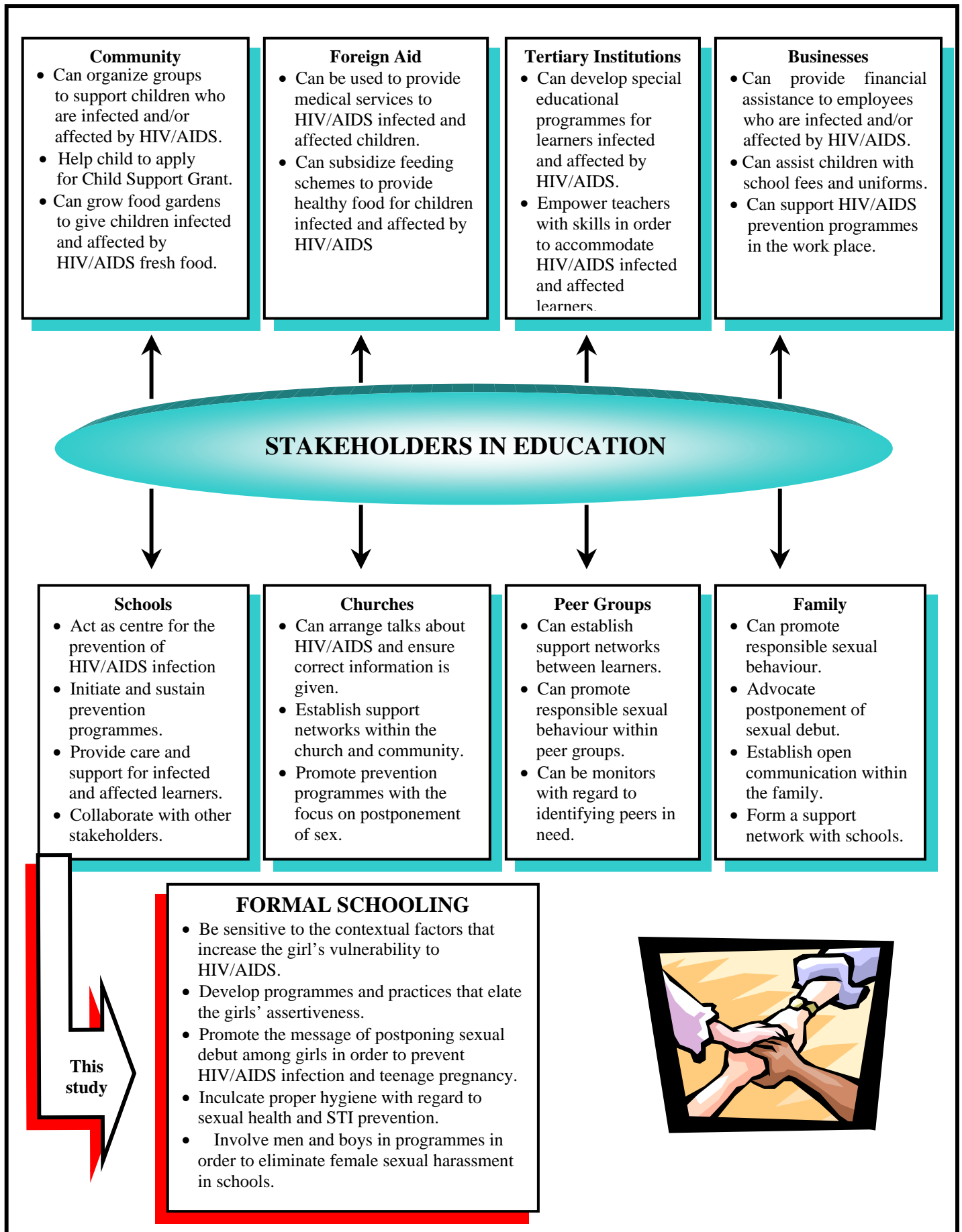
According to Coombe (2001b:1), education can no longer be 'business as usual'. Constructs at the heart of education such as curriculum development and educational support services have to change under the weight of political will and the prevailing effect of the HIV/AIDS pandemic. Prevention programmes, as mentioned above, can only be effective if they reach the people most at risk to HIV/AIDS infection, such as adolescents and especially young girls. Van Rooyen & Hartell (2001:15) emphasize that society expects the school to reduce the spread of the virus and to take up its responsibility in the fight for survival against the dreaded virus. Utilizing educational structures and institutions may be the easiest and most accessible way of getting prevention strategies across to adolescents in an effort to promote responsible sexual behaviour - which appears to be amongst the best strategies in preventing HIV/AIDS infection.

## **2. APPEAL TO ALL STAKEHOLDERS IN EDUCATION**

The identified contextual factors (Figure 14) direct an appeal to all the stakeholders in education. All stakeholders involved in education should be assisting and complementing one another in the effort to curb the rapid spread of HIV/AIDS. Various programmes may therefore be employed by different stakeholders to ensure that awareness and prevention of HIV/AIDS amongst adolescents are promoted (Figure 16).

Kelly (2000:34) is of the opinion that the rationale of all programmes, especially educational programmes, should be the inculcation of values and attitudes that are optimistic to life and reject premature, casual, unprotected or socially unacceptable sex and sexual experimentation.

Figure 16: The role of stakeholders in education





Even though there are many educational stakeholders, as for example mentioned in figure 16, involved in the process of education, this study will focus on formal schooling and what the school as the major educational stakeholder can do to prevent HIV/AIDS infection of the young girl in particular.

### **3. HIV/AIDS: THE BINARY IMPACT ON EDUCATION**

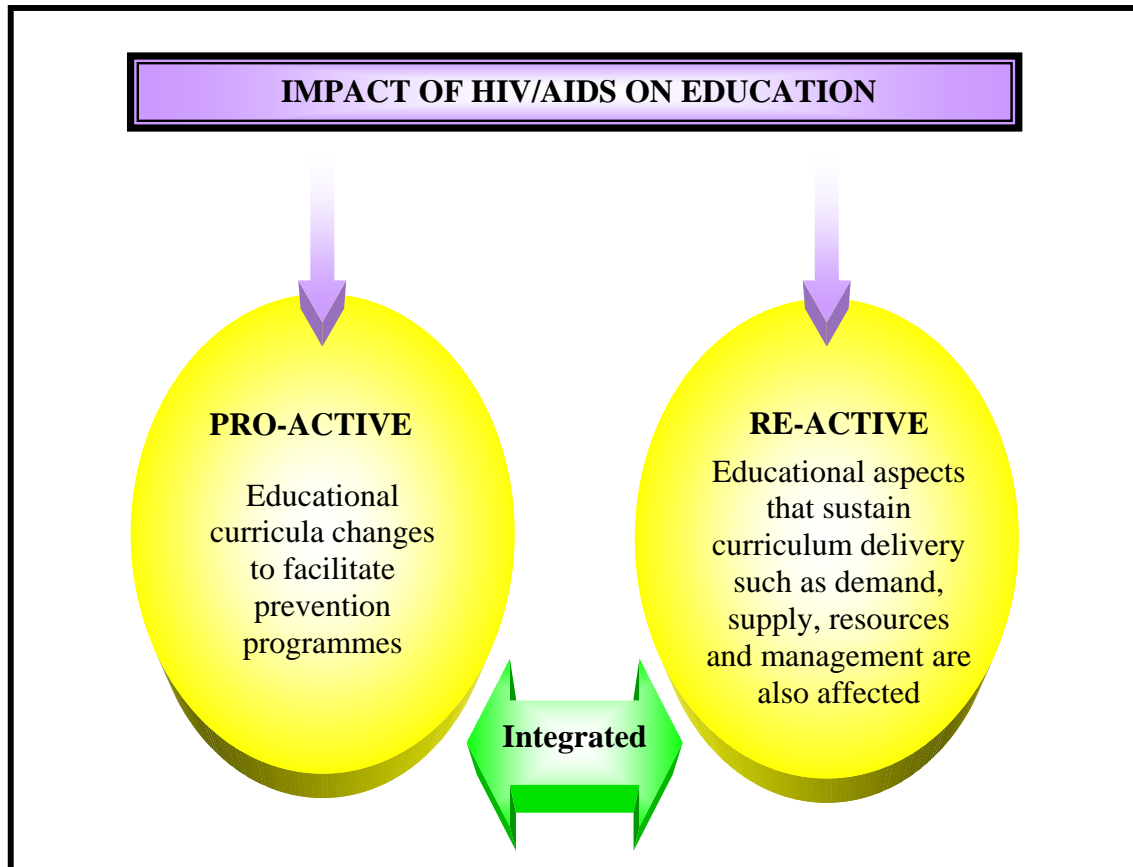
HIV/AIDS appears to have a binary impact on education. It requires extensive and immediate change of the educational curricula, planning and delivery in order to empower the young girl to become more assertive and less vulnerable to HIV/AIDS infection amid many contextual factors that may contribute to HIV/AIDS infection. Further aspects of the education system such as management styles, management of human resources, establishment of support services and resources, demand and supply are adversely affected by HIV/AIDS (Kelly 2000:32).

It is impossible to establish a definite role for education in reducing the spread of HIV/AIDS without taking the impact of the disease on the demand, supply, resources and quality aspects of education into account. It appears that education will have to facilitate both the pro-active strategies such as prevention programmes as well as re-active strategies such as empowering infected and affected learners to care for themselves and cope with living with HIV/AIDS (Figure 17).

Kelly (2000:45) mentions ten different aspects of education that may be affected by HIV/AIDS, such as:

- the demand for education;
- the potential consumers of education;
- the supply of education;
- the process of education;
- the organization of schools;
- the role of education;
- the availability of funds for education
- aid agency involvement in education;
- the planning and management of education systems.

Figure 17: The binary impact of HIV/AIDS on education



The discussion that follows will firstly focus on the demographical impact of HIV/AIDS on educators and learners within the school as educational institution (re-active). Secondly some implications that the impact of HIV/AIDS may have on educational institutions such as schools, in consideration of the fact that adolescents and especially young girls appear to be more vulnerable to HIV/AIDS infection, due to certain contextual factors, and are in urgent need to be empowered by the school to ensure the eradication of their vulnerability to HIV/AIDS infection (pro-active).

In a school's efforts to empower adolescents and especially young girls to become less vulnerable to HIV/AIDS infection, several aspects of schooling, such as the curriculum, management, policy and organization may be implicated. Kelly (2000: 32) states that the role of education in reducing the spread of HIV/AIDS infection is essentially with regard to the subject of curriculum issues, the content of educational programmes and how they are organized and delivered.

### **3.1 The impact of HIV/AIDS on educators and education supply**

Kelly (2000:63) mentions that HIV/AIDS affects the supply of education because of the loss of trained and experienced teachers through death, reduced productivity of ill teachers and the passing away or frailty of education officers, finance officers, inspectors, planning officers and management personnel. In some countries the closure of classes or schools as a result of population decline and the consequent decline in enrolments, or because of teacher shortages, also affect the supply of education.

#### **3.1.1 The impact of HIV/AIDS on educators**

Van Rooyen & Hartell (2001:22) and Kelly (2000:40) state that educators are also a high-risk group with regard to HIV infection. The apparent relationship between level of education and risk of HIV infection may be attributable to the association between higher levels of education and greater mobility that increase the possibility for greater sexual promiscuity. In South Africa educators form the largest occupational group to be infected with HIV/AIDS: 12% or 44 400 of the current 443 000 educators are reported to be infected with HIV (Business Report 17 July 2000:16); 88 000 to 133 000 educators will have died by 2010 (Kelly 2000:64). The immediate consequences of this fact may be as follows:

- an escalation of medical costs,
- an annual increase of the death rate amongst educators who are HIV+ and have no access to appropriate treatment, and die within seven years of infection,
- the number of educators in schools will be reduced, coupled with significant loss of specialization,
- increased absenteeism of educators (bearing in mind that the absence of one teacher has an impact on a large number of children),
- general loss of educators to other sectors of the workplace, due to the need for educated personnel to replace those lost to AIDS,
- reduction in the supply and quality of education,
- deterioration of school effectiveness,
- debilitation of the school's capacity to curb further HIV infection amongst adolescents.

### **3.1.2 The impact of HIV/AIDS on learners and education demand**

Kelly (2000:48) states that HIV/AIDS has severe implications for education demand as there will be fewer learners to educate, fewer learners wanting to be educated, fewer learners able to afford education, and fewer learners who complete their schooling.

#### **3.1.2.1 The ebbing school enrolment**

HIV/AIDS will affect the size of learner populations as the increasing mortality rate among adults of reproductive age and declining fertility rates will result in fewer children being born. The increasing mortality rate of children infected with HIV around the time of birth (of whom the majority pass away before the age of five) results in fewer potential learners than there would have been without AIDS (Abt Associates 2001: 4; Kelly 2000: 48).

The ebbing of school enrolment in South Africa may further decline if orphans and other vulnerable children do not enrol, delay enrolling, or leave school in large numbers (Van Rooyen & Hartell 2001:23). Orphans are more likely to be denied education and children affected by HIV/AIDS often perform poorly at school and their drop-out rates are high (Coombe 2001:11).

Kelly (2000:50) mentions that apart from the direct school fees that have to be paid, learners have indirect costs related to education with regard to educational materials, educational activities, school uniform and transport. Many learners, and especially orphans who may live with HIV+ persons, may not have cash available for these purposes. The family cannot afford to send learners to school, with the result that learners stop attending school following the death of the parent.

#### **3.1.2.2 Erratic school attendance of learners**

Erratic school attendance may occur as school enrolment rates decline and learners experience additional barriers to participate in educational programmes. Van Rooyen & Hartell (2001:23) are of the opinion that traumatized learners, ill learners, caregivers and heads of households may be absent from school for a considerable period of time (in this regard also refer to Chapter 2 paragraph 4.2.7.6 of this study). These

learners may be referred to as “drop-outs” and “drop-ins” who may have the additional responsibility to supplement the family’s income, care for sick parents or family members, or are too discouraged to attend school. A possible implication for educational managers and teachers is that more flexible learning opportunities should be designed, as “drop-outs” and “drop-ins” might want to have a second chance to complete their education.

Kelly (2000:51) attributes possible erratic school attendance to some attitudinal barriers that learners may experience once HIV/AIDS has struck in their families:

- Some learners may be absent because of fear of the stigma and ridicule they may encounter at school or because of the trauma learners have experienced in seeing a parent or beloved family member suffering a mortifying death.
- Parents in certain countries experience a sense of fatalism. The parents question the value of sending learners to school amid the possibility that these learners may die before benefiting from any economic returns for what was spent on their education.
- Some parents may not want to send their children to school in an effort not to expose them to HIV infection. This parental attitude may stem from the apparent correlation between educational status and increased vulnerability to HIV infection that existed in the past. “Parents may value education as opening the door to greater prosperity, but they do not want to expose their children to the risk of HIV infection” (Kelly 2000: 52).
- It also appears that, in the presence of HIV/AIDS related trauma in the family, girls are more likely to be kept away from school than boys. Girls are expected to provide domestic care and service in an HIV/AIDS stricken household, marry early and bear as many children as possible to ensure the continuity of the family (in this regard also refer to Chapter 2 paragraph 6.3.3 of this study) and to qualify for the maximum subsidy provided for teenage mothers by the South African government.

- Some parents do not allow their daughters to attend school or other educational programmes because of certain practices such as the “sugar daddy” ritual, during which older men turn to young girls for sex, or perceive a sexual encounter with a young uninfected girl to be a cure for HIV/AIDS infection (in this regard also refer to Chapter 2 paragraph 2.2.4 of this study).
- Sexual harassment of girls by educators, and submission of girls to teacher harassment out of fear for discrimination, punishment or failure may also contribute to parents withholding their daughters from attending school (in this regard also refer to Chapter 3 paragraph 3.3.3 of this study).
- In some cultures educated, independent and unmarried women are regarded as inauspicious and therefore some girls are not sent to school (in this regard refer to Chapter 2 paragraph 6.3.3.2).
- During periods of unrest and conflict, especially within the refugee situation in some countries, learners’ educational demands are neglected or abolished. These learners may also be characterised as “drop-outs/drop-ins” (in this regard refer to Chapter 3 paragraphs 3.4.1- 3.4.3).

#### **4. IMPLICATIONS FOR EDUCATIONAL PROGRAMMES AND CURRICULA AS EMPOWERMENT TOOLS**

As mentioned in the introduction of this chapter (paragraph 2), the role of the educational sector in curtailing the spread of HIV/AIDS infection essentially has to do with curriculum issues, the content of educational programmes and how they are organized and delivered. In this study the focus will be on curriculum strategies that may empower the girl to be less vulnerable to HIV/AIDS infection.

Kelly (2000:33) states that the objective of all control and preventative programmes since the 1980s and early 1990s focused on how the further spread of HIV/AIDS could be prevented and on promoting change in behaviour that would make HIV transmission less likely. In view of the fact that three-quarters of global HIV transmission occurs through sexual activity, the majority of behaviour-change

programmes are directed towards empowering individuals with knowledge and skills to avoid sexual behaviour that would place them at risk of HIV infection. Therefore, Sexuality and Health Education as a fundamental part of the school curricula has been introduced in both industrialised and developing countries to help disseminate information regarding HIV/AIDS, reproduction, and human sexuality (UNAIDS 2001b:14).

Behaviour cannot be changed by knowledge alone, as adolescents need skills to put what they learn into action (WHO 2002: 29). Skills in negotiation, conflict resolution, critical thinking, decision-making and communication are vital for adolescents, to enable them to relate to each other as equals, working in groups, building self-esteem, resolving disagreements peacefully and resisting both peer and adult pressure to take unnecessary risks.

The teaching response to HIV/AIDS, known as HIV/AIDS Education, Reproductive Health and Sex Education, Lifeskills or Life Orientation, is generally defined as including the ability to distinguish between healthy lifestyles and risky behaviours such as unsafe sex, substance abuse, and violence (Coombe 2001a:16). The HIV/AIDS education and teaching materials are generally supposed to communicate relevant knowledge, inculcate gender appropriate values and attitudes, and the development of a personal capacity among learners to sustain or embrace behaviour that will minimize or eradicate the risk of becoming HIV infected. Sexuality education entails *inter alia*, formal education about HIV/AIDS and other reproductive health matters, and it can be an effective way of providing information to help both adolescents and adults to protect themselves from sexually related illnesses such as HIV/AIDS (UNAIDS 2001a:15).

Kelly (2000:41) is of the opinion that the minimum requirements with regard to curriculum content and delivery strategies should include:

- reproductive health and sexual education;
- HIV/AIDS in the community;
- psycho-social life skills;
- human rights, relationships and responsibilities;
- incorporation of reproductive health and sexual education as part of the curriculum as soon as children start school;

- enhanced reliance on peer education within the school and in the community;
- capitalizing on the resources inherent in persons living with HIV/AIDS;
- extensive involvement of communities, NGO's, businesses, churches and voluntary organizations;
- thorough re-orientation and re-training of teachers;
- establishing linkages with critical support services, especially in the health sector.

#### **4.1 Implications for training and empowerment of educators**

According to Coombe (2001a:5), it is imperative for all educators, students training to be educators and especially education managers, to understand the contextual circumstances under which HIV/AIDS infection increases (in this regard refer to figure 14). Educators are the first barricades, after medical professionals, in the fight against HIV/AIDS infection. Educators' contact with HIV/AIDS infected persons may proliferate as they deal with an increasing number of HIV/AIDS infected learners in their classrooms, as well as in situations where they themselves or their colleagues may be HIV/AIDS infected (Department of Health 2001:1).

##### **4.1.1 The mounting responsibilities of educators**

Van Rooyen & Hartell (2001:17) argue that educators can no longer elude their responsibility to empower and inform learners with regard to comprehending, taking control of and being responsible for their own bodies and sexual health. Educators must acknowledge the dynamic sexual energy that forms part of each human being together with the fact that the adolescent is overwhelmed by sexually provocative material (in this regard also refer to Chapter 2, paragraph 5.2.3 of this study).

The responsibilities and traditional role of the educator amid the challenges of a fast changing world and the immense impact that HIV/AIDS has within the educational sector necessitate that the role of the educator will have to be much more diverse (Figure 18). The National Education Policy Act that outlines the norms and standards for educators (Act 27 of 1996) points out the following seven roles of educators:

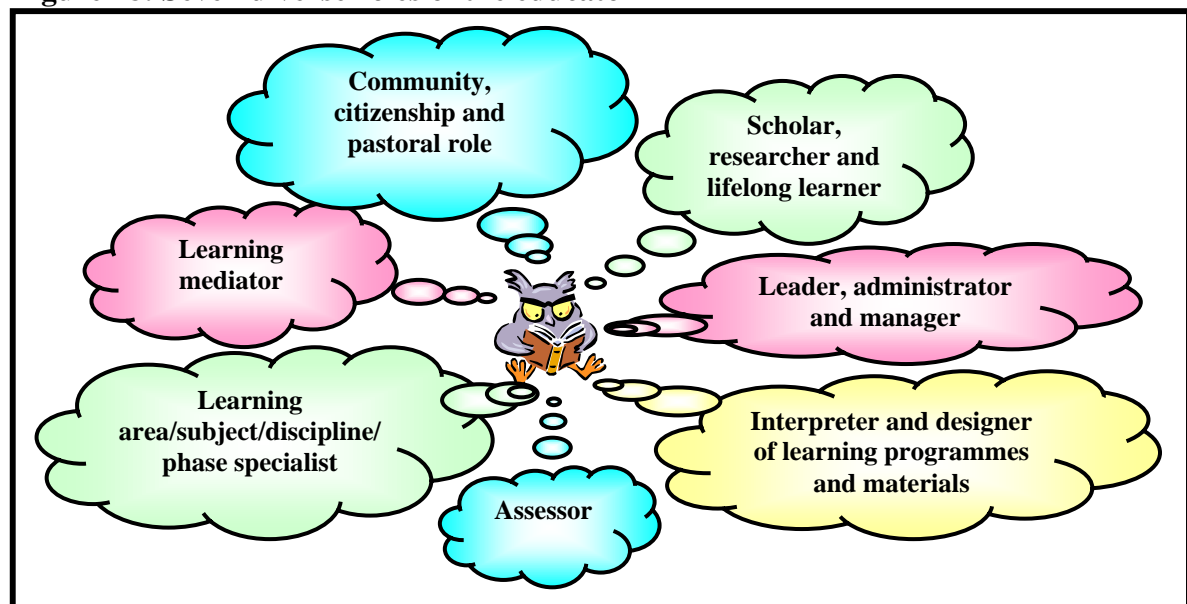


- ❑ Learning mediator;
- ❑ Interpreter and designer of learning programmes and materials;
- ❑ Leader, administrator and manager;
- ❑ Scholar, researcher and lifelong learner;
- ❑ Community, citizenship and pastoral role;
- ❑ Assessor;
- ❑ Learning area, subject, discipline, phase specialist.

According to the Department of Health (2001:6), the roles of community facilitator and pastoral care giver may not have been seen as the task of an educator, even though many educators have historically fulfilled this task on account of the need in their community and it may include one or more of the following tasks:

- ❑ The ability to respond to contemporary social and educational problems such as violence, drug abuse, poverty, child and women abuse, HIV/AIDS and environmental degradation;
- ❑ Gaining access and working in partnership with professional services to deal with these issues (multi-disciplines working together);
- ❑ Render counselling and/or tutoring learners in need of assistance regarding social or learning problems;
- ❑ Demonstrating caring, committed and ethical professional behaviour and a conception of education as dealing with the safety and security of learners and the development of the person in totality.

**Figure 18: Seven diverse roles of the educator**



**Source: Adapted from The Department of Health (2001: 6)**

The primary responsibility of the educator with regard to sexuality or HIV/AIDS education is to teach learners about safe sexual behaviour and the values consistent with healthy community life (Coombe 2001b:5). Furthermore, the National Education Policy Act (Act 27 of 1996) directs educators to:

- ❑ Protect the rights of all learners;
- ❑ Provide education and opportunities to all learners infected with HIV/AIDS;
- ❑ To provide learners with care and counselling;
- ❑ To create a safe and secure environment in institutions of learning;
- ❑ Apply infection control measures universally, regardless of any learner's HIV status;
- ❑ Employ adequate wound management in the classroom, laboratory and on the sports field or playground when a learner sustains an open, bleeding wound;
- ❑ Assist in mitigating the impact of HIV/AIDS on those they teach and support learners to cope with the disaster;
- ❑ Educate learners about their rights concerning their own bodies, to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV/AIDS;
- ❑ Present Life-skills Education on an ongoing basis that embraces HIV/AIDS education and promotes abstinence of sexual intercourse.

According to Coombe (2001a:15), there are fundamental practices that should be evident in learning institutions to mitigate the long-term consequences of the HIV/AIDS pandemic for learners. Educators should be:

- ❑ conversant with HIV/AIDS as a disease, the traumas associated with the HIV/AIDS pandemic, the socio-economic context in which the pandemic reveals itself, and their roles and responsibilities for guarding and guiding children and young people.
- ❑ equipped with basic knowledge and appropriate counselling and caring skills.
- ❑ able to create a learning institution that serves as a safe haven for all those who learn and teach there. This implies zero tolerance for

discrimination, violence or abuse but a guarantee for the safety and security of all learners and educators.

- developing more creative responses to meet the complex learning needs of those who are affected by HIV and AIDS, in order not to lose young people to learning by:
  - reviewing and adapting the curricula to meet the needs of learners who are outside of the formal system;
  - timetabling and setting calendars more flexibly in response to the needs of the community they serve;
  - using teaching techniques like distance learning, peer group work, radio and television that do not require teachers or physical structures;
  - involving community members in schools.

According to Van Rooyen & Hartell (2001:17), learners are in desperate need of the guidance of trained and understanding educators with regard to sensitive issues such as sexual maturation and the coupled rise of the sex urge during puberty, sexual activity as to abstinence, safer sex, masturbation, contraception, and the role of values in responsible decision-making. A trained and motivated educator, who aims at preventing the learner becoming HIV infected and at minimizing the vulnerability and defencelessness which may expose the adolescent to HIV infection during risky circumstances, can successfully address these issues (in this regard refer to Chapter 2, paragraphs 6.3.3; 7.1.2.6; 7.2.3 of this study).

#### **4.2 Impact of HIV/AIDS on management and leadership**

According to Coombe & Kelly (2001:3), the education system has to respond creatively in order to provide meaningful, relevant educational services of acceptable quality to learners in and out of the formal education system. This creative response will also require particular action at the level of education management. Society and especially the community that is served by a school has a need for the school to curb the spreading of HIV/AIDS and to take up its responsibility in the fight for survival against a dangerous, indistinct and obscured rival. Effective management and scrupulous education on the part of the school may produce future citizens with the ability to prove themselves as norm-dependent and conscientious adults who can face

a vigorous, changing world in which some of the values of the past may be inappropriate tomorrow and even today (Van Rooyen & Hartell 2001:1).

Taking the facts with regard to the impact of HIV/AIDS on educators and learners (as mentioned in paragraphs 3.1– 3.2.2 of this chapter) into consideration, education specialists warn that more has to be done than “wearing red ribbons and distributing condoms” (Van Rooyen & Hartell 2001:16).

#### **4.2.1 Preventative orientated management**

The implications of HIV/AIDS, with special reference to the risks that adolescents are exposed to, may have far-reaching implications for the education sector. According to Van Rooyen & Hartell (2001:5), many of the appalling implications may not be known yet, but one recognized implication that influences the school directly and demands the attention of educational leaders and principals, is that effective management and leadership with regard to HIV/AIDS prevention is of paramount importance in every school.

Successful preventative management in a school may commence with a school-orientated strategic plan that is appropriate to manage HIV/AIDS-related crises (Coombe 2001b:34). Van Rooyen & Hartell (2001:10) suggest a triangular management approach based on the Policy of the Department of Education of South Africa (Government Gazette 20372, 1999).

With a triangular management approach (Figure 15) the focus may be on prevention with the aim of reducing HIV infection rates, on formulating coping strategies to mitigate the impact of the disease on learners and educators, and on care that avails post-exposure knowledge and services to all infected and affected persons within the community of the school. The manager of the school or principal should face up to the attack on HIV/AIDS and manage it with the same responsibility and devotion as he or she manages other management areas in the school (Van Rooyen & Hartell 2001:17).

For the purposes of this study, the focus with regard to management of an HIV/AIDS programme within the school will be on the preventative strategies that principals and school managers may develop within the framework of the contextual factors that place the adolescent at risk to HIV/AIDS infection.

#### **4.2.2 Implementing a health and HIV/AIDS information bank**

Health information and knowledge within a school should form part of the Health Education that is presented to all learners. According to Larson & Narian (2001:32), learners should be educated with regard to sexuality, reproductive health and prevention of STIs and HIV before they become sexually active.

The many facets of the child as a human being, such as the physical, emotional, spiritual, social and intellectual, can be distinguished but should be addressed as a whole and never be separated (Van Rooyen & Hartell 2001:26). This awareness of a person that functions as a whole “oneness” forms the basis for a healthy and balanced family life and life style, and it should be kept in mind that a person can only be his or her best if he or she functions holistically. Therefore teachers and principals should keep in mind that a child has to be addressed holistically when health and HIV/AIDS knowledge is presented.

Van Rooyen & Hartell (2001:10) state that with regard to health knowledge the child should acquire and internalise as much knowledge as possible accompanied by relevant skills, as a condition for maintaining good health and a positive lifestyle. Adequate health knowledge may prevent the adolescent from risky, irresponsible and potentially harmful behaviour and may be beneficial with regard to maintaining the best health possible in the midst of an illness.

To start with, the school principal should avail as much information with regard to HIV/AIDS as possible. The vast range of HIV/AIDS documentation includes extensive medical elucidations, extended user-friendly computerised databases, and general information available in almost all languages for readers from of all levels of society. Information exists to inform the illiterate, visually and hearing impaired, young children and isolated rural families who do not have access to media and other resources (Van Rooyen & Hartell 2001:27).

### **4.2.3 The HIV/AIDS school policy as an empowerment instrument**

#### **4.2.3.1 Rationale for an HIV/AIDS school policy**

Considering the fact that many educators and learners are infected and affected by HIV/AIDS (in this regard refer to paragraph 3.1 and 3.2 of this chapter), an HIV/AIDS policy may empower the school with regard to the institution's position and practices relating to all stakeholders of the school community. The policy should be a written document stating the institution's position and procedures that informs concerned stakeholders on what is expected of them (Van Rooyen & Hartell 2001: 27).

#### **4.2.3.2 Function of an HIV/AIDS school policy**

Van Rooyen & Hartell (2001:28) state that it is not a requirement for the school's HIV/AIDS policy to provide for an entire HIV/AIDS programme. The policy should serve as a strong foundation on which to build a sound HIV/AIDS programme. It is suggested that an HIV/AIDS policy:

- ❑ set the framework for communication, debate and consultation on HIV/AIDS;
- ❑ serve as the cornerstone for the school's entire HIV/AIDS programme;
- ❑ enhance consistency and stability within the school;
- ❑ establish principle standards with regard to the behaviour and conduct of all stakeholders in the school;
- ❑ identify the sources of available assistance and the procedures that have to be followed;
- ❑ instruct and direct educational managers on how to address HIV/AIDS in their schools.

#### **4.2.3.3 Discrepancy of an HIV/AIDS policy as to a "Rule Book"**

An established "Rule Book" or code of conduct that may exist at schools usually contains established practices or rules that determine and direct behaviour within a school. Such established practices or rules are often laid down within a school's code of conduct after harmful and risky incidences have occurred and they are usually not established in advance for guiding future behaviour and actions. With regard to the

prevention of HIV/AIDS infection, it may be detrimental and even fatal to postpone the establishment of a policy that guides future behaviour until after harmful and risky incidences have occurred. Policy needs to be established in advance (Van Rooyen & Hartell 2001:28).

#### **4.2.3.4 The National Policy as a guide for an HIV/AIDS school policy**

The development of a unique HIV/AIDS policy within the school is directed by the South African Schools Act, Act 84 of 1996, as it must be kept in mind that the National Policy places an obligation on all parties and functions as the framework for the development of any school policy (South African Schools Act, Act 84 of 1996).

The policy provides the framework for:

- ❑ Compulsory basic education for all learners from the age of seven (or grade 1) to the age of 15 (or grade 9).
- ❑ Banning unfair discrimination policies and discriminatory educational practices in public schools, even though School Governing Bodies (hereafter referred to as the SGB) determine admission policies for respective schools.
- ❑ Admitting learners with disabilities into mainstream schools, where reasonably practicable. Schools are encouraged to ensure that their facilities are accessible to learners with disabilities.
- ❑ The special education of learners (at special schools) that cannot be taught properly at mainstream schools.
- ❑ Ensuring that no learners are excluded from a school because of the non-payment of school fees. Although school fees are determined by majority resolution of the parent body, parents have the right to appeal if they cannot afford to pay school fees.
- ❑ Providing home schooling.

The National Education Policy Act, Act 27 of 1996, and the National Policy on HIV/AIDS for learners in Public Schools, keep to international standards, educational law and the constitutional guarantees of the right to a basic education, the right not to be unfairly discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion, thought, belief and opinion, the right to freedom of association, the right to a safe environment, and the best interests of the learner.

Van Rooyen & Hartell (2001:12) are of the opinion that the SGB, under initiative of the principal, should, as part of their allocated functions (according to the South African Schools Act, Act 84 of 1996) develop a unique HIV/AIDS policy and implementation plan for the school, that reflect the needs, ethos and values of that specific school and its community. The school policy should address aspects such as a detailed plan on HIV/AIDS prevention, coping strategies with regard to care for the HIV/AIDS infected and affected learners and educators, as well as particular attention to aspects such as:

□ **Non-discrimination and equality**

All learners and educators with HIV/AIDS have the right not to be unfairly discriminated against in any way (Department of Health 2001:8). The school's policy with regard to HIV/AIDS should ensure that all learners and educators within the school are treated in a just, humane and life-affirming way (Van Rooyen & Hartell 2001:14).

□ **Admission to school and HIV/AIDS testing**

No learner may be denied admission to a school or be deprived of his or her continued attendance at a school on account of his or her HIV status. Routine HIV testing of learners and educators, to determine the prevalence of HIV/AIDS in a school is regarded as illicit.

□ **School attendance for learners with HIV/AIDS**

The needs and rights of learners infected with HIV to basic education are enshrined within the National Education Policy, Act 27 of 1996. Learners infected with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to function effectively. When learners with HIV become debilitated due to illness, or if they pose a significant medically recognised health risk to others at the school, they may be granted exemption from school attendance (South African Schools Act, 1996, Section 4(1)), or their parents may educate them with material made available for study at home.



□ **Confidentiality, disclosure of HIV/AIDS-information and status**

It is of paramount importance that confidentiality with regard to the HIV/AIDS status of any person be maintained under all circumstances. According to The National Education Policy, Act 27 of 1996, no learner, or his or her parent, or educator, is compelled to disclose his or her HIV/AIDS status to any school authorities.

Any learner (above the age of 14 years) with HIV/AIDS, or his or her parents, is free to voluntarily disclose the HIV/AIDS status of the learner. Sincere voluntary disclosure of a person's HIV/AIDS status should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated.

It is of vast importance for principals and educational managers to see to it that any person, to whom any information about the medical condition of a learner or teacher with HIV/AIDS has been divulged, shall keep this information confidential. Disclosure of a person's HIV/AIDS status to third parties may nevertheless be authorised by the informed consent of the learner (if the learner is above 14 years of age), or his or her parents; or be justified by statutory or other legal authorities. Unauthorised disclosure of HIV-related information could give rise to legal liability.

□ **Ensuring a safe school and learning environment**

In efforts to ensure a safe school and learning environment, universal precautions to effectively eliminate the risk of transmission of all blood-borne pathogens, including HIV, should be implemented. The National Policy on HIV/AIDS for Learners and Educators in Public Schools (Government Gazette, No. 20372, 10 August 1999) includes the following universal precautions (standard precautions):

- All blood and blood-stained fluids must be regarded as potentially infectious. The body fluids to which universal precautions explicitly apply are blood, semen, vaginal secretions, pus, amniotic fluid, breast milk and any other body fluid containing visible blood. Universal

precautions do not apply to faeces, nasal secretions, sputum, sweat, tears, urine and vomit unless these body fluids contain visible blood.

- Injuries, eczema, dermatitis, or any break in the skin should always be covered with waterproof plasters or dressings so that there is no risk to exposure of blood. A supply of waterproof plasters should always be available for this purpose.
- Direct contact with blood or blood-contaminated body fluids should be prevented through the use of waterproof gloves or other protective material such as plastic bags, a folded paper towel or clothing, to safeguard hands from contact with these fluids.
- Hands should be thoroughly washed with soap and water in the case of contamination with body fluids after the gloves have been removed, or after any accidental blood contact. Should the eyes or mucous membranes of the mouth be splashed with blood or blood-stained body fluid, the area should be washed with water immediately.
- Blood-contaminated items such as toothbrushes and razors should never be shared. Extreme care should be taken in laboratories to prevent learners from becoming contaminated with blood by implements used for dissection, or by breakable items.
- Items that are contaminated with blood or body fluids such as sanitary towels or dressings should be carefully disposed of in a sturdily tied plastic bag, and soiled linen should be effectively laundered.

Van Rooyen & Hartell (2001:15) state that principals should bear in mind that the essence of promoting the continual application of universal precautions lies in the premise that in situations of potential exposure to HIV, all persons are potentially infected and all blood and body fluids should be treated as such.

□ **Prevention of HIV transmission during sport and play**

The National Policy on HIV/AIDS for Learners and Educators in Public Schools (Government Gazette, No. 20372, 10 August 1999) regards the

risk of HIV transmission as a result of contact sport and play as generally insignificant, although Van Rooyen & Hartell (2002:15) regard the following precautions during sport and play as extremely important:

- Learners with open wounds, sores, breaks in the skin, abrasions, open skin lesions or mucous membranes that are exposed to infected blood may not participate in contact sport or contact play.
- If bleeding occurs during contact play or sport, the injured player should be removed from the playground or sports field immediately and treated according to the universal precautions.
- Blood-stained clothes must be changed.
- A fully equipped first-aid kit should be readily available wherever contact sport and contact play take place.

□ **Managing blood**

Van Rooyen & Hartell (2001:16) advise that a school policy on the managing of blood should incorporate measures such as the following:

- Extreme caution when handling any blood, whether it is small or large spills, old blood or blood stains.
- The immediate cleansing of the skin with soap and water even if it had been accidentally exposed to blood.
- All open wounds on the skin (including biting or scratching) should be cleaned immediately with running water and/or other antiseptics, dried, and covered with a waterproof dressing.
- Disposable bags and incinerators must be available to dispose of sanitary wear.

#### **4.2.4 Coping with the unforeseen**

As mentioned in paragraph 4.2.3.3 of this chapter, it is imperative that an HIV/AIDS policy be developed in advance of possible risky and harmful incidents that may facilitate HIV infection. The fact inevitably remains a reality that within a school unforeseen situations may occur which require immediate decisions and actions, e.g.: An educator discloses that he or she has HIV and this results in shock, discrimination and colleagues who refuse to work with the relevant educator (Van Rooyen & Hartell 2001:30). The following suggestions may serve as guidelines for the principal:

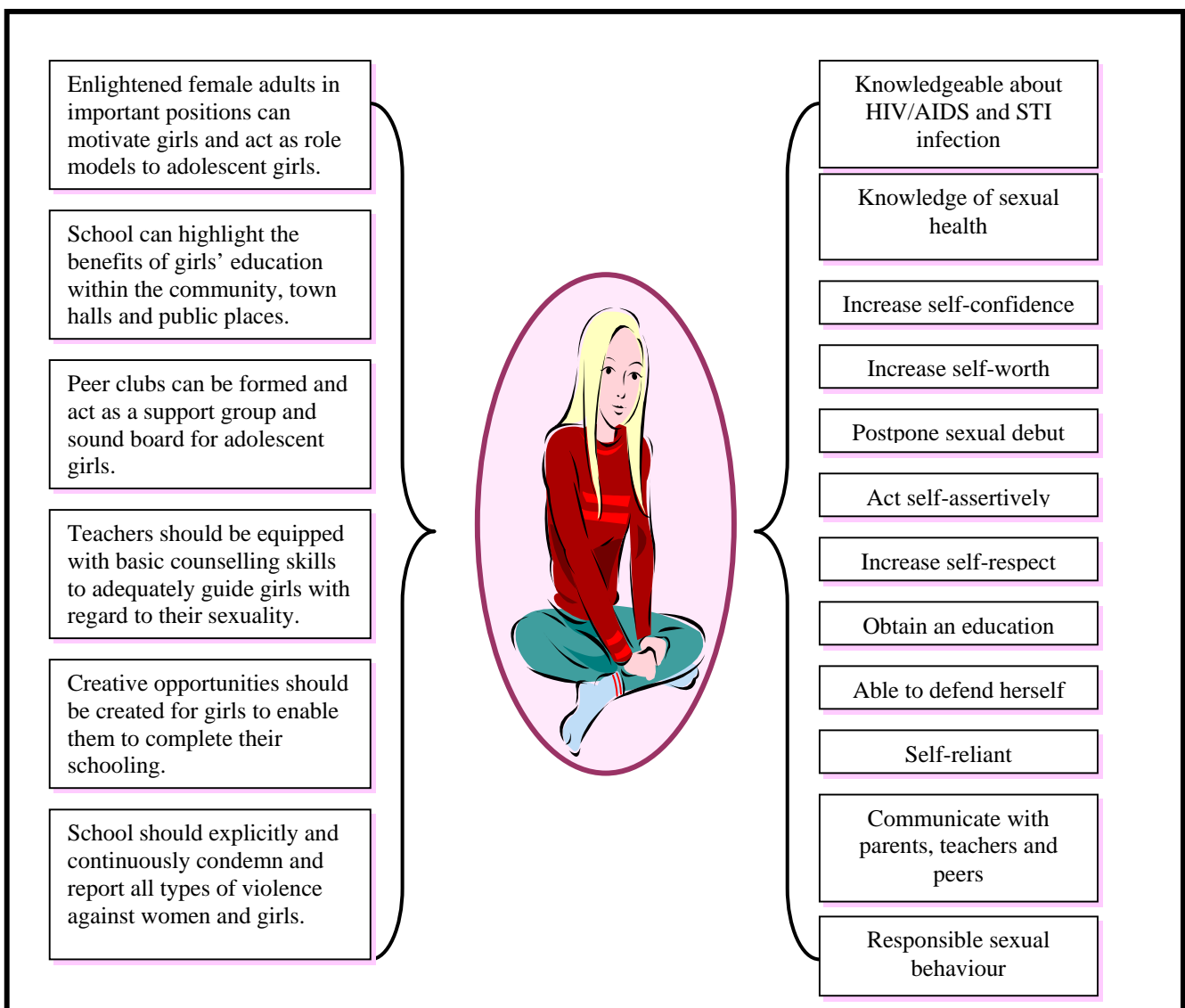
- ❑ Remain calm and act as a true leader. The leadership of the principal will influence his or her ability to command respect and foster confidence for action that has to be taken.
- ❑ Act immediately and take the needs of the institution, colleagues, learners and other individual stakeholders into consideration.
- ❑ Maintain confidentiality and privacy regardless of the steps that are to be taken.
- ❑ Prevent discrimination at all cost.
- ❑ Ensure that the universal precautionary measures with regard to first-aid and infection control are implemented.
- ❑ Utilize and access all relevant resources that may be available both inside and outside the school.
- ❑ Consult the official policy documents or get legal advice before any actions are taken. Decisions and actions during an emergency have to comply with departmental and state laws.
- ❑ Involve and consult other stakeholders before deciding on the best course of action.
- ❑ Assure fellow employees that everything is under control by means of open communication.
- ❑ Consult with other principals and other educational managers who might have had the same experience.
- ❑ Implement education programmes, as the educator's reaction may be ascribed to ignorance.

## **5. THE EMPOWERMENT OF THE GIRL**

As mentioned in paragraph 3 of this chapter, the school has an obligation to empower the girl to become less vulnerable to HIV/AIDS infection. Many contextual factors, such as the biological susceptibility of girls to HIV/AIDS infection (Chapter 2), social disposition of girls and women (Chapter 2), rape and sexual abuse (Chapter 3), the woman's susceptibility to STI infection (Chapter 3), refugee situations (Chapter 3), poverty (Chapter 3), certain cultural practices such as FGM (Chapter 2), and parenting styles (Chapter 2) may predispose the girl to HIV/AIDS infection, and direct an appeal to the school to empower the girl to become more assertive and eventually decrease her vulnerability to HIV/AIDS infection.

The school’s educational programmes and efforts to decrease the girl’s vulnerability should inculcate values and attitudes that are optimistic to life and promote responsible sexual behaviour such as postponement of sexual debut. In light of the mentioned contextual factors that increase the girl’s vulnerability to HIV/AIDS infection, the school curriculum should focus on aspects such as assertiveness, self-worth, and self-confidence in order to prevent HIV/AIDS infection (Figure 19).

**Figure 19: Empowerment of the young girl to become less vulnerable to HIV/AIDS infection.**



## 6. SUMMARY

The vast impact that HIV/AIDS has on society and the evident disruption of the educational sector ironically place a further urgent demand on education itself to curb the spread of the pandemic. The educational response to the challenges of HIV/AIDS

implies radical changes to existing practices and requires critical reflection on what the business of education entails and how it can best be delivered.

The implication for the educational manager or principal entails facing up to new challenges and responsibilities with regard to the effective management of institutions that may be severely affected by HIV/AIDS. The reality is that HIV/AIDS is in our schools and communities, and failure to manage an educational institution without considering the impact of HIV/AIDS, is failure to accommodate the needs and distress of the learners.

The impact of HIV/AIDS in the context of education as an empowering institution against HIV infection implies that planning and management must be directed towards flexibility, diversity, affordability and quality.

## CHAPTER 5

### REFLECTION, FINDINGS AND RECOMMENDATIONS

#### 1. THE AIM OF THIS CHAPTER

The aim of this chapter is to summarize and reflect upon the findings of the research conducted in this study. The main research findings will be brought in line with the research questions that were set in Chapter 1. Recommendations based on these findings will be suggested. The recommendations in this chapter may contribute to diminishing of the young girl's vulnerability with regard to HIV/AIDS infection and promoting the provision of relevant education in the midst of the HIV/AIDS pandemic.

#### 2. REFLECTION

In this study entitled **“Contextual factors affecting adolescents’ risk to HIV/AIDS infection: Implications for education”**, several contextual factors that contribute to and increase the adolescent's (especially the young girl's) vulnerability with regard to HIV/AIDS infection, as well as the implications thereof for education, were investigated.

In the preliminary investigation several facts became apparent. The staggering number of people living with HIV/AIDS is increasing and projections are that life expectancy in Southern Africa may drop to merely 30 years by the year 2010 (in this regard refer to paragraph 3 in Chapter 1). The reality of sexuality being the primary factor that fuels the spread of HIV/AIDS also became evident.

A further fact that surfaced was that more girls are living with HIV/AIDS than their male counterparts. By 2001 a total of 56% of the 4.7 million South Africans that were living with HIV/AIDS, were females. This fact might be ascribed to many contextual factors that increase the young girl's vulnerability with regard to HIV/AIDS infection. A further fact that surfaced, was that adolescents and especially young girls appear to be in need of educational programmes that address their vulnerability with regard to HIV/AIDS infection.

The fact that the HIV/AIDS prevalence rate remains high, despite many prevention strategies that have been in place for several years, also became obvious. The most prominent prevention strategies appear to be education and positive changes in sexual behaviour. It became clear that sexuality education in schools might not be curbing the infection rate, as projected mortality rates among adolescents became a reality.

Several contextual factors that contribute to the escalating infection rate among adolescents also became evident. In the light of this reality several implications surfaced for the school as an institution that must assist in curbing the spread of HIV/AIDS as part of its obligation to the community. The role and obligation of the school with regard to the community and especially with regard to learners in the shadow of HIV/AIDS infection were kept in mind when the primary research question was formulated, namely: **“Which contextual factors affect the adolescent’s (especially the young girl’s) risk to become HIV/AIDS infected and what are the possible implications for education?”**

With regard to the aims of this study, the researcher distinguished between a primary aim and certain secondary aims, after the formulation of research questions. Many other questions became apparent from the primary research question and, by researching the answers to these questions, the primary question could be answered. The aims gave focus and direction to the study in such a manner that meaningful theoretical research could be conducted.

In Chapter 1, a background and orientation with regard to the study were presented. The aims of the study, the procedures and the methodology were accounted for, and key concepts were explained.

The vulnerability of the young girl was investigated in Chapter 2 and Chapter 3. In Chapter 2 attention was given to specific contextual factors that contribute to the young girl’s vulnerability with regard to HIV/AIDS infection. The influence of the parenting styles that are realized within a family, and the ways in which these might predispose the girl to become HIV/AIDS infected, were investigated. The types of families in contemporary society as well as the vulnerability and deterioration of the family were investigated with regard to the possible predisposition of girls to become HIV/AIDS infected. In this chapter attention was also given to gender inequalities and to specific perceptions of traditional gender roles that might contribute to the



vulnerability of the young girl with regard to HIV/AIDS infection. This chapter was concluded with an investigation into physiological factors that contribute to the vulnerability of the young girl to HIV/AIDS infection.

In Chapter 3 a study was undertaken of the socio-economical situation of women and young girls that increases their vulnerability to become HIV/AIDS infected. Socio-economic factors such as poverty, violence against women, sexual behaviour and prostitution, as well as conflict and displacement were investigated.

Several implications that the adolescent's and especially the young girl's vulnerability with regard to HIV/AIDS infection has for education were set out in Chapter 4. An overview was given of the impact that the HIV/AIDS pandemic has on education with regard to management, educators and learners. Particular attention was given to ways in which the young girl can be empowered to become less vulnerable with regard to HIV/AIDS infection.

### **3. FINDINGS**

The following are meaningful findings of this study:

- 3.1 In Chapter 1 it was found that
  - 3.1.1 an estimated 40 million people around the world are living with HIV/AIDS and the number is rapidly increasing;
  - 3.1.2 the infection rate among girls is 5 times higher than among boys of the same age group;
  - 3.1.3 youth sexuality is characterised by sexual debut at ages as young as 12 years, prostitution, rape and sexual assault;
  - 3.1.4 ignorance with regard to the transmission, prevention and cure of HIV/AIDS still prevails among the youth;
  - 3.1.5 HIV/AIDS could be prevented by means of relevant education and positive changes in sexual behaviour;
  - 3.1.6 young men have more sexual partners and enforce more power within a sexual relationship, while most HIV/AIDS programmes usually exclude males and focus on females.

- 3.2 In Chapter 2 it was found that
- 3.2.1 the child-rearing style of the parent impacts on the personality development and social adaptation of the child;
  - 3.2.2 warm parenting leads to more assertive behaviour and a more unlikely predisposition to risky situations in which the girl can be sexually exploited;
  - 3.2.3 cold parenting leads to less assertive behaviour and predisposes the girl to situations in which she may substitute the lack of parental warmth and affection with instant sexual gratification;
  - 3.2.4 dominant parenting increases the probability of risky sexual behaviour which in turn increases vulnerability with regard to HIV/AIDS infection;
  - 3.2.5 permissive parenting intensifies the girl's feelings of insecurity and uncertainty and predisposes her to unfavourable influences that increase her vulnerability with regard to HIV/AIDS infection;
  - 3.2.6 intolerant, autocratic parenting creates an openness and conformist attitude that leaves the girl more vulnerable to sexual exploitation and risky sexual behaviour;
  - 3.2.7 involved parenting coupled with excessive physical pampering and lack of boundaries for physical contact predispose the girl to sexual exploitation and sexual abuse;
  - 3.2.8 indifferent parenting leads to feelings of inferiority, a negative self-concept, and inadequate social skills that predispose the girl to superficial interest, love and sexual exploitation;
  - 3.2.9 the patriarchal family has the potential to obstruct the child's adequate socialization and gradual social integration with the possibility of child sexual abuse and increased vulnerability with regard to HIV/AIDS infection;
  - 3.2.10 the open family within a closed circle, town or neighbourhood exposes the child to harmful social behaviour such as drug abuse and risky sexual behaviour;
  - 3.2.11 the closed family that isolates itself from society may predispose the child to identify with harmful practices, such as drug abuse and promiscuous behaviour, in an attempt to escape from the family's social isolation;

- 3.2.12 the hostel family lacks intimate family relationships and consequently predisposes the child to a search for intimacy in relationships with strangers in which sexual exploitation, drug abuse and other harmful practices are possibilities;
- 3.2.13 the chaotic family life and disordered relationships within the neglected family predispose the child to look for “easy” relationships that offer comfort and communication. The child is then predisposed to sexual exploitation;
- 3.2.14 the child in the inflexible family is inadequately equipped with social skills in order to act assertively and negotiate responsible sexual behaviour within a relationship;
- 3.2.15 the modern, big-city family, that surrenders its functions to society, is open to society’s influences such as drug abuse and promiscuous behaviour that predispose the child to HIV/AIDS infection.
- 3.2.16 the responsibilities that the girl within the child-headed family faces increase her vulnerability with regard to HIV/AIDS infection, as many of these girls resort to prostitution in order to provide for the family’s material needs;
- 3.2.17 the modern nuclear family experiences economical, social, emotional, pedagogical, and communicative vulnerability;
- 3.2.18 the vulnerability of the nuclear family leads to inadequate inculcation of social skills and results in the social insufficiency of the child;
- 3.2.19 the deterioration of the nuclear family leads to inadequate guidance with regard to acceptable social conduct and causes the girl to be influenced by negative social factors, through which her vulnerability with regard to HIV/AIDS infection is increased;
- 3.2.20 gender inequalities with regard to perceptions of traditional gender roles, education, sexuality, and economical inequality render the girl vulnerable with regard to HIV/AIDS infection;
- 3.2.21 the unique physiology and anatomy of the female body and certain genital conditions render the female more vulnerable to HIV/AIDS infection than her male counterpart;
- 3.2.22 some girls engage in risky sexual activities (such as oral and anal sex) in order to protect their virginity and in this way increase their vulnerability with regard to HIV/AIDS infection;

- 3.2.23 the presence of a STI increases the girl's vulnerability with regard to HIV/AIDS infection;
  - 3.2.24 consequences of female genital mutilation increase the girl's vulnerability with regard to HIV/AIDS infection;
  - 3.2.25 cultural beliefs and traditions increase the girl's vulnerability with regard to HIV/AIDS infection (such as the "sugar daddy" syndrome and infant rape).
- 3.3 In Chapter 3 it was found that
- 3.3.1 poverty predisposes a girl to situations that compel her to participate in high-risk sexual activities that increase her vulnerability with regard to HIV/AIDS infection;
  - 3.3.2 poverty disempowers the girl and renders her powerless to negotiate safer sexual practices and therefore increases her vulnerability with regard to HIV/AIDS infection;
  - 3.3.3 self-efficacy and assertiveness is necessary for the prevention of HIV/AIDS infection;
  - 3.3.4 ill-health as a result of poverty places the girl in a more vulnerable position with regard to HIV/AIDS infection;
  - 3.3.5 violence and coerced sex increase the girl's vulnerability with regard to HIV/AIDS infection;
  - 3.3.6 the incapacity to negotiate safer sex practices increases the girls vulnerability with regard to HIV/AIDS infection;
  - 3.3.7 sexual violence increases the girl's vulnerability with regard to HIV/AIDS infection;
  - 3.3.8 incest as a form of sexual abuse and sexual violence contributes to the vulnerability of the girl with regard to HIV/AIDS infection;
  - 3.3.9 statutory rape, date rape, gang rape and infant rape create violent situations in which the girl is exceptionally vulnerable with regard to HIV/AIDS infection;
  - 3.3.10 abused and sexually violated children are more likely to engage in risky sexual behaviours that increase their vulnerability with regard to HIV/AIDS infection;
  - 3.3.11 during conflict and refugee situations, which are often characterized by male dominated political violence, the girl's vulnerability with regard to HIV/AIDS infection increases.

- 3.4 In Chapter 4 it was found that
- 3.4.1 it is expected from the school as service deliverer to the community to be the vanguard in the prevention of HIV/AIDS infection among adolescents;
  - 3.4.2 the vulnerability of the adolescent (especially the young girl) with regard to HIV/AIDS infection directs an appeal to the school to persevere in its mandatory obligation and responsibility in addressing the prevention of HIV/AIDS infection;
  - 3.4.3 the totality of a school (the curriculum, management, policy and organization) is affected by HIV/AIDS;
  - 3.4.4 stakeholders in education should be involved in efforts to prevent the further spread of HIV/AIDS;
  - 3.4.5 HIV/AIDS impacts on the education supply and delivery in a school;
  - 3.4.6 the HIV/AIDS school policy:
    - 3.4.6.1 is mandatory and has to follow guidelines directed by the South African Schools Act, Act 84 of 1996, the National Education Policy Act, Act 27 of 1996, and the National Policy on HIV/AIDS for Learners and Educators in Public Schools;
    - 3.4.6.2 is a valuable document which describes the institution's procedures and practices when dealing with HIV/AIDS issues;
    - 3.4.6.3 serves as a foundation for a sound HIV/AIDS programme;
    - 3.4.6.4 must be developed according to the unique circumstances and needs that prevail within every school;
    - 3.4.6.5 has to be established in advance as part of a pro-active strategy and in the light of unforeseen situations that might occur within any school;
    - 3.4.6.6 should prohibit any form of discrimination against a learner or educator, who has, or who is perceived to be infected with, HIV/AIDS;
    - 3.4.6.7 must ensure the utmost confidentiality with regard to the HIV/AIDS status of all learners and educators;
    - 3.4.6.8 contributes to creating a safe school and learning environment by sanctioning the universal precautions as stated by the National Policy on HIV/AIDS for Learners and Educators, which is in line with the Constitution of South Africa;

- 3.4.6.9 should provide for prevention of possible HIV transmission during sport and play and therefore be in place at all times;
- 3.4.6.10 must clearly stipulate sound blood management throughout all school activities;
- 3.4.7 the school's curriculum:
  - 3.4.7.1 must be in line with the Sexuality Education and HIV/AIDS Education (Learning Area: Life Orientation) that have been introduced and made compulsory in schools on a national level;
  - 3.4.7.2 has to be implemented at all pre-primary, primary and secondary schools;
  - 3.4.7.3 has to address the vulnerability and consequently the empowerment of the adolescent, and particularly that of the young girl with regard to HIV/AIDS;
- 3.4.8 the management of the school:
  - 3.4.8.1 should follow a triangular management approach that focuses on prevention, care and support, and coping strategies have to be implemented with responsibility and devotion (pro-active as well as re-active strategies);
  - 3.4.8.2 is responsible for comprehensive strategies with regard to fighting HIV/AIDS in a school that include prevention, care, treatment, and support interventions;
- 3.4.9 the educational programmes within the school:
  - 3.4.9.1 should address the contextual factors that increase the vulnerability of the girl with regard to HIV/AIDS infection;
  - 3.4.9.2 should empower the young girl with knowledge, skills and values that reduce her vulnerability with regard to HIV/AIDS infection;
  - 3.4.9.3 should aim at producing norm-dependent and conscientious adults according to the norms and values of the family and community;

- 3.4.9.4 should inter alia inculcate values and attitudes that are optimistic to life and reject premature, casual, unprotected or socially unacceptable sex and sexual experimentation;
- 3.4.9.5 that address the prevention of HIV/AIDS, should not be limited to a particular period or lecture but should encompass all the endeavours within the school;
- 3.4.9.6 must include an HIV/AIDS Education information bank that is based on a holistic approach, with the shaping of the total child in mind when HIV/AIDS knowledge is presented;
- 3.4.9.7 have to present adequate health knowledge, skills and values that can prevent the adolescent from risky, irresponsible and potentially harmful behaviour;
- 3.4.9.8 should embrace creative ways of providing HIV/AIDS infected learners with continued education, such as flexible timetabling, travelling teachers, and catering for “drop out – drop ins”;
  
- 3.4.10 the educators within the school:
  - 3.4.10.1 have to be empowered with skills and knowledge with regard to HIV/AIDS, and especially with regard to addressing the vulnerability of the girl to HIV/AIDS infection; this should be achieved by means of pre-service and in-service training;
  - 3.4.10.2 have a responsibility to teach learners about responsible sexual behaviour and the values consistent with living in a healthy community;
  - 3.4.10.3 have to be made aware of the seriousness of the vulnerability and defencelessness that predispose the adolescent to HIV/AIDS infection;
  - 3.4.10.4 have to acknowledge the dynamic sexual energy that characterizes the adolescents in their care and should have knowledge of the manner in which this contributes to their vulnerability with regard to HIV/AIDS infection;
  - 3.4.10.5 have to adopt a more diversified role (he or she is also for example community counsellor, pastoral care giver and support to learners infected and affected by HIV/AIDS);

3.4.10.6 have to acquaint themselves with ways of establishing supporting links with appropriate social, health or welfare services.

#### 4. RECOMMENDATIONS

4.1 In the light of the findings with regard to paragraphs 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.4.1, 3.4.2, 3.4.3, 3.4.5, 3.4.6.1, 3.4.7.1 to 3.4.7.3, 3.4.8.1 and 3.4.8.2 it is highly recommended that

4.1.1 the provision of Sexuality and HIV/AIDS Education of high quality in schools should be enforced and controlled.

4.2 In the light of the findings with regard to paragraphs 3.1.6, 3.2.16, 3.2.22, 3.3.2, 3.3.5, 3.3.6, 3.3.7, 3.4.5 and 3.4.7.3 it is recommended that

4.2.1 HIV/AIDS intervention and prevention programmes should target boys as well as girls, in order to free both young men and women from the dangers of coerced and unwanted sex, and to empower them to feel comfortable when discussing sexual matters and negotiating responsible sexual behaviour;

4.2.2 adolescents, and especially adolescent girls, should be equipped with skills in assertiveness, negotiation, conflict resolution, critical thinking, decision-making and communication;

4.2.3 adolescents and other persons living with HIV/AIDS should be employed to reinforce information amongst other young people about the need to adopt and maintain responsible sexual behaviour.

4.3 In the light of the findings in paragraphs 3.2.1 to 3.2.15, 3.4.1 and 3.4.4 it is recommended that

4.3.1 schools should provide a parent counselling programme in which parents can be empowered and guided with regard to pro-active strategies to enrich their family lives and by so doing reduce the vulnerability of their daughters with regard to HIV/AIDS infection;

4.3.2 family counselling that promotes open communication with regard to sexuality should be encouraged within the family with the aim of



empowering adolescents to make safe and informed choices with regard to sexual intercourse;

4.3.3 more programmes should be developed that empower parents and other adults in the community to overcome their discomfort as well as their lack of information with regard to sexuality and HIV/AIDS;

4.3.4 access to livelihoods, education and services should be made available to enable adolescents and especially young girls to complete their school careers and build their futures.

4.4 In the light of the findings in paragraphs 3.2.17, 3.2.18, 3.2.19 and in addition to the recommendations made in paragraph 4.3 further research with regard to the development of a parent support structure is recommended.

4.5 In the light of the finding in paragraphs 3.1.3, 3.2.20, 3.2.21, 3.2.23, 3.2.24, 3.2.25, 3.3.11 and 3.4.4 it is recommended that

4.5.1 all sectors of society are also indirectly co-educators and should therefore take up their responsibility and involve themselves in programmes that empower adolescents and especially young girls with reproductive health education;

4.5.2 youth-friendly health services, that provide a full range of services and information to adolescents, should be made easily accessible throughout the country;

4.5.3 health services should be extended and should include help to prevent HIV and STIs, by providing access to programmes on abstinence, the use of condoms and voluntary counselling and testing, and support with regard to HIV/AIDS infection;

4.5.4 voluntary counselling and testing should be made accessible to all adolescents, including marginalized groups such as refugees, migrant workers and youth sex workers;

4.5.5 schools and communities should unequivocally condemn sexual violence, abuse and exploitation of children and adolescents, as well as violence against females in general;

4.5.6 the government should enact and enforce laws that protect young women from all forms of sexual violence, by encouraging the reporting of such cases and consistent law enforcement;

- 4.5.7 mass media should more prominently publicize equality between men and women and denounce all forms of violence against women, children and adolescents.
- 4.6 In the light of the findings in paragraphs 3.4.1, 3.4.9.1 to 3.4.9.8, and 3.4.10.1 to 3.4.10.6 it is recommended that
- 4.6.1 educators should be empowered through pre-service and in-service training in order to successfully teach Life Skills;
  - 4.6.2 educators should receive regular refresher courses;
  - 4.6.3 information with regard to sexuality and responsible sexual behaviour should be regularly updated and keep abreast with new developments;
  - 4.6.4 educators should be empowered with first aid skills and frequent refresher courses;
  - 4.6.5 adolescents should be involved in training programmes as peer counsellors.
- 4.7 In the light of the findings in paragraphs 3.1.5, 3.4.1, 3.4.2, 3.4.8.1, 3.4.8.2, and 3.4.9.1 to 3.4.9.8 it is recommended that
- 4.7.1 the Department of Education should render managerial support to schools by means of control and advice to school management teams with regard to the development and implementation of an HIV/AIDS policy in the school;
  - 4.7.2 sufficient funds should be made available for the implementation of prevention programmes in schools;
  - 4.7.3 policy makers must ensure that adolescents have the education, information, services and support they need.
- 4.8 In the light of the findings in paragraphs 3.4.3, 3.4.4, 3.4.6.3, 3.4.7.1 to 3.4.7.3 and 3.4.9.1 to 3.4.9.8 it is recommended that
- 4.8.1 the school has to implement a comprehensive programme with regard to HIV/AIDS, that includes strategies for prevention, coping, care and support;
  - 4.8.2 the programme has to promote responsible sexual behaviour;
  - 4.8.3 sound educational guidance with regard to sexuality should be the foundation of a school's HIV/AIDS programme;

- 4.8.4 creative ways for continued education provision to HIV/AIDS infected and affected learners should be implemented;
  - 4.8.5 a youth-friendly information bank should be established within every school;
  - 4.8.6 the school has to encourage and promote the involvement of all stakeholders (co-educators) within the HIV/AIDS programme of the school.
- 4.9 In the light of the findings in paragraphs 3.4.6.1 to 3.4.6.10 it is recommended that
- 4.9.1 every school should develop and implement an HIV/AIDS policy;
  - 4.9.2 the school's HIV/AIDS policy should be developed according to the school's unique circumstances and should address the particular needs of the community within the school;
  - 4.9.3 educational authorities have to enact and enforce the development and implementation of such a policy;
  - 4.9.4 the policy should prescribe procedures and practices that deal with particular HIV/AIDS issues;
  - 4.9.5 the HIV/AIDS school policy should be established in advance;
  - 4.9.6 sound blood management should be part of the school's HIV/AIDS policy;
  - 4.9.7 a first-aid kit should be readily available and accessible to educators and learners;
  - 4.9.8 persons responsible for the maintenance of a first-aid kit should be appointed and empowered through adequate training.

## **5. RECOMMENDATIONS FOR FURTHER RESEARCH**

- 5.1 In the light of the findings in paragraphs 3.2.1 to 3.2.19 and 3.4.1 to 3.4.4 further research with regard to the development of an effective parent counselling programme is recommended.
- 5.2 In the light of the findings in paragraphs 3.2.20 to 3.2.25 further research with regard to the role of the male in establishing an assertive attitude amongst females is recommended.

- 5.3 In the light of the findings in paragraphs 3.4.9.1 to 3.4.9.8 further research is recommended to develop an assessment strategy that ensures quality Sexuality and HIV/AIDS Education in schools.

## 6. CONCLUSION

In this study consideration was given to contextual factors that contribute to the vulnerability of the adolescent, and especially of the young girl, with regard to HIV/AIDS infection, and the consequent implications that these have for education (particularly the school). By conducting extensive research, more insight was gained with regard to factors that contribute to the high HIV infection rate amongst young women. The research produced answers to the primary as well as the secondary questions, and consequently led to the achievement of the primary aim of this study, namely an investigation into contextual factors that contribute to the vulnerability of adolescents (especially young girls) with regard to HIV/AIDS infection, and the implications thereof for education.

The research revealed that the socio-economical and physiological vulnerability of women and young girls, together with factors such as violence against women, gender inequality and sexism, need to be addressed by means of sound education in order to reduce their vulnerability. Several implications, that the adolescent's and especially the young girl's vulnerability with regard to HIV/AIDS infection has for education, were identified.

Scientific findings formed the basis on which the recommendations were made. These recommendations are aimed at the empowerment, enrichment and development of young girls in order to prevent HIV/AIDS infection.

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