

## CHAPTER 1

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### BACKGROUND AND ORIENTATION

*'Culture describes how things are and acts as a screen or lens through which the world is viewed.'*

(Stoll 1998:9)

#### 1.1. Introduction

The UNAIDS Annual Report (UNAIDSb) presented that in 2008 successful antiretroviral treatments assisted to decrease the number of people living with HIV globally to 33.4 million. Although this was not so in Sub-Saharan Africa effective education and treatment appeared to have resulted in the epidemic evening out steadily in many regions around the world. UNAIDS (UNAIDSb) has noted that seventy-one percent of all new HIV infections have emerged in Sub-Saharan Africa where sixty percent of those living with HIV were women. Further, South African statistics (UNAIDSb) revealed that this country had the largest number of approximately one million people living with HIV and on treatment. The UNAIDS interagency task team on HIV has become more responsive to the fact that young people from the age of ten to twenty-four are particularly at high risk of contracting HIV. As a consequence, communities globally are more attentive to their obligation to augment HIV/Aids knowledge among the youth so that the latter are able to develop sustainable attitudes and behaviour in terms of the disease.

South African studies (Barnett and Whiteside 2006:24) confirm that AIDS will claim the lives of a significant percentage of adolescents as this group is seen as a vulnerable sector of society. Research by Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, Parker, Van Zyl, Zungu, Pezi and the SABSSM III Implementation Team (2009:1) as well as statistics provided by UNAIDS (2008) illustrated that there were 180 722 South African males and 831 445 females between the ages 15 and 24 living with HIV/Aids during that period. Kelly (2000) maintains that while African societies are responsive to the demands of HIV/Aids, there is a tendency to delegate a more prominent role to the school to create safe sexual behaviour among adolescents. Consequently, there has been a concerted effort by affiliated South African authorities to modify the school curriculum, incorporating

HIV/Aids into the life skills programme. This was a step towards guiding the adolescents to deal with HIV-related problems not just from a preventative perspective but also from a social perspective so that they could make informed, life-changing decisions competently (Kelly 2000:31-32).

Such a commitment to assist adolescents becomes the responsibility of the influential “network structure(s)” (Bandura’s 2001:3) in the individual’s life. In Bandura’s (2001:3; 1994:2) words particular “network structure(s)” (including culture) as well as “social and self-regulative skills” can impact upon a person’s knowledge, attitude and behavioural modification in the face of HIV/Aids. The theoretical framework of the study demonstrates that parents and teachers within the school culture can inspire positive changes to ensure the learner’s success in attaining safe-behavior to avoid HIV/Aids (Bandura 2001; Elbot and Fulton 2008). As a result, the culture of a community, according to Schein (2004:21) is structured and “influences the group’s behavior”. However, it is not the intention of this thesis to promote any religion or religious group but to assess the basic values relevant to sexuality and HIV/Aids. Regardless of their social or religious backgrounds it is apparent that adolescents can benefit from the teachings of significant adults in their communities. Elbot and Fulton (2008:2/5) in their discussion of school culture suggest that parents and teachers within the family and school culture can inspire positive changes thus ensuring the learners’ success. As a consequence, the contention of this study is that values regarding what is right and wrong in terms of HIV/Aids are conveyed as a result of the youth’s relationships with adults within the family culture and school culture. Consistent with what Van der Walt (1994:44) proposes about the formation of one’s life- and worldview it means that the adolescent’s attitudes and behavior will develop within the context of HIV/Aids accordingly.

Thus this chapter explains strategic research preferences against which the thesis should be read. Contextual frames of reference will substantiate the assertion within my study that reflect upon the <sup>4</sup>Muslim adolescent’s knowledge and attitudes in respect of HIV/ Aids within the realm of family and school culture. The introductory paragraphs to this chapter

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<sup>4</sup> The word ‘Muslim’ will be used interchangeably with ‘people of Islamic descent’

deliberate the concept of culture and consequently, the dual relationship between culture and education. These viewpoints are followed by discussions of global and South African literature based on HIV/Aids in general, since further explanation appears in Chapter 2. Chapter 1 also provides a concise account of the methodology (as a prelude to chapter 3), a clarification of the main concepts in the inquiry and an outline of the chapters in this thesis. I have also included a detailed elucidation of the focus of this thesis which is “culture” and will communicate the manner in which the concept impacts upon HIV/Aids education of Muslim adolescents.

Literature reviews (Elbot and Fulton 2008:2; Schein 2004:17-21) have recognized that “culture” has an indisputable role in any community since it distinguishes particular social groups and focuses on salient definitive issues in respect of the lives of the people. The dynamic nature of culture necessitates that individuals adapt certain personal characteristics including their knowledge and attitudes according to the social transformations that occur in the sphere of society over time. Within the context of this chapter and later in Chapter 2, I define the concept of “culture” *per se* and then, as it appears in this study as “family culture” and “school culture”. For the purposes of this inquiry the research site was an independent Islamic institution that covered distinctive Muslim cultural attitudes within basic Islamic principles.

The foregoing views on culture support the contention that societal values which are often derived from family and school culture do exercise some control upon an individual’s behavior particularly in the context of HIV/Aids (van Wyk and Lemmer 2007:312-313; Nupen 2006:95). My goal in conducting this research therefore was to establish whether the Muslim family culture and the Muslim school cultural has in any way influenced a lower HIV prevalence in that community (Kagee, Toefy, Simbayi & Kalichman 2005). This investigation was initiated as a result of my curiosity to establish what the Muslim community was doing right in order to present a lower prevalence of HIV in their communities. Accordingly, I concluded that the findings of this study of Muslim adolescents’ knowledge of and attitudes towards HIV/Aids might prove beneficial in preventing the further spread of HIV among the youth in other South African communities.

## 1.2. Rationale

The challenge of HIV/Aids within the South African milieu demands further scholarly deliberation for the reason that there is a high HIV prevalence among adolescents (Louw 2009:163). It ought to be noted that even though the term “prevalence<sup>5</sup>” has been used in this study, UNAIDS (UNAIDSa) has suggested that there be changes implemented to refer HIV and AIDS statistics in the future. It has been found that data in relation to the term “prevalence” (which is a percentage) was often difficult to interpret since it could not account for changing patterns in the survival period from infection to death because of antiretroviral therapy. The submission now means that the term “incidence<sup>6</sup>” will be used instead since it is “more sensitive to the changing dynamics of disease transmission” (UNAIDSa). However, even though data referring to incidence are recommended, it scientists warn that that these figures are more difficult to obtain.

As verified by an HSRC report the number of young South African adults living with the virus is one in six (Informer 2006). South African studies confirm that AIDS will claim the lives of a significant percentage of adolescents as this group is a vulnerable sector of society (Barnett and Whiteside 2006:24). A recent investigation by Louw (2009:163) has found that the South African youth is perplexed by contradictory messages in terms of HIV/Aids that even the school does not assist to demystify. In terms of Louw’s (2009:164) study South African youth displayed scant regard for the consequences of risky behavior since they believed that they could not be affected by HIV. It was my view that there was a nonchalant attitude pervading South African schools thus justifying the need for further scientific inquiry into these aspects of HIV/Aids so as to assist the youth to overcome their ignorance and avoid HIV infection.

My reason for selecting adolescents of Islamic descent is significant since the HIV infection rate among the Muslim youth in South Africa is hypothetically low and they are

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<sup>5</sup> “prevalence” refers to the number of people who are living with HIV at a given point in time (Berry & Noble 2010)

<sup>6</sup> “incidence” refers to the number of new HIV cases in a given population during a certain period (Berry & Noble 2010)

from one of the many conservative communities with stringent moral rules pertaining to pre-marital sexual activity (HIV/Aids education more especially). It also became apparent that the Muslim community was most representative of the South African population since Muslims come from all races and language groups. As a result, my study would be more meaningful although I accepted that it could not be generalized to other populations and samples. Within the context of the high prevalence of HIV infections among the adolescents in South Africa I was motivated to find out what the causal factors (in the family and school) were for the low infections among the Muslim youth. However, according to Positive Muslims, a non-profit organization from Cape Town (Esack 2005), Muslims did not readily acknowledge that HIV or AIDS existed among them and they responded towards the epidemic as if it belonged elsewhere (other religious and racial groups). The report by Esack (2005) also states that Muslims then did not consider any other factors such as drug abuse or rape as being contributing factors for HIV infection. Stemming from these perceptions, I endeavored to investigate by means of a case study the relationship between social and cultural practices within the Muslim family and Islamic schools in respect of the Muslim adolescent learner's attitudes and responses regarding HIV/AIDS.

Paruk, Mohamed, Patel and Ramgoon (2006:511) are of the view that an individual's belief system is an important factor in the attitude that one displays towards HIV/Aids. In relation to my investigation it is a point of query as to whether the Islamic cultural belief system has an impact upon the knowledge and attitudes of the Muslim adolescent. This is one factor that might dictate the low prevalence of HIV infection amongst them and the Islamic community in general. A further point of consequence for my study and one which is pointed out within the "pilot" study conducted by Kagee *et al.* (2005:16) is that Muslims supposedly have a low infection rate within the South African milieu. It will therefore be interesting to investigate the reason for this low prevalence amongst Muslims and to illustrate the manner in which the family and school culture have influenced the knowledge and attitudes of the Muslim adolescents to HIV/Aids.

It is possible that the Muslim youth adhere to certain values or perspectives in their culture that can be useful or significant to other cultural and racial groups in the attempt to prevent HIV infection among the youth. This particular exploration into the youth and HIV/Aids from a social, cultural, family and school perspective attempted to establish the shortcomings in the researched literature on HIV/Aids and education particularly in terms of adolescents. Hence, my study was crucial since research regarding the Muslim adolescents' knowledge and attitudes towards HIV/Aids is limited and could contribute to the curbing HIV infections among the youth. Within such a framework, my research population was representative of a hybrid Muslim population including a blend of races, language groups, ethnic origins and sexual orientations (Kagee *et al.* 2005).

Consequently, the focus of my investigation was based primarily on the following assumptions as a statement of purpose:

- that the school is an extension of the community and reproduces the community's (family's) cultural and social practices and should therefore influence the way in which Muslim adolescents respond to HIV/Aids (Elbot and Fulton 2008:2/5; Nanavati & McCulloch, 2003:3);
- that interventions by the South African Department of Education and the Department of Health are not accomplishing the goal of significantly reducing the rate of HIV infections among the South African youth (van den Berg 2005:228-229; Hartell 2005:170); and
- that Muslims as a cultural group in South Africa display low HIV prevalence (Paruk, *et al* 2006:511; Kagee *et al.* 2005:7; Khan & Hyder 2001).

In their study, Kagee *et al.* (2005:5) aimed to establish the prevalence of HIV among the Western Cape Muslim community. They (Kagee *et al.* 2005:24-25) concluded that HIV was not a "trivial" issue within this community and that it was therefore imperative that a concerted effort be made to mitigate the proliferation of the pandemic. Studies like mine within the South African Health or Education sectors that explore the impact of the family

and school culture upon HIV/Aids are therefore relevant to the process of HIV prevention (South African Government 2007:17/33).

Of particular consequence to the present research, was an investigation conducted by Reddy, James and McCauley (2005) that analyzed the result of putting into practice an HIV/Aids programme during Life Orientation (LO) for Grade nine at a Kwa-Zulu<sup>7</sup> Natal school. The findings of this study indicated that the programme enhanced the learners' knowledge of HIV/Aids – an advantage to the existing positive attitudes that the children had towards sexual behavior (Reddy *et al.* 2005:2-3). Despite the many insecurities and quandaries the teachers talked about during the research (Reddy *et al.* 2005:2-3), their enthusiasm to have more teaching materials was just as high as learner-enthusiasm to grasp information in respect of such an crucial issue as HIV/Aids. An important component of the study undertaken in the Western Cape Province of South Africa in the Muslim community was to gauge the role of life skills in terms of HIV/Aids at school level.

It is a reality that HIV/Aids education and policy implementation, as well as the realization of curriculum guidelines from the Department of Education regarding HIV/Aids education are not consistent throughout all schools in South Africa even though HIV affects all South African cultures (Mosia 2009). The study by Reddy *et al.* (2005) demonstrated that the development and implementation of the curriculum was just as important to the teaching of HIV/Aids as teachers who were suited to the task and committed to encouraging positive behavior-change in the learners. Some South African school cultures dictated that HIV/Aids education was discretionary since these school cultures contended that learners from such schools were not affected by the virus. A study by Varga (1997:47) discusses awareness, communication and socio-cultural factors in the fight against AIDS as well as the oversight of individuals in some communities where HIV prevalence is believed to be low and individuals feel that they are “safe” – hence not taking AIDS education seriously. In keeping with the foregoing assertion my line of reasoning was that it would be interesting to investigate how the Islamic institution (boys and girls school) in the study responded to the epidemic.

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<sup>7</sup> Province in South Africa

As a consequence of the above assertions this study was based on the rationale that further enquiry could augment knowledge and its findings could contribute to an enhanced interpretation and effective implementation of guidelines that existed in HIV prevention policy at schools (Moletsane, 2003:2). The findings of this study, although scholastic, could contribute to the strategies of the Department of Education, policy makers, teachers, religious leaders and parents since these highlight the influence of family and school culture on the knowledge, attitude and responsiveness of adolescents to HIV/Aids in an attempt to curb the further spread of HIV/Aids among South African adolescents.

### **1.3. Contextualizing this study**

#### **1.3.1. Dual relationship of culture and education**

Schools are embedded in communities and reflect the values, beliefs and cultures of the families and communities they serve, reproducing the community's cultural and social practices. Culture shapes education while education can serve as a medium to preserve and promote culture. Culture therefore influences content and subsequently, content can promote culture. Accordingly, while a particular school culture is recognizable by its unique values, beliefs, climate, ethos, atmosphere, character and tone as indicated by Elbot and Fulton (2008:18-19) and Barth (1990:513), the school culture also imbibes certain characteristics from the community it serves. This finding in terms of the dual relationship between the school and family culture is significant as my study attempted to illustrate if the family and school culture had influenced the youth's interpretation of the world and consequently of HIV/Aids.

Hallinger and Leithwood (1998:132) declare that the characteristic relationships within the school culture or climate will be determined by the defining features of the environment and society that such a culture emanates from. Be it in the home or at school, the child socializes within a specified cultural backdrop uncovering skills and knowledge that could sanction confident social integration and communication (Hallinger and Leithwood 1998:131). By this definition one is able to establish the relationship between school and home that is instrumental in shaping the child's cultural credence and diversity. The



multidirectional outcomes of such relationships could allow for the mutual benefit of cultural groups at large and cultural leadership within the school climate.

### **1.3.2. Education and Culture in the context of HIV/Aids**

Hartell (2007) is of the view that in terms of HIV/Aids, there is a categorical mutual relationship whereby culture affects education which in turn functions to reproduce and preserve culture whereby learners imbibe the distinctive values, knowledge, attitudes and skills within a divergent socio-educational milieu. Recent literature reviews (Rose-Innes, 2006:4; Muturi 2005:77, 82; Paruk *et al.* 2006:511; Khan & Hyder 2001) expose the fact that adolescents are desperately attempting to make sense of their world by looking to their families and educational institutions and programmes.

Rose-Innes (2006:4) points out that in some areas adolescents do not possess significant formal education and have not received reliable, beneficial information on HIV/Aids and sexuality from either the family or the school, believing instead in dangerous cultural myths and misconceptions. Cultural myths and misconceptions are major contributors to why South Africa has a fast-growing HIV/Aids rate, with highest prevalence (15.64%) among young people (15 to 24 years), especially females (Hartell, 2005). Thus, schools that do not take HIV/Aids education seriously create scope for myths and misconceptions among adolescents.

The opinion of Aarø, Flisher, Kaaya, Onya, Fuglesang, Klepp and Schaalma (2006:150-151) is that effective control of HIV infections can be achieved if unique socio-educational and cultural situations that engender vulnerability are researched and taught. The concept is supported by Wilson & Miller, (2003:84-85) who contend that scientific knowledge can constructively influence adolescent knowledge and attitude and consequently behavior. Adolescent behavior-change can be the product of revised learning programmes that are followed by revised mind-sets that result in the youth's predisposition to indulge in non-risky behavior that prevents HIV infection (Panchaud 2005:6). It is acknowledged that the youth are vulnerable to HIV infection but Pembrey (2007) asserts that they are also most

likely to make an effort to modify their behavior to prevent infection if they are positively influenced by family culture and school culture.

The behavior of an adolescent in relation to HIV/Aids is influenced by the original cultural background of the adolescent in the form of the family and community (Airhihenbuwa and De Witt Webster 2004:4). These stimuli will encompass the youth's beliefs and values and may not always lead to positive behavior or care and support of people living with AIDS. Airhihenbuwa and De Witt Webster (2004:8-10) aver that it is possible for cultural interventions to produce positive values and dependable, safe relationships that may assist the adolescent in his judgment in the face of HIV/Aids. It is imperative that a superior educational curriculum in respect of HIV/Aids will take cognizance of such cultural concepts and make it accessible to all children (Hartell 2007).

### **1.3.3. Life Orientation and HIV/Aids education**

Jansen (2007:12) is of the view that the school curriculum can incorporate HIV/Aids as a central theme in an active endeavour to deal with the pandemic from a socio-educational as well as a cultural perspective. From the perspective of the South African Department of Education it is a requirement that all schools provide LO and life skills education with the emphasis on HIV/AIDS. In addition, research (Reddy *et al.* 2005:4-5) confirms that the effective implementation of HIV/Aids education as part of the life skills programme during LO lessons can produce positive attitudes and behavior from the learners. The South African Department of Education has a specific curriculum in relation to the Life Skills aspects of LO with reference to HIV/AIDS for Grade 10 learners. One of the questions that I needed to respond to within my research was whether the Muslim school considered HIV/Aids education important enough to be included as part of Life Orientation curriculum.

Panchaud (2005:6) is of the view that the school curriculum together with the co-operation of crucial role-players in the child's life such as parents, teachers and religious leaders can assist the child with knowledge to appreciate the social and cultural aspects of HIV/Aids and to overcome myths and stigma related to the disease. Although parents generally leave

HIV/Aids education to the schools, many school communities are of the view that HIV/Aids should not be emphasized as the disease had not affected their community or school. As a result, it is unfortunate that many South African families and schools ordinarily provide little information regarding HIV/Aids (Campbell, Foulis, Maimane & Sibiya 2004; Kelly 2000:5). Further, at school level some teachers are not aware of any HIV/Aids prevalence and feel that the school is not affected by the pandemic (Hartell 2007). Teachers at these schools do not consider HIV/Aids education and LO as being relevant to their learners' educational needs thus perpetuating myths and misconceptions that result in the further spread of HIV infections (Mosia 2009:1; Berry 2007).

On the other hand the learner who is guided by the teacher about life skills will be able to make informed decisions with regard to personal health and HIV/Aids (Mosia 2009:8). According to Mosia (2009:11-12) there are many challenges that prevent the realization of Departmental goals in terms of Life Orientation and Life Skills education which forms an integral part of the curriculum. These may be that there is:

- A dearth of qualified teachers in LO;
- No specific Life Orientation and Life Skills teaching strategies are provided for the teachers to follow;
- An inadequate LO and Life Skills training development programme for teachers;
- An insensitivity of teachers to deal with topics such as sexuality;
- A constant change of staff in charge of Life Orientation and no communication and exchange of ideas from one teacher to the next;
- A difference between the teachers' ideals and the principles within the LO curriculum; and
- The problem of organizational difficulties which included time restrictions and cumbersome class sizes (Mosia 2009:13-17).

Hence, the failure on the part of LO teachers to deliver in terms of life skills and HIV/Aids prevents the child from acquiring knowledge to develop the relevant attitudes, values and coping strategies to deal with HIV/Aids. Difficulties in respect of the implementation of

LO programmes and HIV/Aids education at school level do not bode well for the realization of the “HIV/Aids and STI Strategic Plan for South Africa, 2007-2011” as well as the Department of Education’s policies considering the fact that schools are an excellent point of contact to work with the youth (Berry 2007). The position of my research was that it was essential to explore how Islamic Institutions of learning viewed and implemented HIV/Aids education and how this education influenced Muslim adolescents’ views with regard to HIV/Aids.

#### **1.3.4. Implementation of the HIV/Aids education at South African schools**

Nanavati and McCulloch (2003:3) and (7:2002) claim that the manner in which a school will resolve the implementation of an active HIV/Aids programme will be determined by the school culture which is influenced by the attitudes and values of the principal, teachers, families, learners as well as the school Trust, Parent-teacher association or Governing body that acts on behalf of the parents. Vollenhoven’s (2003:246) inquiry into the role of governing bodies in South Africa during the time, reveals that school governing bodies generally do not have a proper understanding of National Policy on HIV/Aids and no clear strategy to respond to the impact of the disease. In addition, school programmes are apparently not successful in the structure or application of HIV/Aids education since the 15 to 24 age-group has the highest rate of HIV infection (Statistics South Africa 2006b:3). The recommendation from this research is that all educational institutions ought to be aware of law and policies relating to HIV/Aids to be able to assist teachers in their duties in this regard (Vollenhoven’s 2003:246).

According to Mary Crewe (2004:3), the Director of the Centre for the Study of AIDS at the University of Pretoria, presently South African state directives are meant to result in “ [...] effective and functioning school system(s) and the most basic education, to HIV Prevention”. The Education White Paper 6 (2001) that dealt with “Special needs education” in South Africa affirmed the following major points in relation to HIV/Aids education:

- i. *The development of inclusive education and training to include HIV/Aids (1.6.1. p23);*
- ii. *The Ministry will analyze the impact of HIV/Aids consistently and aim to develop and implement appropriate and timely programmers one of which will be the development of teaching guidelines (2.2.8.1/2.2.8.2. p34; 4.3.11.1/4.3.11.2 p50).*

London and Robles (2000:1267) are of the view that educational programmes ought to advocate knowledge that clarifies the manner in which HIV can be transmitted or prevented. Debatably, the school's life skills curriculum is said to be implemented at 100% of the schools but what is not documented is what percentage of this curriculum focuses on HIV/Aids education nor the capacity of the teacher to execute this educative task effectively. Researchers (Mosia 2009; Reddy *et al.* 2001) argue that the South African school's LO Programme can initiate behavior change via the teaching of life skills to encourage adolescents towards non-risky behavior. This line of reasoning is supported by the South African Department of Education (2003) that provides that the learning area of the LO programme at schools is meant to uphold a 'holistic approach':

*The focus is the development of self-in-society and this encourages the development of balanced and confident learners who will contribute to a just and democratic society, a productive economy and an improved quality of life for all. Life Orientation guides and prepares the learners for life and for its responsibilities and possibilities. This learning area addresses knowledge, attitudes, values and skills about the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity and career choices. It equips learners to solve problems, to make informed decisions and choices and to take appropriate actions to enable them to live meaningfully and successfully in a rapidly changing society. (South African Department of Education 2003)*

Should the school be mono-cultural (as in the case of my study, Muslim), this in turn will influence what aspects of the HIV/Aids curriculum will be taught, who will be responsible

to do so, how such aspects of the curriculum will be taught and whether the school culture will dictate if it is necessary to teach HIV/Aids education at all. Researchers such as Mosia (2009), Hartell (2006) and Varga (1997:47) have confirmed that LO and HIV/Aids education is not uniformly implemented as there are South African schools that consider that HIV/Aids is no “big deal” for them. This outlook emanates from the attitudes pervading the family and school culture of those schools where HIV prevalence is low and people feel they are “safe” from infection and adolescents are at a disadvantage.

Of significance to my study is that within the framework provided by the Department of Education, the LO teachers are supposed to ensure that learners are taught about HIV/Aids and sexuality. Research by Mosia (2009) and Prinsloo (2007) has revealed that the teachers did not understand and implement the LO programme correctly since they were generally dissatisfied with the content and aims of the programme as well as the standard of training that was provided to them by the Department of Education. Some schools from rural areas and poor socio-economic sectors were most adversely affected in terms of delivery as they did not have the necessary community involvement with the school, there were poor role models for the children to emulate and there was a lack of acceptable societal value systems that could assist the teachers with this LO programme (Mosia 2009; Prinsloo 2007:162-164). The teaching of LO is left to teachers who often do not make it to the lesson since the subject is not taken seriously. The teachers were also aware that their teaching did not go beyond the classroom as learners forgot what they learnt when they were faced by influences outside the school (Mosia 2009; Prinsloo 2007:165). According to Mosia (2009) and Prinsloo (2007:165), the teachers who participated in their studies articulated that multi-cultural classes made LO difficult since it was an arduous task to cater for so many cultures in one classroom.

Although many teachers are not aware thereof, the Department of Education does have certain policies and strategies in place to support schools and families in the awareness and prevention of HIV/Aids among learners. Some of these that are relevant to this study are:

- HIV/Aids Educational Resources: DOE guidelines for learners and teachers;
- “Develop an HIV and AIDS plan for your school” for school governing bodies, managers, teachers as well as parents (Department of Education 2003a);
- “What parents need to know” (Department of Education 2003b);
- “National Curriculum Statement Grades 10-12” (Department of Education 2007) – guide for teachers; and
- The HIV/Aids Emergency: Department of Education Guidelines for teachers (Department of Education 2002).

Mosia’s (2009:2-3) investigation contemplated the teachers’ knowledge and execution of the LO programmes as recommended by the Department of Education in South Africa. These Departmental directives specify that it is important to take into consideration the “professional backgrounds and educational levels of the teachers” within the particular school situation in order that teachers are able to provide learners with the “knowledge, skills, attitudes and values that will empower them to cope with the challenges of life” (Mosia 2009:11-12; Department of Education 2002:1-3). This implies that teachers ought to be equipped professionally as well as morally in order to teach skills and values to children taking into consideration the dynamics of the specific community and the world in general.

It was fundamental to my research to consider Mosia’s (2009:3-5) conclusion that teachers with conflicting personal values experienced difficulties in trying to include the culture of the school community within the LO and Life Skills. In addition, an analysis conducted in Cape Town of the teacher’s views within the realm of HIV/Aids and school culture, Adonis (2005) found that there was an irrefutable connection between school culture and the teachers’ professionalism and presentation. Most of the teachers in the inquiry by Adonis (2005) had formed a beneficial relationship with the parents and other relevant members of the school community so that the ideals of the society could be fostered for the benefit of the child’s progress at school. The school culture in this study was the same as that of the community’s hence teachers were able to work as a team while they upheld both modern and traditional notions of the school culture. However, Adonis did find that the

one teacher who did not belong to that community and who differed in his outlook to the rest of the teachers found great difficulty in applying his philosophy of education as it did not blend in with the school culture.

Researchers such as Terry, Mhloyi, Masvaure and Adlis (2006:39) and Moletsane (2003:2) emphasize that school laws, policies, customs and aspects that pertain to school culture can either ensure or fail to ensure that there is substantial focus upon HIV/Aids Education within a school culture. It has been established (Moore, Gullone and McArthur, 2004:210) that there is frequently an increased risk of HIV infection where school cultures negatively influence adolescent attitudes regarding stigma, discrimination, silence and denial within communities. Factors in terms of the manner in which school cultures influenced HIV/Aids education were significant for my study particularly in the construction of research questions that would expose the competency of the Muslim culture to promote correct AIDS education to benefit adolescents.

#### **1.4. HIV/Aids in South Africa**

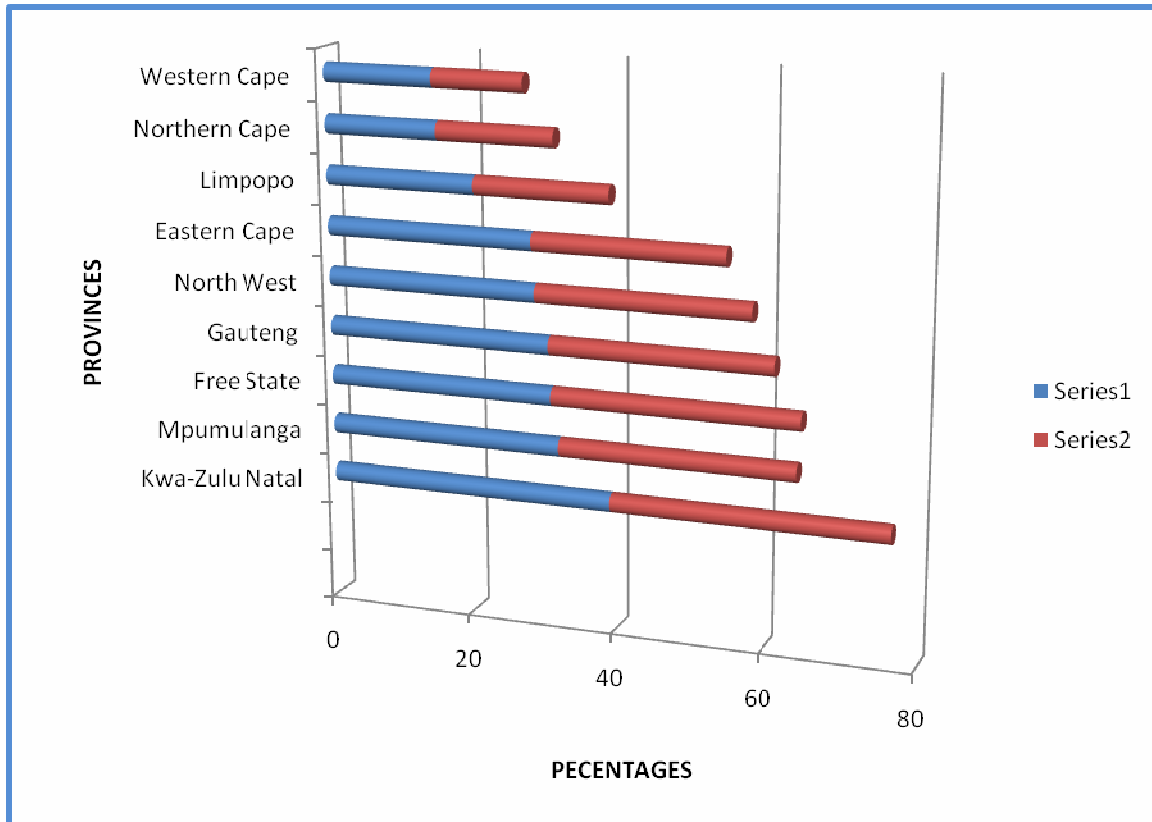
AIDS is a generalized epidemic in most African countries and has stabilized in South Africa but at a high level – hence the need for interventions to control the spread of HIV/Aids (UNAIDS/WHO 2008). Despite the introduction of fundamental HIV/Aids educational programmes in various sectors of the South Africa community, 947 AIDS-related deaths occur every day in South Africa alone (Nicolay 2006). The representation below derived from “The National HIV and Syphilis Prevalence Survey South Africa” (2007:11) demonstrates the consistently low HIV prevalence in the Western Cape of South African where my study was conducted:



**Figure 1: National statistics for HIV prevalence in South Africa**

*Adapted from ‘The National HIV and Syphilis Prevalence Survey South Africa- 2007’*

*(South African Government 2007:11)*



Series 2: 2007

Series 1: 2006

Although statistics provide by the Population Census 2001 (Statistics South Africa 2006a) that demonstrate the difference of HIV prevalence in each cultural group in South Africa are not available it is important to note that there is a consistently low HIV prevalence in the Western Cape where my research was conducted. This region of South Africa also has a significant Muslim community of 292 895 which is followed by Christians and then those with no religious affiliation of the almost 4 million population in that province. Hence, these statistical factors form crucial support for my investigation and could encourage further research to uncover what socio-educational and cultural factors are contributory towards a serious HIV infection rate among South Africa youth. Further justification for my study was that a key priority of the “HIV/AIDS and STI Strategic Plan

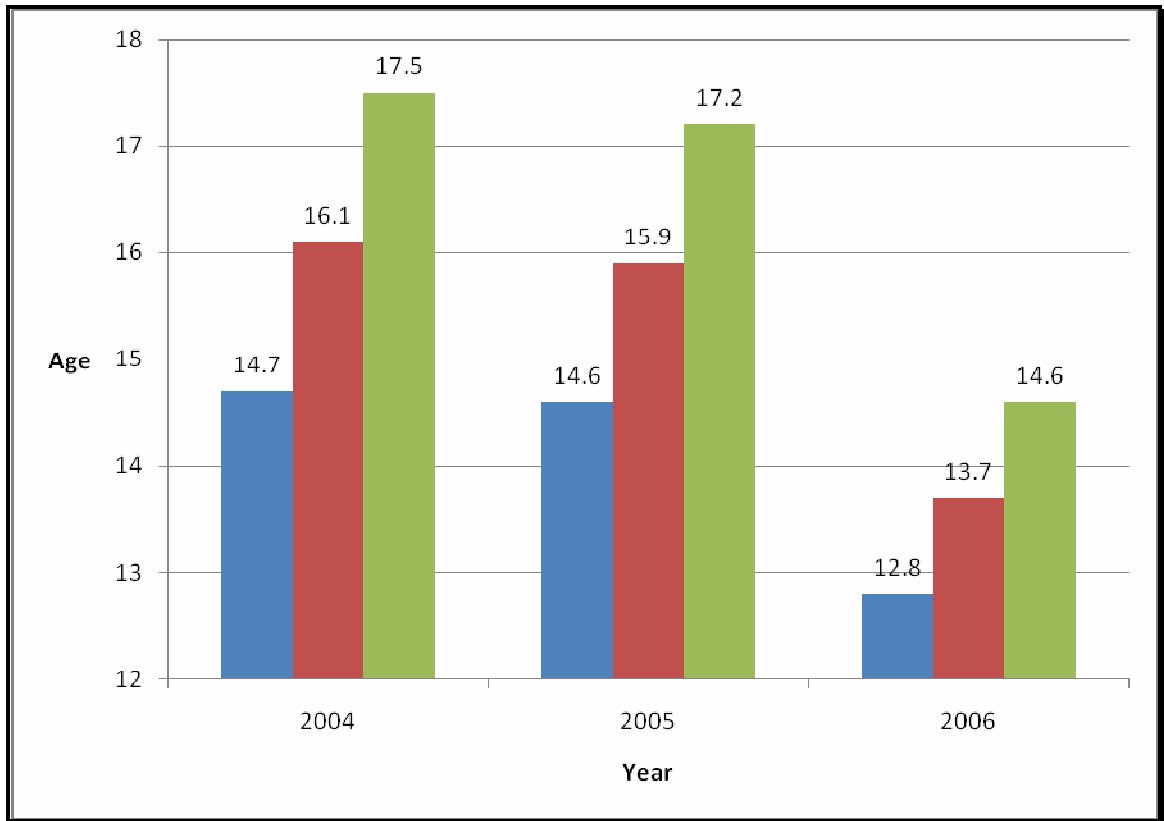
for South Africa, 2007-2011” (South African Government 2007:9), was the development of strategies by the school so as to influence knowledge, attitude and finally behavior change in relation to HIV/Aids.

The UNAIDS (2008) AIDS Epidemic 2007 Update is of special significance to my research as this depicts that South Africa was even then one of the countries that has the greatest number of HIV infections in the world. This reality is further underscored in the most recent UNAIDS/ WHO Update (2008:3) that states that South Africa is the country with the “largest number of infections in the world”. According to UNAIDS/WHO (2008:10), it is apparent that the relevant South African Departments of Education and Health have not succeeded in dealing with both tuberculosis and HIV as a result of inadequate public awareness, education, reporting, identification and treatment. The disproportionate number of HIV infections among the different racial and religious groups in South Africa is a clear indication that preventative strategies initiated by the South African Department of Education and the Department of Health cannot be considered meaningful (Ghandi 2006). Information *vis-à-vis* HIV/Aids is therefore important to this study as the adolescent’s knowledge of and attitude to HIV/Aids are of great consequence to uncovering elements that will assist in curtailing HIV infections among high-risk groups.

Of singular note is the evidence provided by South African antenatal attendees for the period 2000-2006 that confirmed a decline in the number of pregnant women (15-24 years) infected with HIV although this group accounted for almost 90% of new HIV infections until 2007 (UNAIDS/WHO (2008:10). The Republic of South Africa Report to United Nations General Assembly (2008:31) outlines the following for the age group 15 to 24 years:

**Figure 2: Prevalence of HIV infection for the age group 15-24 in South Africa**

*Adapted from Republic of South Africa report to UNGASS: Age group 15 to 24 years (2008:31)*



From the above illustration it is logical that there is a gradual decrease in the prevalence of HIV infection in the 15 to 24 age group. However, the report from which it is taken also confirms that there is still a need for more scientific research among the youth in an effort to ensure that HIV/Aids education is effective thus assisting to curb the further spread of HIV infections. Researchers like Pettifor, Rees, Kleinschmidt, Steffenson, MacPhail, Hlongwa-Madikizela, Vermaak and Padian (2005:1526) contribute that while the HIV prevalence in the 15 to 19 group of females are considered to have evened out, that in the 20-24 age-group has swelled significantly to thirty percent since 2002. Rose-Innes (2006:4) as well as Hartell (2005:172) are of the opinion that although the South African

youth generally display a significant understanding of AIDS, there are still those who are ignorant of the hazards of risky behavior.

South African research in the field of HIV/Aids among Muslims is inadequate but studies conducted by South African researchers Kagee, Toefy, Simbayi & Kalichman (2005) and Paruk, Mohamed, Patel & Ramgoon (2006:511) do highlight the associated controversies. Statistics provided by the aforementioned researchers and The World Bank (2006) indicate that the rate of HIV infections among Muslims is supposedly low but may be higher than it really is indicated to be. Globally, socio-educational studies pertaining directly to HIV/Aids data in respect of religious groups and racial sectors are rare. In view of the fact that HIV and AIDS statistics within the South African research milieu concerning the youth and culture is inadequate, it is crucial to scientifically investigate this topic because information and findings resulting from such research can provide an important base for educational interventions (aimed at reducing further transmission).

## **1.5. Research Questions**

### **1.5.1. What is the problem?**

From the preceding discussion and the consequent elaboration of literature studies in Chapter 2, it is apparent that the prevalence of HIV/Aids is high among adolescents in South Africa, especially girls (Louw 2009). By and large, the South African youth may still lack HIV/Aids knowledge and some may have an apathetic attitude on the matter (Louw 2009). However, it is apparent that Muslims in general have a low prevalence of HIV infections within their community (World Bank 2006; Kagee *et al.* 2005) – a fact that stimulates inquiry as to what makes this hypothetically low prevalence possible. It therefore becomes necessary to consider whether and how their Muslim family and school culture influence their knowledge and attitudes, consequently their behavior thus resulting in a low prevalence of HIV in that community. In keeping with the theories proposed by Elbot and Fulton (2008:2) and Schein (2004:17-21) such an argument may be a subject for further debate as to if there really is a dual relationship between “culture” and “education” (see page 7). This begs the question as to whether there is a relationship between this Muslim family and school culture and do these aspects influence the Muslim adolescent’s

knowledge of and attitudes to HIV/Aids. Accordingly, the purpose statement forms the general framing for the specific main research question as well as the sub-sequential questions as indicated below.

The main research question of this study was defined as:

**How do the culture of the family and that of the school contribute towards inculcating knowledge of and attitudes to HIV/Aids among Muslim adolescents?**

The research sub-questions were:

1. What does the Muslim family regard as good education in terms of its culture?
2. What does a Muslim family regard in terms of its culture, as the responsibility of the school, in respect of HIV/Aids and sexuality education?
3. What does the school regard as its role and responsibility in relation to HIV/Aids education?
4. What is the primary aim of the school with regards to HIV/Aids education?
5. How does the school contribute towards HIV/Aids education?

## **1.6 Aim of the study**

The main aim of this study was to investigate how the relationship between the culture of the family and that of the school contributed towards inculcating knowledge of and attitudes to HIV/Aids as well as responsible sexual behavior among adolescents. Initially, the present study sought to establish what the Muslim family regarded as suitable HIV/Aids and sexuality education in accordance with their culture and what was therefore the school's responsibility. On the other hand, the study intended to expose what the school perceived as its responsibility towards HIV/Aids education. In addition the research had to determine what the school considered to be the expectations of the Muslim family regarding HIV/Aids education. Furthermore, the study endeavored to confirm what cultural practices within particular families influenced school culture and how school culture influenced teacher's perceptions and their teaching of HIV/Aids. Finally, it was imperative that I examined the manner in which the adolescents' understanding and experiences of the

culture of the family and the school influenced their knowledge of and attitudes to HIV/Aids.

## **1.7. Explanation of Core Concepts in relation to the study**

The subsequent discussion clarifies the following:

### **1.7.1. Culture**

Regardless of the demographics, each society has unique value systems within its culture that are imbibed by the people who form part thereof – the way they perceive their environment and what they derive from the conventions within that community (O'Hagan, 1999:273). According to Christopher (1996:18) “culture” shapes the course of an individual’s moral disposition and “moral vision” which refers to the “constellations of cultural values and assumptions that shape our experiences of life and the stances we adopt toward it”. Within the context of any organization or society there are “social constructs” (Jonsson, 2003:15) or time-honored moral standards that operate as a guide to the people within such a society about norms, beliefs and attitudes or rights and wrongs (Bourdieu 1977). An analysis from a human rights perspective reveals that such principles will steer children in particular towards the acceptable doctrines that are socially and historically relevant within the particular community (Smith 2000).

Knutsson’s (1997:43) take is that one facet of reality that is responsible for the development of an all-inclusive social life and that encompasses the manner in which people communicate, conduct themselves and construe circumstances is “culture”. According to UNESCO (2004), it is mandatory that the term ‘culture’ be comprehended as ‘ways of life, traditions and attitudes, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communication, etc’. Jansen (2006:59) emphasizes the role of traditional culture and values in the sphere of HIV/Aids in view of the fact that these concepts have a bearing on the nature of relationships that exist within social groups and that can therefore influence the adolescent.

According to Hallinger and Leithwood (1998:130) the embracing culture of a social group will display the actions, values and behavioural norms within that group. Thus a child who is exposed to these essential core values that are acquired from a culture is influenced with regard to understanding of knowledge and behavior and consequently the formulation of attitudes (Hartell 2007). Kelly (2002:10) draws attention to research that has found a stark difference between the dissemination of cultural knowledge pertaining to males and females and the consequent behavioural diversity and intensity of HIV infections in these groups of youth. Despite the fact that certain cultural values will be emphasized more than others in each social group, research has shown that there is even more variation within school cultures of any particular social group (Hallinger and Leithwood 1998:147).

In terms of this study “culture” was accepted as UNESCO prescribed but my interpretation also included the opinion of Christopher (1996:18) above. In other words that culture impacts upon the behaviour of all human beings determining the way of life, traditions, attitudes and behaviour as well as moral wisdom within a particular social group. Hence, within the context of such reasoning, culture can be expected to operate as an evolving influence within an adolescent’s life controlling the individual’s attitude towards HIV/Aids.

### **1.7.2. School Culture**

One feature of social culture pertinent to this study is ‘school culture’ which is considered to be a “hidden curriculum” that encompasses the entire mechanism of the school incorporating all aspects of communication and associations (Wren 1999:1). School culture forms part of this “hidden curriculum” that is often found at schools whereby certain activities take place despite the fact that these are not written within the rules and regulations of the school (Jerald 2006:1). The ethos of any school will be determined by this influential ambiance that affects the teaching and learning of a school in a multitude of ways. From a historical perspective it is apparent that the different school cultures or climates will have a constructive or negative effect upon the running of each school differently depending upon the scope and quality of involvement of all the benefactors within each cultural group (Wren 1999:2-3; Hallinger and Leithwood 1998:141).

It is also important within the realm of this study to contemplate the theoretical interpretation of ‘school culture’ that is aptly presented by Boyd (1992: 3) which state that the concept refers to:

- The attitudes and beliefs of the individuals within the school and outside the school;
- The cultural norms pertinent to each school comprising informed, accepted policies that dictate behavior in the school and the society; and
- The group and individual level interactions within the school i.e. the principal, the teachers, the learners as well as the parents.

For the purposes of this study the general concept of “school culture” that can vary from school to school was taken into account together with Barth’s (2002,7) definition which states that a “school’s culture is a complex pattern of norms, attitudes, beliefs, behavior, values, ceremonies, traditions, and myths that are deeply ingrained in the very core of the organization”. Being an entrenched power of authority, the school culture permeates the moral fibre of the school affecting thought and behavior of all role-players significantly (Hallinger and Leithwood 1998:140). Accepting that the issue of HIV/Aids conjured up the idea of safety, the interpretation of Edwards (2006) was also reflected upon as this definition deemed that school culture promoted a “safe, orderly climate conducive to learning”. My inquiry incorporated the foregoing explanation by Boyd (1992) as it is evident that culture and school culture, in particular, have a direct effect upon a Muslim individual’s response to HIV/Aids and whether or not the school culture had a compelling mandate to regulate the further spread of HIV infection among adolescents.

### **1.7.3. Family**

There appears to be no single definition of the term “family” but some experts (Allen 2000; Fine 1993) agree that the definition is guided by theory, history, culture and situation. Further, the definition of “family” is dependent upon cultural aspects of particular social situations where members are related either biologically, emotionally or legally (McDaniel, Cambell, Hepworth and Lorenz 2005; Diem 1997). The social interactions within the



central structures of a society will therefore define a “family”. Scanzoni, Polonko, Teachman & Thompson (1989:27) aver that traditionally a “family” could be defined as two parents, and a child or children. From an anthropological perspective, “family” may be defined in terms of biological and marital nuances within any cultural context (Diem 1997:1). The rules of kinship within a culture will then dictate whether the connotation is based on patriarchal, matriarchal, or a combined biological interpretation. According to the United Nations (1948) definition of “family” the concept stands for ‘the natural and fundamental group unit of society and is entitled to protection by society and the State’. Stack (1996:31) considered the family to be ‘the smallest organized, durable network of kin and non-kin who interacts daily providing domestic needs of the children and assuring their survival’.

Dhami & Sheikh (2000) maintain that the Muslim “family unit is regarded as the cornerstone of a healthy and balanced society” and is a constituent of the “Islamic Social Order”. On the other hand, Ahmad (2009), is of the view that the Muslim family is structured in a three-fold manner consisting firstly of “the husband, wife, their children, their parents who live with them and servants”. Then the central section of the family within which there can be no inter-marriage, is made up of “close relatives... who have special claims upon each other”. Emotional ties are strong with this group that represents “the nucleus of relationships”. Another relationship evident in these groups is “polygamous relationships” (a marital relationship in which a person has more than one spouse at the same time) that are permitted in Islam with “strict conditions and when no better alternative is available” (Badawi 1998). All other interactions beyond these two groups form the third group or “outer periphery of the family”. According to Haggag (2010), Muslim families ought to relate to one another closely observing certain values and traditions pertaining to Islamic Shariah (laws).

I estimated that the concept “family” even within the Muslim society, is transforming regardless of the context of HIV/Aids. For this reason Stack’s (1996:31) deliberation was important to my study as it encompasses factors that are applicable to my insight into the term “family” considering that I accepted that learning within the family context was

imperative to the well-being of the adolescent since it encouraged togetherness, sharing and know-how.

#### **1.7.4. Family Culture**

“Family culture” is an expression that ought to be considered together with the changing nature of the family in this century and encompasses the cultural traditions of the family. It is therefore a vital part of an individual’s life. Kahn’s notion (2007:46) is that the role of the family in the adolescent’s sexual decision-making is irrefutable since the exchange of ideas with dependable parental role models as well as peers can inculcate appropriate HIV/Aids knowledge and attitudes. Smart and Shipman (2004:492) take into account the opinion of Beck and Beck-Gernsheim, who contemplate the transformation featuring in modern relationships within “family landscapes”, the decline in “traditional certainties” together with the risk of personal relationships.

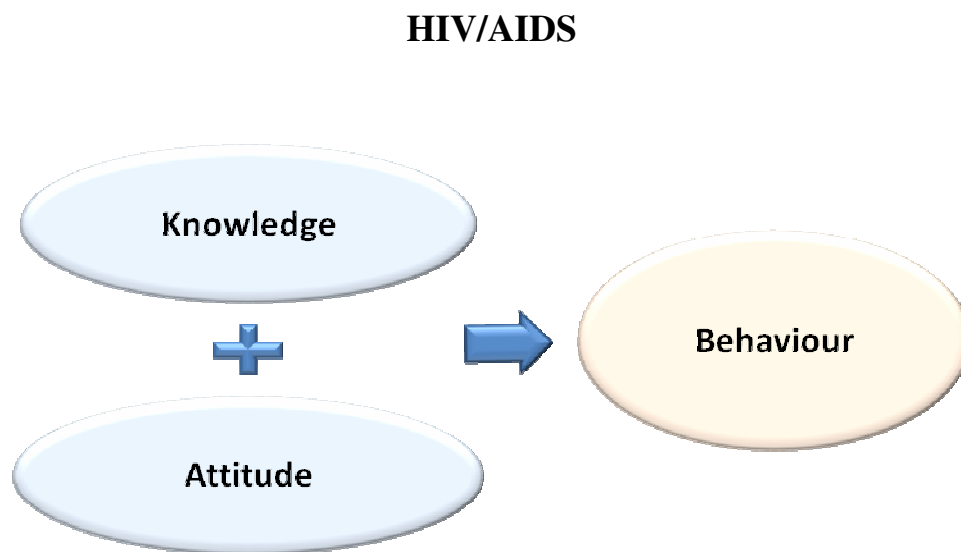
Values and experience form indisputable components of social configuration and consequently social groups, social relations and finally social identities within family cultures (Irwin 2003:567). Wadud (2003) challenges the issue of irregularities between intent and experience within the family and aimed to throw light on the concept of “family”, concentrating on what she found to be supportive and what was destructive within existing Islamic cultures. A singular nurturing, supportive family environment can lead to the necessary foundation that adolescent Muslims require in order to modify what they know and consequently their responses to HIV/Aids. As indicated by Smart and Shipman (2004:507) cultural traditions and practices evolve with each generation in keeping with the hurdles that need to be overcome.

This inquiry assigned significance to the connotations attributed to “family culture” by Irwin (2003) and Wadud (2003) who are of the opinion that the adults in the family ought to set appropriate examples for their children (in this case Muslim children) in order to exemplify the values, nurture, support and social identity of a family.

### 1.7.5. Knowledge of and attitude to HIV/Aids

The following is a representation of the main themes of this investigation in terms of the Muslim adolescent's knowledge of and attitude to HIV/Aids. The contentions of researchers (Kelly 2000:5; Panchaud 2005:6) in this field regarding adolescents were relevant for the purposes of this inquiry since these uphold that once the adolescent accepts the knowledge imparted certain attitudes are formulated influencing certain forms of individual behavior:

**Figure 3.: Adolescent's HIV/Aids Knowledge, Attitude in relation to Behavior**  
Adapted from information from Kahn (2007) and MacPhail & Campbell (2001)



Explanations relating to the relevance of the above concepts and others pertinent to the study are explained hereafter:

#### 1.7.5.1. Knowledge

Clarke (2001) concedes that “a body of facts and principles” is generally referred to as “knowledge”. Acknowledged hypotheses regarding “knowledge” speculate that the term encompasses “a reality, outside the human mind” that is therefore “intrinsic or implicit

within individual humans” (Clarke 2001). Kahn (2007:3) and MacPhail and Campbell (2001:1614) are of the opinion that “knowledge” in the form of norms and values derived from the adolescent’s socio-cultural and socio-educational environments, contribute to the shaping of the adolescent’s understanding and attitude which lead to certain behavior in respect of HIV/Aids. Research data pertaining to the South African adolescent’s knowledge and consequent sexual behavior is limited thus it is difficult to ascertain what knowledge derived from social environments or cultural practices will produce appropriate behavior change to contribute to reducing risky sexual attitudes and behavior (Kahn 2007:3-4; MacPhail and Campbell 2001:1614).

Within the context of this study, the term “knowledge” with reference to HIV/Aids acknowledged the awareness and skills acquired by an adolescent through experience or education (Clarke 2001; Kahn 2007; MacPhail and Campbell 2001). Hence, “knowledge” was associated with the Muslim adolescent’s “perception, learning, communication, association and reasoning” in respect of HIV/Aids.

#### ***1.7.5.2. Attitude***

In their analysis of “attitude” Fishbein and Ajzen (1980:63) present the term as a collection of beliefs that are demonstrated in an individual’s response or behavior to something. These beliefs are the result of various encounters between the child and other individuals. According to Breckler and Wiggins (1992:409), “attitudes” are “mental and neural representations, organized through experience and exerting a directive or dynamic influence on behavior” (p. 409). On the other hand LaPiere (1934:230) considered “attitude” to be a “behavior pattern [...] conditional response to a social stimuli”. All of the foregoing definitions have some bearing upon the interpretations adopted by this study.

However, for the purposes of this investigation I took into account the definition of “attitude” provided by Pötsönen and Kontula (1999:473) that states that attitudes are “what people think (cognition), feel (affect) and how they would like to behave toward an attitude object (connotation)”. Hence, my line of reasoning contemplated the cognitive and emotional traits of the Muslim adolescent which resulted in certain forms of behavior in

the sphere of HIV/Aids. In conjunction my study also took into account the influence of the family and school culture, on the Muslim adolescent's attitude towards HIV/Aids and the way in which the Muslim adolescent thought, felt and behaved within the context of HIV/Aids. I also reflected upon the contentions of Rimal and Real (2003:370-371) who emphasize the relationship between attitudes and beliefs with regard to risk perception and low-risk behavioural responses to HIV/Aids.

## **1.8. Methodology**

The Social Cognitive Theory as well as the Eight Gateways described by Elbot and Fulton (2008) constituted the theoretical frameworks of the study which in turn supported an interpretivist epistemology. The preferred qualitative case study method culminated in the choice of an independent Islamic institution as the case study in question.

### **1.8.1. Theoretical Frameworks**

#### ***1.8.1.1. The Social Cognitive Theory***

I conducted my analysis under the umbrella of the Social Cognitive Theory that has evolved from the belief of earlier theorists that behavior is mechanically produced. This philosophy impacted upon my research into the Muslim adolescent's knowledge of and attitude to HIV/Aids since these characteristics eventually influence behavior. The framework of the Social Cognitive Theory facilitated the investigation underpinning the cultural background of the research into the Muslim adolescent's knowledge of and attitudes to HIV/Aids. I considered the most recent paradigm shift within the Agentic Perspective of the Social Cognitive Theory that suggests that behavior is the deliberate product of cognitive factors (Bandura 2001:2). Hence, according to the theory an individual has to acquire "knowledge" in order to develop "self efficacy" to achieve the goal to remain free of HIV infection (Bandura 2010:144). Based on a computational model this recent modification considers the role of the multi-level cognitive network that an individual is privileged to possess in the execution of any action. This can be interpreted as a unique conscientious effort (derived from knowledge) towards regulating behavior (dependent upon attitude) and being fully aware of the environmental factors (Muslim family and school culture) as well as the consequences of certain deliberate actions (Bandura 1989:9).

More recently Bandura (1994) deliberated the role of social interventions and personal preventative measures in respect of AIDS within the context of the Social Cognitive Theory (Bandura 1994:2). Bandura's exposition confirmed that an individual's knowledge or enhanced comprehension of HIV/Aids does not necessarily result in "self-directed" behavior-modification towards non-risky behavior. On the contrary, while directives via the social environment are vital, Bandura stresses that it is also imperative for one to be resolute in one's attempts to change one's attitudes and then behavior in order to avoid the disease (Bandura 1994:2). While it was central to this exploration to consider societal regulations in the form of culture it was also important to explain the role of the "self-regulative skills" of the Muslim adolescent. Considering the framework of my investigation the query was whether the Muslim family culture and school culture exerted any influence upon the knowledge, attitudes and consequent behavior of the Muslim adolescents within the HIV/Aids context. A more intensive discussion of the theory appears in Chapter 2.

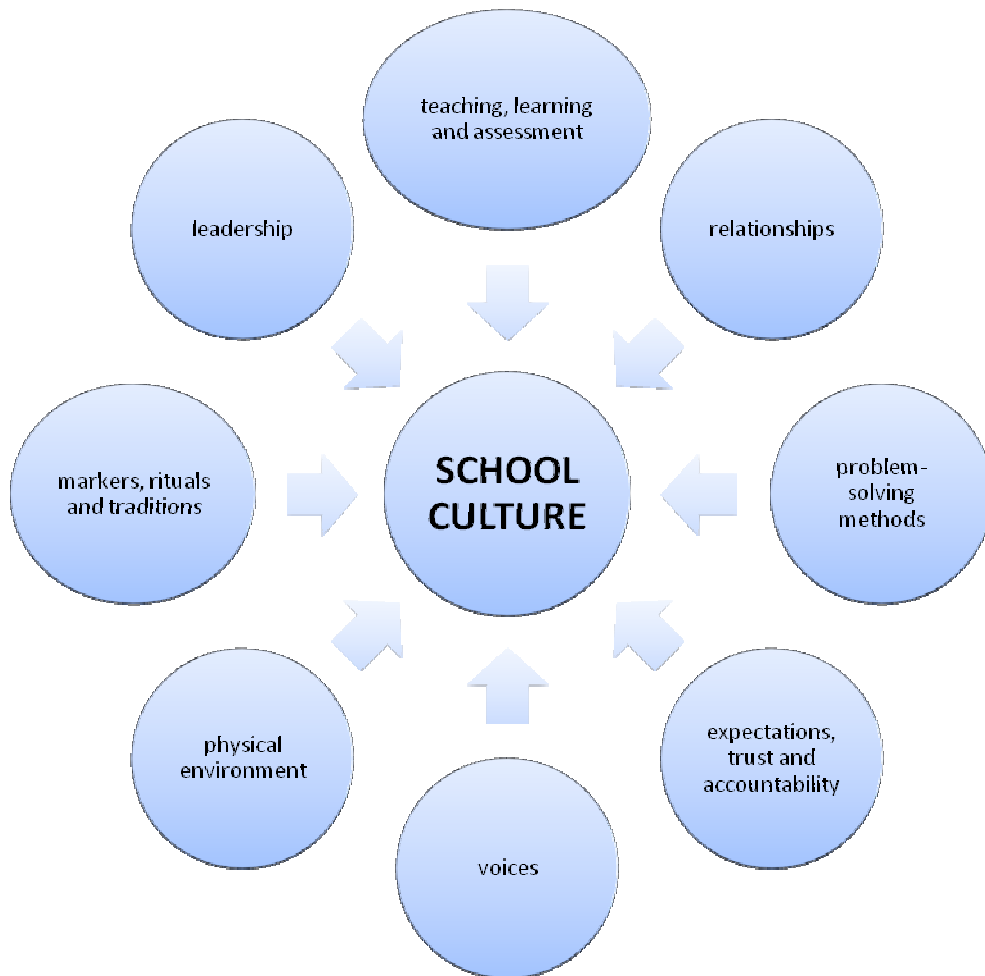
#### ***1.8.1.2. Eight Gateways***

In view of the assertions discussed in the introductory chapters regarding the dual relationship between culture and education, it was important for this study to consider Elbot and Fulton's (2008:74-105) Eight Gateways<sup>8</sup> that are seen as "entry points" that contribute to any school culture. My research assumed that in terms of the Eight Gateways pertaining to school culture the following characteristics were relevant:

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<sup>8</sup> Elaboration of *Eight Gateways* in Chapter 2, 2.6.

**Figure 4: “Entry points” contributing to School Culture**  
**Adapted from information in Elbot and Fulton (2008)**



Such characteristics or “entry points” in the establishment of the school culture have been found to be influential to varying degrees within the school culture (Elbot and Fulton’s 2008:74-105). A more detailed explanation of each of these Eight Gateways is found in Chapter 2 (paragraph 2.12.2.) of this thesis.

### **1.8.2. Research Paradigm**

In order to incorporate the perception advocated by Nieuwenhuis (2007a:50-51) I interpreted my research problem from the epistemological perspective of interpretivism

and from a qualitative research paradigm. The position of the research participants' regarding their knowledge and attitudes in the context of HIV/Aids and the meaning they attributed to their experiences contributed to my interpretation of the research questions. Consequently, from this explanation I was able to make deductions at the end of my study regarding the manner in which school culture and family culture were influential upon the Muslim adolescent's knowledge, perceptions, beliefs, norms and attitudes with reference to HIV/Aids.

The epistemological assumption of this qualitative research examined the extent of the Muslim adolescent's knowledge and attitudes regarding HIV/Aids within the family and school cultural contexts (McMillan, 2008: 271). Nieuwenhuis (2007a:50-51) contends that qualitative research is a study of people *in situ* wherein the researcher's processes as well as the social and cultural contexts form the basis of human behaviour. Hence, I uncovered rich descriptions within a naturalistic context of a detailed case study research method that resulted in a comprehensive understanding of the complex adolescent knowledge and attitude towards HIV/Aids in respect of family culture and school culture (Yin 2003:13; Creswell 2002:61). The interpretive, qualitative research process allowed me a "holistic, in-depth investigation" (Tellis 1997:1), a concise clarification of the reality as perceived by the participants and represented my results precisely (McMillan 2008:272-273). These ideas are exemplified in Chapter 3.

### **1.8.3. Research Approach**

The strategy to employ the qualitative case study research approach was principal to my study that aimed to conduct an in-depth inquiry into the explicit social group which is the Muslim Grade 10 adolescent in relation to the school and family cultures *vis-à-vis* their knowledge and attitudes towards HIV/Aids. I was able to observe the human element of an authentic societal milieu within the social theoretical framework of the Social Cognitive Theory during this inquiry (Cohen, Manion and Morrison 2005:181).

The case study as a qualitative research design necessitated the in-depth examination of chosen Muslim adolescents from an Islamic institution that was composed of a Girls'



school and a Boys' school. Within the boundaries of this case study design I proposed to obtain a comprehensive insight into the knowledge and attitude of the Muslim adolescent as these characteristics might be influenced by Muslim family and school culture. A more detailed discussion of the case study is presented in Chapter 3.

#### **1.8.4. Data Collection Strategies and Sampling**

A purposive research sample had been identified within the population of an independent Islamic institution. Further details of the research sample, data collection strategies and sampling will be communicated in Chapter 3, together with the details pertaining to the permission to conduct the research at the Independent Islamic Institution (sought via the proper ethical channels as prescribed by the University of Pretoria). Once the necessary permission from the relevant school officials was sought and gained, the research participants were then engaged in the data collection processes of the individual semi-structured interview and the focus groups interviews. These two strategies subsequently sanctioned descriptive researcher observation (McMillan 2008:277-279). The principals, parents, members of the School Trust/PTA and the learners were sources of rich data that allowed me to respond to the main research question of this study.

The sample was chosen from the large Muslim population in Cape Town which is a metropolis in the Western Cape of South Africa. The population of Muslims in South Africa is free to practice their religion like other religious and cultural groups in the country. There are Muslims from all parts of the world in this city but the significant portions of the community are Muslims of Malayan descent and Muslims of Indian descent. I discovered that there were social differences even within their community which indicated that despite their common Islamic religious faith, they practiced the religion in varying ways. Hence, depending on their heritage the different sectors of the Muslims in the Cape dressed and socialized as they had learnt from their forefathers. The Muslim Private School selected for the research was attended by children of Muslim parents who could afford the fees and wanted their children to have the benefit of a reputable school that insisted on strict adherence to Islamic cultural and religious values.

The population of the school was made up of children from Muslim families not only from the suburb the school was situated in but also from other areas as it was a Muslim Private school that catered also for the religious needs of the learners. The learners who were between fifteen- and seventeen-years of age were from varying socio-economic homes as some of them who could not afford the fees were on scholarship to the school. The adolescents admitted that although they were allowed by their parents to socialize with children from all other races, religions and cultures, some of them socialized only with their Muslim peers since they found this convenient. The interviews later indicated that the Muslim learners found it was simpler to observe their Islamic religion and customs if they did not have to explain to their peers why they were unable to socialize in certain ways. As a result of the representative nature of the Muslim population, school population and chosen sample, the data gleaned from the study was pertinent and satisfied the aim of the study.

#### **1.8.5. Data Analysis**

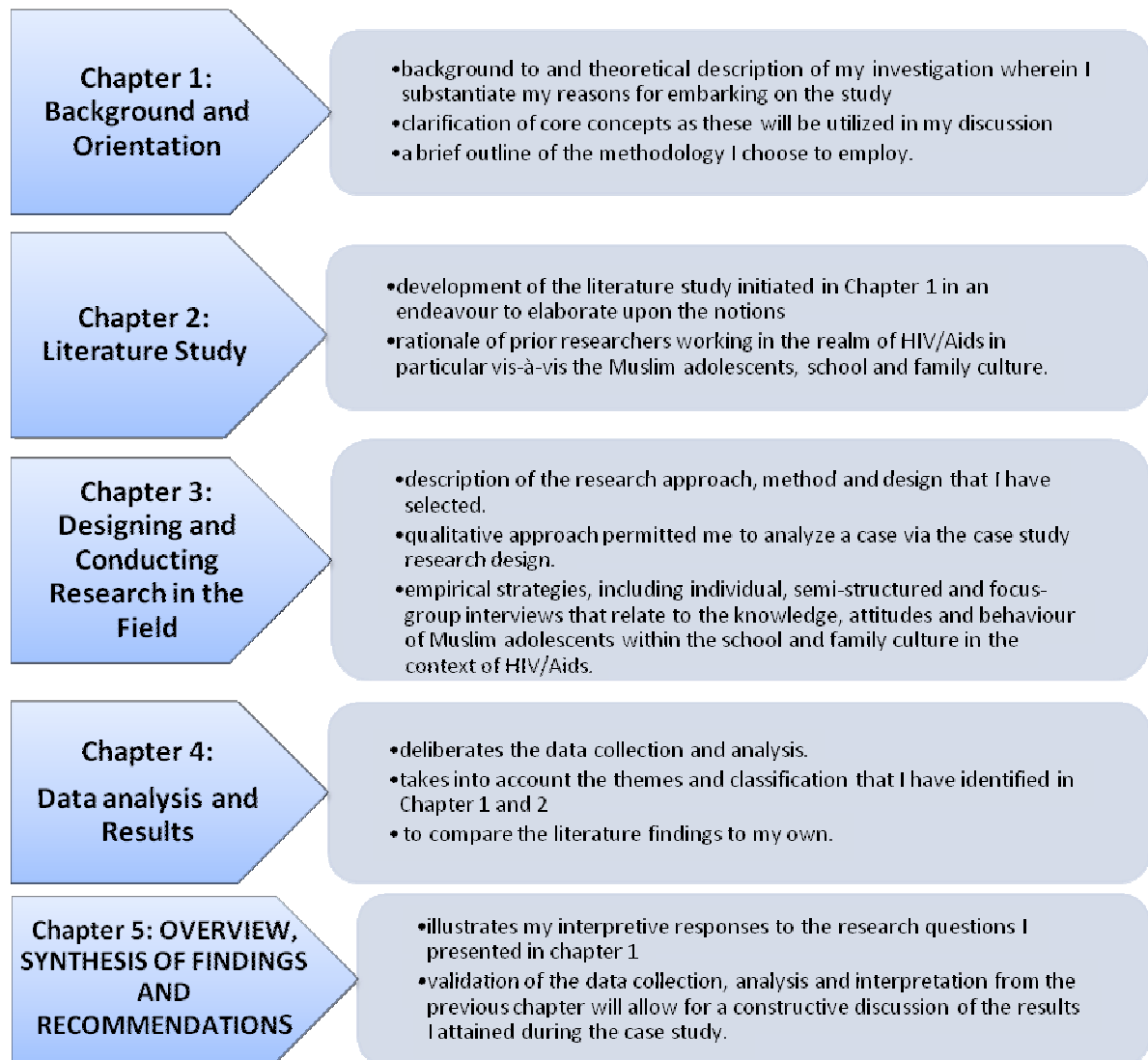
The analysis consisted of the organization of the *emic* data collected from the participants' personal expressions as well as the *etic* data that were derived from my interpretations of the former exemplified themes (McMillan 2008:283). The thematic arrangement of data allowed me to produce a system of coding that represented various aspects of the research such as the perspectives of the research participants as they represented it together with details of my observation (McMillan 2008:283). Thereafter, I considered the said categories and codes (which are described in Chapter 3) to establish relationships and patterns that allowed for deductive reasoning. Details in respect of the data analysis follow in chapter 3.

#### **1.9. Credibility of the Qualitative Case Study**

Like any Qualitative study, this case study was intended to generate trustworthy, constructive and plausible outcomes (McMillan 2008:283). Convincing themes and relationships (as portrayed in Chapter 3) in addition to clear-cut, meaningful and comprehensive deductions were considered important in order to enhance the integrity of this study. The credibility of my research depended upon the reliability of data collection

together with aspects of scrutiny and inferences in relation to the actual data analysis. It was also necessary for me to verify the data with the research participants after the transcriptions were completed.

### 1.10. Organization of Thesis



### 1.11. Conclusion

Statistics with reference to HIV/Aids in the South African context still display the need for rigorous programmes to reduce the prevalence especially amongst the youth (UNAIDS 2008:31). A source of deliberation for my study is submitted on account of a study by

Kagee, Toefy, Simbayi and Kalichman (2005) that reports a 2.56% HIV prevalence in a Muslim community sample of over-15-year-olds which is well below the South African National percentage for this age group. However, as mentioned the relevance within the bigger picture was to ascertain whether Muslim cultural factors might be influential in the supposedly low rates of HIV in this community and if so, could other youth benefit from similar cultural philosophies.

Also of relevance to this study was that HIV/Aids education within the South African schools programme was supposed to be included within the ambit of the LO curriculum as discussed by Prinsloo (2007:155). Prinsloo (2007:155) and Urdang (2007) stress that such programmes around the world teach adolescents to become well-balanced individuals who make the right choices within morally upright relationships in the face of HIV/Aids. The attainment of the research aim determined how Muslim family cultural values and the school cultural patterns influenced moral and traditional practices and ultimately knowledge and attitudes among Muslim adolescents. The literature to support the presentation in this chapter will be discussed in Chapter 2.

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## CHAPTER 2

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### LITERATURE STUDY

*“Like people and schools of criticism, ideas and theories travel – from person to person, from situation to situation, from one period to another. Cultural and intellectual life are usually nourished and often sustained by this circulation of ideas...”* (Crewe 2004:7)

#### 2.1. Introduction

Barnett and Whiteside (2006:3) advocate that while it is generally accepted that HIV/Aids is a sexually transmitted disease, it is important to note that there are predisposing conditions that result in a global AIDS epidemic. Adults are considered as suitable guides to adolescents who fall into a high-risk group that needs to be reminded of the morbidity of the disease and avoid HIV infection (Helleve, Flisher, Onya, Mukoma and Klepp 2009:191; Hartell 2007). The research I conducted scrutinized the influence of the “social capital” (Portes 1998) which is a reference to the “social resources available to children” - thus a reference to the Muslim family and school culture - to encourage “educational growth” in terms of HIV/Aids (van Wyk and Lemmer 2007:301; Coleman 1998:1994). My focus of interest in terms of the social capital referred to the influence of parents and teachers who might have shaped the adolescent’s knowledge of and attitudes to HIV/Aids as well as their sexual behavior.

I adopted the standpoint that just as the social capital and the associated culture are said to promote the well-being of members in a society this inquiry aimed at comprehending whether the family and school culture could positively inspire the course of a child’s responses to the pandemic (Christopher 1996:18; Portes 1998:5-9). The role of “culture” is pivotal in the awareness of HIV infection and was vital in this study (Hartell 2007). Further, it was accepted that there was a dual relationship between culture and education (see paragraph 1.3.1.) whereby culture is transferred to the child from the home and school and might have manipulates the way the child comes to terms with HIV/Aids. Therefore, discussions in chapter 2 provide literature details of the essence of the culture of an institution, the culture of the family and that of the school together with descriptive

accounts of Bandura's interpretation of the Social Cognitive Theory and the Eight Gateways as presented by Elbot and Fulton (2008). Viewpoints of researchers within the context of culture and HIV/Aids and literature based on the adolescent's HIV/Aids knowledge and attitudes are also reflected upon in this chapter. In addition, other information in this chapter appears in the form of research reports, literature studies and the South African state of affairs that are relevant to HIV/Aids. Reviews in respect of HIV/Aids from Islamic countries and the situation in South Africa are also presented.

## **2.2. Education and HIV/Aids**

Social disparities, differing access to education and the vulnerability of women within South African society, do not bode well for effective responses to HIV/Aids. Gregson, Waddell & Chadiwana (2001) assert that "education itself may influence HIV transmission" if productive educational programmes are implemented cooperatively. They state that their experience has proved that "formal education" is a vital solution to the challenge that AIDS presents. Leclerc-Madlala's (2002) argument is that school interventions can be successful if policymakers understand youth sex culture and base their programmes on these. In her estimation, "infection prevention information" will be most effective if "pre-existing sexual patterns and gender inequalities" are addressed Leclerc-Madlala (2002). It is therefore important for the school curriculum to take cognizance of these aspects in delivering HIV/Aids education.

Kelly (2000) acknowledges the role of the school in HIV prevention but is critical of the school curriculum since he believes that the programmes at the time had failed since these were created without proper consultation with the children and community members. Therefore, Kelly (2000) advocates the involvement of parents and other influential members of the community to successfully provide for the needs of adolescents confused by mixed messages. He also stresses the importance of "participatory methods and experiential learning techniques" that would enhance the interest of the learners and encourage behavior-change (2000:6-11). Adolescents are supposed to be encouraged by their teachers, who must buy into the programme, to practice behavior that signifies "respect, responsibility and rights" and to abstain from early sexual encounters to ensure

that they are HIV-free (Kelly 2000:7-11). Visser (2005) suggests that effective school-based life skills education that includes HIV/Aids should take into account input from all stakeholders who willingly support the implementation of such programmes. Hence, there is a collaborative effort to work within the sphere of influence of the social capital within a community.

### **2.3. Influence of culture in the context of HIV/Aids**

Academics and researchers such as Helleve, Flisher, Onya, Mukoma and Klepp (2009:191) as well as Airhihenbuwa and Webster (2004:5) are of the view that the predominant “culture” of a community plays a fundamental role in a society’s efforts to educate individuals about HIV/Aids. I argued that “culture” was influential upon a person’s norms, beliefs, attitudes and even their sense of what is right and wrong thus children were guided by the social capital of the community in this regard (Gould, Marsh and El Bushra 2007:1-2; Christopher 1996:18). Further to the definition of Christopher (1996:18) in Chapter 1 (1.7.1.), “culture” may be seen as “a system of interrelated values active enough to influence and condition perception, judgment, communication and behavior in a given society” (Mazrui 1986:239). The foregoing contentions in terms of “culture” are indispensable for the purposes of the present study of HIV/Aids education. I undertook research that was designed to ascertain whether the adolescent’s knowledge of and attitudes to the disease were structured upon the relationship between the culture that permeated the Muslim family and school,

Airhihenbuwa and Webster (2004:5) found that the cultural context of an individual’s social interactions had a significant impact upon that person’s intention to remain free of HIV/Aids. These researchers (Airhihenbuwa and Webster 2004:5) founded their discussions upon “a culturally based strategy for implementing and evaluating” HIV/Aids by applying the PEN-3 model. Their assumption was that a knowledge of the prevailing culture allowed for “empowerment” to work towards behavior changes to address HIV/Aids (Airhihenbuwa and Webster 2004:5). Accordingly, in Christopher’s (1996:17) definition of “culture” there is a reference to the “webs of significance” from distinctive institutions and family structures can inspire the child’s decisions that affect health, lifestyle and attitudes. In order to exemplify the impact of this social capital and the family

and school culture upon the adolescent's attitude towards HIV/Aids Christopher's (1996:17) ideology was used as an analogy.

However, it was my assertion that Gould, Marsh and El Bushra (2007:4) were correct in proposing that while a cultural approach can contribute positively in the mitigation of HIV/Aids, there are certain cultural practices that can impede positive behavior change. Gould, Marsh and El Bushra (2007:4) together with those authors mentioned below contend that some practices assuming cultural undertones within South Africa might have hindered progress towards enabling safe behavior in terms of HIV/Aids and might have exacerbated HIV prevalence in this country:

- Leclerc-Madlala (1997) examined the cultural practices pertaining to virginity testing and fertility tests procedures that require that girls prove their virginity or fertility prior to marriage. These invasive procedures result in the possibility of multiple-partner relationships, interference and rising HIV infection rates (Preston-Whyte 1994; Leclerc-Madlala 1997). A similar risk may be posed by unsafe sex within polygamous relationships allowed within some cultures;
- Kelly and Ntlabati (2002:44) researched “gender-related oppression” and sexual violence, paying attention to the superior role of the male in relationships within certain cultures. The researchers contented that such aggressive attitudes and sense of male superiority affected women adversely as the females often became victims of rape and eventually HIV.
- Investigations (Leclerc-Madlala 2002:28) emphasizing the detrimental role of misguided cultural beliefs in terms of condom-use highlight the fact that such values lead to “unfaithfulness, lack of trust, lack of love, disease and incompatibility with manliness” that translated into risky sexual behavior and HIV/Aids;
- South African studies (Shisana *et al.* 2009; Varga 1997:47-48) indicate that women face unfair challenges in terms of HIV/Aids since they are often unable to negotiate safe sex and condom use within their restrictive cultural settings;
- Leclerc-Madlala (2002:28; 1997) ascertained that the delusion of older men that “sex with a virgin can cure AIDS” perpetuates sexual violence and the abuse of minors resulting in increased HIV prevalence;



- Although circumcisions are generally performed by competent practitioners, some circumcisions that are executed by inept traditional healers during initiation ceremonies result annually in numerous maimed or fatally wounded initiates. Peacock and Khumalo (2007) assert that as a result of the unhygienic procedures and botched circumcisions employed the youth are placed at risk of becoming HIV infected;
- The concept of the “sugar daddy<sup>9</sup>”, which is the deep-rooted cultural control of the older male over the much younger women illustrating female sexual obedience, is responsible for the prevalence of HIV following violent, unsafe sexual behavior (Leclerc-Madlala 2002:23; Schwab Zabin and Kiragu 1998).

According to the researchers mentioned above, cultural practices can sometimes work against concerted efforts to reduce the rate of HIV infections in South Africa. As indicated by the literature study it was imperative to concede that any research in the field of HIV/Aids ought to take into account the role of culture within the process of HIV/Aids education from the family and the school. This study concurs with the line of reasoning presented by Leclerc-Madlala (2002) that HIV/Aids is considered by recent researchers and academics as a “social and cultural problem that often and effectively dis-enables youth from transforming safe sex knowledge into functional, health-promoting, safer-sex behaviour”. However, at the same time the study considers the role of the Muslim family and school culture in the modification of adolescent attitudes and behaviour in response to HIV/Aids education.

### **2.3. What is school culture?**

Schools impart the norms and values prescribed by the communities that they serve (Osher and Fleischman 2005:84-85). Therefore, the school culture is representative of a diversity of individuals within the school as well as the community along with the attitudes and perceptions of each component. Hence, a mono-cultural school, like the one in my study will exhibit a school culture that is dominated by the culture it represents. The school in my

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<sup>9</sup> This refers to a father-figure who embarks on sexual relationships with young girls in exchange for expensive gifts or favors.

research displayed a dominant Islamic culture that conformed to the values of the school community it represented. The school represented the ideology of Osher and Fleischman (2005:84-85) alleging that the culture of a school will be determined by caring connections, positive behavioural supports as well as social and emotional learning.

Wren (1999:1) reasoned that school culture that is often a disregarded aspect of the educational curriculum represents the “implicit” school curriculum or culture which in turn is dictated to by the social group represented by the school. In keeping with what Samdal, Nutbeam, Wold and Kannas (1998) state school culture too can differ from school to school depending on the values, beliefs, power relations and practices within the particular families that belong to that community the school represents. Higgens-D’Alessandro and Sadh (1998:566) argue that school culture is also strongly affected by teacher-perceptions and attitudes which often need to be adapted to suit the needs of the particular school community and culture.

The school culture plays an undeniable role in facilitating the child’s ability to make informed decisions about personal well-being and HIV/Aids (Barth 1990:512-516). Stoll (2002:4-6) presents that “school culture” forms part of an influential social paradigm that inculcates in children a “sense of self” and “perceptions of reality”. As a result, Barth (1990:512-516) and Stoll (2002:4-6) express views that are particularly relevant to my study as they emphasize the “collaborative relationships” within the school culture and relevance to the impact of HIV/Aids on the adolescent’s life. It is also important to note Barth’s contention that the relationships involving teachers, parents and learners ought to be “trusting, generous, helpful and co-operative” - characteristics that will operate agreeably within the ambit of HIV/Aids. In my study this exchange of ideas from family to school and vice versa contributed to determine the impact upon the knowledge, attitudes and subsequent behavior of the Muslim adolescent-learners.

#### **2.4. Influence of school culture on the child**

In view of the fact that learners come from diverse backgrounds and may feel vulnerable and uncomfortable in disclosing their personal opinions regarding HIV/Aids, the support

system at a school in the form of the school culture can play a significant role in allowing the adolescent to adapt (Schaps 2003:31-32; Moore 1996:597-598). Osher and Fleischman (2005:84-85) assert that explicit behavioural expectations and support in addition to reinforcement regarding behavioural expectations from a school culture perspective, will lead to improved behavior. In order to draw attention to the individuality of each school Stoll (1998:9) describes the school culture as being distinctive to each school setting. Thus, what holds one school culture together will not necessarily work for another since each school culture is dependent upon the community it caters for (Stoll 1998:9).

Stoll (1998:10) explains that the “social mix” in terms of the learners is also significant as this will portray the way in which learners relate to each other and to others in their “social networks” within the school culture. Although social networks are not always “a natural given”, adolescents, like their adult role models are social creatures who form relationships within networks such as families and communities that depend upon specific cultures as frames of reference (Portes 1998). One such social organization is the school that according to Stoll (1998:9) is a “complex and important” facet of education. In keeping with the idea of working towards common goals within the school culture, Elbot and Fulton (2008:2-4) are of the view that learners learn lessons from the “beliefs, values and behaviors” that emanate from role models within their school and family culture.

The accent is placed upon the value of “the school **touchstone**” which is similar to a mission statement but is meant to express the “how” or operational focus of a school (Elbot and Fulton 2006:2). The touchstone expresses the collaborative endeavors of the school to achieve “academic” and “ethical” goals within the school culture (Elbot and Fulton 2008:2-4). The “touchstone” helps to mould the school culture and enhance the attitudes and behavior of the learners (Elbot and Fulton 2008:2-4). What I found was important in this discussion by Elbot and Fulton was that apart from teachers and learners, parents are encouraged to also follow suit extending the value of the “touchstone” or “north star” to provide direction to their children in their own way and encourage empowering values which are beneficial in the teaching and learning.

According to the results of the study undertaken it was found that symbols are particularly apt for the inculcation of values and attitudes that assisted adolescents to avoid being HIV/-infected (Chapters 4/5). The contention submits that this process is enhanced by the creation of a “family-like” ethos within the school so as to promote an attentive, sensitive setting for the adolescent to learn in (Baker’s 1998:39). Baker’s (1998:31) review of “the social context of development” concurs with the assertion above that children interact within a culture with the intention of seeking out suitable role models to uncover “norms” and “shape behavior” for “future social interactions”. With reference to my study the Islamic culture of the Muslim family and the independent Islamic institution were the focal points in the development of “values, beliefs and assumptions” that influenced the Muslim adolescent’s knowledge and attitude in respect of HIV/Aids (Kezar and Eckel 2002).

## **2.5. Influence of parental child-rearing on the child**

Family and school cultures are both social concepts that relate to learned and shared human patterns that filter through human and social interactions discussed by Airhihenbuwa and De Witt Webster (2004) who found that family culture was influential upon the behavior of an individual. An aspect relevant to my study was that Airhihenbuwa and De Witt Webster (2004) and Sweeting and West (1995) indicated that a “culture-centered approach to prevention” of HIV/Aids could be effective. Researchers (Sweeting and West 1995) were of the view that family structure and functioning that affected an individual’s cultural values had a direct impact upon the general well-being of adolescents.

This investigation takes cognizance of Pretorius’s (1998:3) discussion of Angenent’s theories maintaining that parental child-rearing behavior significantly influences the personality traits and behavior of the child. The way in which a child is raised and the manner in which parents behave towards a child are decisive factors in the development of the child’s personality, behavior, values and social interaction (Pretorius 1998:3). Literature indicates that Van den Berg (2005:36-51) is in agreement with Angenent’s hypothesis and Pretorius’ (1998:62) assertion that parental child-rearing styles and responses to a child could impact upon the way a child responds to risky behavior and HIV/Aids. As a consequence, a parent who has an affectionate, tolerant relationship with

his child will be able to communicate in a meaningful way so as to prepare the child adequately to be able to deal with risk situations and personal vulnerability to HIV/Aids (Pretorius 1998:43). On the other hand, a child may be afraid to talk about her fears and anxieties regarding HIV/Aids should her parents be apathetic, cold or domineering (van den Berg 2005:41; Le Roux 1992:152). Van den Berg (2005) employed Angenent's theory in his research and also discovered that parenting styles had an undeniable impact upon the way in which a child reacts to HIV/Aids and to life in general. Consequently, my research had to consider the impact of the Muslim parents' child-rearing styles and communication as presented by Pretorius (1998:43), van den Berg (2005:41) and Le Roux (1992:152).

Marsiglia, Nieri and Stiffman (2006) also portrayed that HIV/Aids constitutes an inextricable aspect of conversation among families. Their research has revealed that family communication about HIV/Aids has a positive effect upon adolescent responses to this important risk in their lives. Adu-Mireku (2003) examined the relationships between parents and adolescents and the role that the family plays in influencing adolescent behavior. A significant finding of Adu-Mireku's study (2003) was that family communication regarding HIV/Aids was pivotal in the adolescent's life. However, just as Adu-Mireku (2003) discussed in that study, Moosa (2009:86/161) also draws attention to the reality that some Muslim families avoid discussions pertaining to sexuality and HIV/Aids. Such an avoidance to discuss salient issues in respect of the child's sexual development can lead to a lack of correct knowledge about HIV/Aids, denialism and condemnation of people living with HIV or AIDS (Moosa 2009:86/161). It was my opinion that such an assertion by Moosa (2009:86) was of particular importance to the findings of this research regarding the Muslim parent as well as the teacher.

As a result, the study endeavored to investigate the nature of the communication with regard to HIV/Aids within the family and school culture of the Muslim adolescent and the manner in which that communication shaped the attitude of the Muslim adolescent to HIV/Aids.

## 2.6. Adolescents' perceptions of their susceptibility to HIV/Aids

Hartell (2005:177) is of the view that some South African adolescents “do not see AIDS as a personal threat” therefore indulging in unsafe sexual behavior. Since the youth are exposed to mixed messages in terms of HIV/Aids, they prefer to believe myths that perpetuate the risk of their being infected (Hartell 2005:178). Ambiguous HIV/Aids communication is one of the reasons that the South African youth is still vulnerable to HIV/Aids (Louw 2009:163; Barnett and Whiteside 2006:24). The disease is a threat to many young South Africans if it continues to be a puzzling concept that they cannot relate to (Louw 2009:163).

Studies (Louw 2009; Nupen 2006; Galloway 1999; Visser 1995; Carelse 1994;) have shown that more often than not adolescents appear to have a basic knowledge of HIV/Aids but they nevertheless believe that they cannot be infected or they do not translate that knowledge into non-risky behavior. Louw (2009:165-166) asserted that learners in his study lacked proper adult guidance in terms of HIV/Aids thus they were indifferent to HIV/Aids and had casual unprotected sex sometimes with multiple partners. Despite the cultural values they were taught, the learners ignored their cultural background and indulged in premarital sex.

A report by Kelly (2002) upheld that at the time youth lacked accurate knowledge and consequently considered that they were beyond the risk of being personally infected – a fact that has had far-reaching effects upon the sexual behavior and proliferation of the pandemic. Special reference to the youth in recent times draws attention to the fact that some youth are generally more knowledgeable about the prevention of HIV though the extent of far-reaching accurate facts among the 15-24 age-groups is still minimal in most countries (UNICEF 2007:3). A UNICEF (1995) study showed that the following adverse factors in terms of HIV/Aids education made learners more susceptible to HIV infection:

- ✓ ‘conflicting messages’
- ✓ ‘lack of knowledge, confidence and skills to talk’
- ✓ ‘belief in myths’
- ✓ ‘Lack of support services’ (Hartell 2005:173).

Nupen (2006:50) ascertained in her study on youth that some of the learners were ill-informed and conceived that the risk of being HIV infected was “problematic only for others”. The investigation (Nupen 2006:52) displayed that in some of the researched societies there existed the notion that there was no need to fear HIV/Aids until the youth themselves were infected. In addition, the learners explained that their lack of fear and casual sexual behavior stemmed from the fact that “the only people we hear about with the disease are of a different race and from a different area” (Nupen (2006:53). The study verified that as a result of their cultural beliefs some of the learners did not want to make use of condoms but nevertheless indulged in “high-risk sexual behavior” (Nupen (2006:53). Nupen concluded that “the learner’s sense of invincibility is greater than their conceptions of risk and fear of the disease”. Louw (2009) also found that adolescents in his study refused to recognize the importance of condom-use since they felt that they were not vulnerable in terms of HIV/Aids.

Data for the 15-24 age group internationally (UNICEF 2007:32) reveals that a large number of youth do not appreciate what the best ways are to prevent HIV or that the youth are unaware of their personal susceptibility to HIV. An investigation into the education, knowledge and attitudes of 15-16 year-olds has uncovered vital gaps in the knowledge of HIV/Aids and the researchers suggest that educational programmes ought to stress safe relationships while they impart accurate knowledge (Thomson, Currie, Todd and Elton 1999:368-369). Louw (2009) and Gurung (2004:9) studied the knowledge and sexual behavior of youth maintaining that adolescence is an important phase in an individual’s life as key values are formulated and sexual experiences may be initiated during this period. For this reason Louw (2009) and Gurung (2004:9) are of the view that the teenagers’ vulnerability makes them a high-risk group in the context of HIV/Aids. Chapter 4 and 5 of this thesis indicate that the contrary was found in the study of Muslim adolescents.

## **2.7. Knowledge of adolescents with regard to HIV/Aids**

Studies by Samdal, Nutbeam, Wold and Kannas (1998:/383-384) and Pötsönen and Kontula (1999:479-483) verify the reasoning that the school provides the ideal platform as

a “structured” setting to convey affirmative messages on the subject of risk behavior as well as the treatment of people living with AIDS within the existing curriculum (Dias, Matos and Gonçaves (2006:213). Hartell (2005:178) contends that adolescents often do not have suitable adult support and are found wanting in “negotiation skills in sexual relationships”. In terms of Mosia’s (2009) experience and Nupen’s (2006:88) conclusions, school programmes were unproductive and teachers ill-informed thus leaving the adolescents ignorant or misled about the virus. Hence, in Nupen’s study, the learners were “bored” by the HIV/Aids information they were exposed to ignoring the warnings about risky behavior.

The recent study by Louw (2009) discovered that adolescent’s lacked the vital guidance and education that could have been acquired from the family or school to equip them with better decision-making skills and to handle peer pressure in order to curb the spread of HIV/Aids. This community-based inquiry by Louw (2009) exposed the inconsistencies in educational programmes even at schools that could have made the adolescents more aware of cultural principles to enhance safe behavior among them. Therefore, the youth in Louw’s (2009) study found their peers the most convenient source of information which resulted in their acquiring inaccurate and misleading information about HIV/Aids. The adolescents in this study (Louw 2009) therefore picked up inconsistent messages from inaccurate sources that resulted in a sense of personal invulnerability when it came to sexual encounters and HIV/Aids. Further, Louw (2009) discovered that the youth indulged in risky sexual behavior ignoring the reasoning behind condom-use exacerbating the situation especially for females.

The vulnerability of a female learner is heightened by her incapacity to sometimes access accurate knowledge and her inability to get past threatening sexual situations that endanger her (van den Berg 2005:167). The investigation by van den Berg (2005:146) confirms that it is imperative to educate learners in terms of their ‘decision-making and communication’ skills. Such knowledge, according to van den Berg (2005:146) could assist the adolescents to become more confident to resist peer pressure in threatening situations that test their exposure to HIV/Aids. Van den Berg (2005:138) argues that the school can play an



important role in educating children about the merits of behaving responsibly to avoid HIV infection.

Research conducted by Louw (2009) and another by Griessel-Roux, Ebersöhn, Smit and Eloff (2005) based on what learners want from HIV/Aids programmes, found that:

- the learners recognized the importance of HIV/Aids education and that more time ought to be given to this aspect at school level;
- they wanted specific aspects of HIV/Aids education to be taught and in a specific way at school;
- they felt that people who were directly affected by HIV/Aids could provide them with vital information;
- they appreciated the factual information up to a point and saw the need for particular details that would suit their needs; and
- They considered that the aspect of fear ought to be instilled in learners to make them more aware and cautious in their behavior.

Hence, researchers such as Louw (2009) as well as Griessel-Roux, Ebersöhn, Smit and Eloff (2005) have exposed that there are adolescents who question the wayward behavior of their peers. Learners in this study realized the dangers associated with risk-taking sexual behavior and that this could lead to HIV/Aids. These learners also accepted that the adults in their lives could assist them to add to their knowledge of HIV/Aids in order to change their attitudes and behavior positively to avoid the disease.

## **2.8. Attitude of adolescents with regard to HIV/Aids**

It was relevant to this analysis to incorporate the interpretation of Hunter, Levine and Sayers (1976:3) who consider that “attitudes” refer to “the intensity of positive and negative effects towards concepts, persons, ideas,” and deem it fit that attitude ought to be related to belief systems. The perception emphasizes that in order to alter ‘attitude’ the education or message had to target broader contextual concepts of good health and responsible behavior and then move towards specific ones relevant to HIV/Aids. It means that education is ultimately meant to instill attitudes relating to healthy lifestyles and not

being HIV infected (Hunter, Levine and Sayers 1976:3). Hence, the interpretation was most relevant to my study as I was investigating the Muslim adolescent's attitude and consequent behavioural response to HIV/Aids.

Explanation by Hausmann-Muela, Ribera and Nyamongo (2003) regarding HIV/Aids education is that specific knowledge gives rise to revised attitudes and behavior in individuals. Such an assertion pertaining to behavior-change is central to the themes of my study of the Muslim adolescent's knowledge of and attitudes to HIV/Aids. The assertions of Hausmann-Muela *et al.* (2003) are confirmed by the recent study by Louw (2009) that found that schools were not delivering on the required HIV/Aids curriculums hence adolescents were receiving confusing, inaccurate information. Louw (2009:164) was of the opinion that adolescents did not cope with the demands of their age-group and indulged in irrational, risky behavior being laid back in their attitude to HIV/Aids. This study (Louw 2009:164) further revealed that the participants did not consider that they could become HIV infected since their attitude was that it was a disease that affected "older people" and they could easily identify those who had it.

Nupen (2006) investigated Grade 10 learners at some Secondary schools in the Western Cape in respect of risk. Her study revealed that the adolescents thought they were "invincible" when it came to HIV/Aids which impacted upon the high possibility of their contracting the HIV infection. Hence, Nupen's (2006:91) conclusions were that the school and family did not play their expected roles in affording the adolescent with the necessary guidance to develop the necessary attitudes that would assist them to avoid risky sexual behavior. Researchers Kuhn, Steinberg and Matthews (1994) all found that the adolescents in their investigations were knowledgeable about HIV/Aids but did not practice safe sex as they felt that they were not vulnerable. Their findings were in accordance with those of Carelse (1994) who established in research on adolescents' sexual behavior that the adolescents were sexually active and most vulnerable to HIV/Aids.

In a study by Dias, Matos and Gonçalves (2006:208) the perception of adolescents in respect of AIDS-related stigma and attitudes towards AIDS-infected people was

investigated. This study by Dias *et al.* (2006:208) found that adolescents were uncomfortable when they had to consider having to deal with people living with AIDS and that this attitude might be categorized as discrimination. The investigators declared that AIDS-related stigma and discrimination are generally allied to inaccurate notions and misapprehension. Parker and Aggleton (2003:13) and London and Robles (2000: 1267-1268) on the other hand, are of the view that these two aspects of AIDS research have not been sufficiently explored in order to conclude that stigma is strongly associated to mistaken beliefs as these are particularly complex aspects of AIDS research. What is significant in the study by Dias *et al.* (2006:213) is the conclusion that individuals of influence in the adolescents' lives such as the parents, peers and those individuals within the school climate can foster positive attitudes towards people living with AIDS and help to dispel myths and misconceptions associated with the pandemic.

## **2.9. Relationship between knowledge of and attitudes to HIV/Aids**

A point of argument in this study was to contemplate whether the knowledge that children received in respect of HIV/Aids, assisted them to develop attitudes that allowed them to assume that they were able to steer clear of high-risk behavior. In this regard the contentions of Rimal and Real (2003:370-371) are of further consequence to my study since they emphasize the relationship between attitudes and beliefs with regard to risk perception and low-risk behavior. Shepherd (1985), in a study involving behavioural choices, supports this ideology and emphasizes that specific learning will dictate what attitudes people have and how they will ultimately behave. Further, reports by Kim and Hunter (1993), Petty and Cacioppo (1981) and Ajzen and Fishbein (1980) have also upheld the assertion that there is a positive relationship between attitudes and behavior that stem from what an individual knows – declarations that impact upon my deliberation of risky behavior and HIV/Aids.

Nupen (2006) and Van den Berg (2005) demonstrated another concept relevant to my study which is that of school culture wherein they upheld that learning via school culture definitely had an impact upon student behavior or response to HIV/Aids. On the other hand, other researchers (Dias *et al.* 2006:213) asserted that the nature of the information

presented via individuals representing the family culture could assist the adolescent to dispel erroneous opinions and understand the true nature of risky behavior. While these considerations regarding HIV/Aids knowledge and culture are salient, it is imperative to take into account social traditions and practices that will promote and support the modification of the behavior of youth who are at high risk to HIV infection. With reference to the family culture, Nupen (2006) found that the instability of the home and family life did not provide children with the necessary knowledge and guidance especially on the topics of sex and HIV/Aids that they so required.

A study of contextual factors and adolescents' risk in terms of HIV/Aids was conducted by Van den Berg (2005). This inquiry revealed that although the school's culture could play a pivotal role in HIV/Aids education in order to stem the tide of HIV infection the important role of the home to inculcate appropriate "cultural beliefs and traditions" could not be discounted especially for adolescents who are most susceptible to HIV infection. As indicated in 2.2. above, cultural factors that affected the incidence of HIV infections in communities were invasive virginity testing and fertility tests procedures (Leclerc-Madlala 1997; Preston-Whyte 1994), multiple-partner relationships (Leclerc-Madlala 1997; Preston-Whyte 1994), unsafe sex within polygamous relationships and sexual violence (Kelly and Ntlabati 2002:44), misguided beliefs about condom-use (Leclerc-Madlala 2002:28), restrictive cultural settings that prevented safe sex (Shisana *et al.* 2009; Varga 1997:47-48), myths about sex with a virgin being a cure for AIDS (Leclerc-Madlala 2002:28; 1997), botched circumcisions (Peacock and Khumalo 2007) and female sexual submission that often lead to violent, unsafe sexual behavior including HIV (Leclerc-Madlala 2002:23; Schwab Zabin and Kiragu 1998).

A further investigation by van den Berg (2009) presented findings that parents were not directly involved with the school in terms of HIV/Aids education as they believed that the school ought to handle these affairs. However, research (Moosa 2009:86/161; van den Berg's 2009; Adu-Mireku 2003) indicates that there were teachers and parents who often found it difficult to communicate important and correct knowledge about sexual matters and HIV or who deem that such discussions are taboo. In terms of van den Berg's (2009)

research, the existent culture in that study saw parents refusing to talk about HIV/Aids and sexuality to their children. Hence, this researcher (van den Berg 2009) found that myths about HIV/Aids (similar to those indicated in the preceding paragraph) were perpetuated in that community and within the school unless the teachers took the trouble to correct the learners. It was important for the study that I undertook to show how parents and family culture played a role in developing the child's knowledge and attitude to HIV/Aids.

## **2.10. HIV Prevalence among Muslims in South Africa**

Although it is acknowledged that there are significantly low HIV infection rates among Muslims in South Africa (World Bank 2006), Kagee *et al.* (2005) claimed in relation to their study that behavioural risks for HIV infection among Muslim individuals, was possibly higher than it is generally accepted. This may be attributed to underreporting as a result of the stigma associated with HIV (Paruk *et al.* 2006:511; Khan and Hyder 2001). It is common knowledge that there is limited reporting of AIDS in South Africa even among Muslims - consequently this study will also take into account the data and reports of other predominantly Islamic countries in order to evaluate what the Islamic perspective and reports of HIV/Aids are (<http://www.Islam and HIV/AIDS/ 2007: 17>).

It must be taken into account that since UNAIDS figures are dependent upon reporting in any particular country the effectiveness or the lack thereof will determine HIV estimates (CAGE 2007). Evidently many countries such as South Africa and predominantly Muslim countries such as Thailand, Bahrain, Iran and Qatar had officially identified cases of HIV by the middle eighties and early nineties but there was a noticeable lack of action to control the spread of the disease. Among Islamic communities, denial, the conviction that HIV would not gain a foothold and the belief that an enhanced value-system would prevent the proliferation of HIV infections, were responsible for the casual reaction to HIV/Aids (Islam and HIV/AIDS 2007: 17). The rapid development of the burden of the disease has been masked by the lack of proper surveillance and under-reporting in countries where there is a majority of people of Islamic descent (Islam and HIV/AIDS 2007: 17).

The South African Muslim AIDS Programme (MAP NEWS 2007) acknowledges that, notwithstanding the low HIV infection rate among Muslims in South Africa, HIV is a serious problem that could become more prevalent in the Islamic community as the root of the problem is sexual promiscuity and drug abuse - two of the principal means of transmission (MAP NEWS 2007). Hasnain (2005) is of the view that the concept of social stigma that impedes progress in HIV/Aids prevention is more pronounced in Islamic cultures. Cultural factors together with low HIV prevalence among people of Islamic descent make for inspiring and logical research since the findings may in some way contribute to future programmes for all youth, not only those of Islamic descent (Kagee *et al.* 2005; Paruk, Mohamed, Patel & Ramgoon 2006:511).

In the main, South African Muslims had until the latter part of the last decade distanced themselves from HIV/Aids, believing that they could not be affected (Mohamed 2005:3). According to Moosa (2009:66-67), the “strict moral code of conduct” that Muslims are expected to live by often created the misapprehension that HIV/Aids would not affect them. Such a standpoint emanated from the idea that as HIV infections were spread by homosexuality and promiscuity they would be safe since such conduct was taboo in Muslims’ lives (Moosa 2009:66-67). Moosa (2009:76-77) emphasizes that AIDS is a “social disease” and Muslims have since realized that they are not exempt. Despite the fact that data in relation to South African Muslims is not available and considered low in relation to other religious groups, the prevalence of AIDS could be on the increase in this community (Moosa 2009:77; Esack 2005).

Academics and researchers (Moosa 2009:77; Esack 2005) concede that Muslims had for a long time not readily acknowledged HIV/Aids – hence there was a lack of correct data in respect of HIV prevalence and deaths from AIDS-related diseases. It is acknowledged that there are significantly low HIV infection rates among Muslims but Kagee *et al.* (2005) claim that in relation to their study behavioural risks for HIV infection among Muslim individuals, is possibly higher than it is generally accepted. The World Bank (2006) presented that although data displayed a low HIV prevalence among Muslims this might be

attributed to underreporting as a result of the stigma associated with HIV/Aids (Paruk *et al.* 2006:511; Khan and Hyder 2001).

The Programme (MAP) is an umbrella body for the Jamiatul Ulama, the Islamic Medical Association and Islamic Careline that have all adopted the stance that sexual abstinence will prevent the further spread of HIV infections ([http://www.jamiat.co.za/newsletter/online\\_newsletter\\_0446.htm](http://www.jamiat.co.za/newsletter/online_newsletter_0446.htm) 2009). The practice of circumcision is another cultural practice amongst Muslims that is said to act as a preventative measure against HIV infection but not in isolation. It is recommended that in addition to the practice of circumcision, individuals are still required to avoid risky sexual behavior. However, contrary to the South African adage “Safe Sex” that encourages the use of condoms, MAP demands “Save Sex” stating that the distribution of condoms encourages risky behavior in adolescents (Mohamed 2005:2). The organization (MAP) promotes the philosophy among its followers - Muslim or non-Muslim - that acceptance and acknowledgement of the disease will help to reduce the prevalence (Mohamed 2005).

Moosa (2009:84) is of the view that some Muslims believe that if they become HIV infected it is as a result of fate (*taqdir*) and ought to be accepted unquestioningly as a curse from God for immoral behavior. The writer (Moosa 2009:84) alleges that the Muslim religious leaders and *ulama* can assist to change the mindsets of the Muslims so as to engender more realistic ideas about the scourge that will help people to respond positively. The perception is that Islamic tenets can definitely work towards the mitigation of AIDS since these guides teach morally correct behavior and values (Moosa 2009:85). In 1996, against Muslim traditions and during a period of doubt and fear of AIDS amongst Muslims, a Western Cape Muslim woman, Ms Faghmeda Miller, came out publically to declare that she was HIV positive ([www.samedical.org](http://www.samedical.org) 2009; Moosa 2009:78). Despite being ostracized by her community for her bold actions, she was determined to increase consciousness among Muslims and inform South Africans that no-one is exempt from HIV/Aids.

The most recent development regarding AIDS in the Muslim community is that Maulana Rafeek Shah, a South African Muslim, has recommended that couples be amenable to HIV tests prior to marriage (<http://www.BBC/news/africa/SAmuslim.htm>). This proposal, according to the Muslim leader is necessary not to promote stigma but to create more awareness about the disease. He asserted that “HIV poses a far more serious threat to security of South Africa and South African society as a whole than any other conventional threat” (<http://www.BBC/news/africa/SAmuslim.htm>). Although he has already placed the proposition before the United Ulama Council of South Africa, AIDS activists have completely rejected the idea stating that such a step was undemocratic and will merely isolate people further.

## **2.11. HIV/Aids and Islam**

### **2.11.1. What is Islam?**

Islam is one the major religious denominations globally and in South Africa with the largest numbers in the Western Cape. Islam is an unconditional customary way of life present in all aspects of a Muslim individual’s daily activities from dress to diet to relationships (Horrie and Chippindale 2003:3). The holy *Qur’an* considered by Muslims to be the authentic word of Allah, consists of verses that are fully appreciated and understood only in the Arabic language (Horrie and Chippindale 2003:18-19). According to the basic religious principles, Islam stresses high moral standards and values conforming unconditionally with those of HIV prevention policies in general (Paruk *et al.* 2006:511).

Islam’s creed and the four mandatory obligations constitute the core of Islam stringently regularizing the Muslim individual’s behavior within the context of Islam (Horrie and Chippindale 2003:25). The main characteristics are:

1. *Salat* – ritual prayer five times every day;
2. *Zakat* – the disbursement of tax relief for the underprivileged;
3. *Sawm* – fasting for the duration of *Ramadan*; and
4. *Hajj* – pilgrimage to the holy Ka’bah and Mecca (Horrie and Chippindale 2003:25).



### 2.11.2. Islamic ideology for Muslims

In any social group it is imperative for parents to take cognizance of an adolescent's entire context of social influences and/or cultural surroundings as well as the youth's physiological and psychological development in trying to assist the growing child (Beshir and Beshir 2002:1). Such parental care and supervision is especially a pre-requisite in the Muslim home and family. In their book which acts as a functional manual for Muslim parents, Beshir and Beshir (2002:38/49) emphasize that parents ought to ensure that there is a good channel of communication between their children and themselves so that they can ensure that the children are able to absorb the knowledge and values that are so important for them to develop strength of character. This Guide (Beshir and Beshir 2002) further explains that parents who enlighten their children in terms of their cultural and religious beliefs are able to assist the youth to deal with the problems that face the children nowadays.

In keeping with the themes of this research, the rudiments of the Islamic culture with regard to what adolescents ought to know in terms of the *Quran* are that Islam dictates that it is compulsory to incorporate the importance of principled behavior and correct values in any effort towards the mitigation of AIDS (Mohamed 2005). Hence, the Islamic way of life as stipulated by the *Quran* requires that with the threat of HIV/Aids, individuals ought to encourage morally upright behavior yet be caring and supportive of those already affected. With reference to my study it is imperative to take note of the role of traditional Muslim family culture upon education within the school the adolescent attends. Engineer (2008:3) outlines that the doctrine of Islam and the *Quran* dictate that all Muslims strictly maintain justice, benevolence, compassion and wisdom. In terms of teaching children moral values, Bham (2008:1) states that the following principles are foremost in the effort to reduce the prevalence of HIV/Aids:

- *Spiritual self-purification;*
- *Punitive steps to regulate behavior;*
- *Concerted efforts to prevent immoral behavior.*

In a guide to Muslim teenagers, “Starting and Growing in Islam”, Maqsood (2001) portrays the fact that the Muslim youth has the same dilemmas that the youth in any other racial or cultural groups have. Maqsood (2001:6-7) stresses that Muslim teenagers also experience the frustrations of being trapped between developmental stages questioning all that is put to them. During this complex stage, if adolescents find it difficult to explain to their parents what the confusions and conflicts are, they may resort to unethical irreligious behavior without the adults knowing (Beshir and Beshir 2002:10). The youth need to deal with issues relating to religion especially to consider the direction of their faith and acceptance of “Allah” without compulsion (Maqsood 2001:15-19). Admittedly, adolescents will have to learn to make important decisions some of which may be life-changing and this decisiveness can only be developed if a parent grooms the child to handle this aspect of life and if the school culture is able to complement this development (Beshir and Beshir 2002:54-55).

It is accepted that Muslim adults can act as suitable role models in children’s lives according to Beshir and Beshir (2002) who assert that they can meet social challenges by displaying the following attributes to understand the child, never resort to force, express feelings and share happiness and pain, be clear in communication, be an active listener, assist in skill development, use examples from their environment and use a holistic approach. (Beshir and Beshir (2002:143). The social actions of the individual within the Muslim family are directed by the social control exerted by that society and its ability to act in a unified manner (Barnett and Whiteside 2006:93). Social control in terms of HIV/Aids and sexuality will be dependent upon factors such as family culture and religious control.

## **2.12. Theoretical Framework**

### **2.12.1. Social Cognitive Theory**

As with any scientific inquiry, the establishment of a constructive theory upon which the study was carried out is fundamental. This research encompassed the study of HIV/Aids-related knowledge and attitudes of adolescents influenced by socio-educational situations (within the family and school culture). Validation for this is that the theory I utilized

allowed me, as the researcher, to establish what factors or relationships provided the directions for certain attitudes and responses that the Muslim adolescents expressed in this study. Hence, the theory authorized me to explore how rationally or irrationally certain attitudes and behavior in relation to HIV/Aids had been adopted and how individual social and cultural interactions had influenced these types of behavior (Gandelman and Freedman 2002:1). Accordingly, within the context of what Anfara and Mertz (2006: xvii) and McMillan and Schumacher (2001) proclaim about the criteria needed for theories to be constructive I make the following assertions:

- The Social Cognitive Theory I have opted to work within has provided a simple explanation of the observed relations relevant to the phenomenon of HIV/Aids within the family and school culture and the Muslim adolescent's knowledge and attitudes (Bandura 1994);
- It was found to be consistent with both the observed relations and an already established body of knowledge (which in this case is based on the rather limited research available within the South African context within the chosen area of research);
- At the outset the theory is considered a tentative explanation and should provide means for verification and revision by means of the eventual data analysis within my study; and
- It should stimulate further research in areas that need investigation in the region of HIV/Aids education and the family and school culture.

The Social Cognitive Theory, according to Bandura (1994:2), depicts an apt theoretical background for this research. Bandura (1994:2) is of the view that while knowledge in the form of public awareness is important to change risk-taking behavior and the proliferation of HIV infections, it is also imperative to instill personal "skills in self-motivation and self-guidance" to change behavior for the better. Reflection upon a correlation between Bandura's (1994:2) ideology and my study on Muslim adolescents leads to the question whether the learners were being provided with the necessary knowledge within their

Islamic cultural family and school contexts towards that inculcated “self-belief in (their) efficacy” to modify their knowledge and attitudes towards HIV/Aids.

Bandura (1994:2) further stipulates that an individual’s attitude and behavior can change if there is a concerted personal attempt to avoid risky behavior and if the individual is assisted within a social or cultural context to do so. This particular characteristic of the Social Cognitive Theory can be extended to this study to mean that Muslim adolescents will benefit from their own “self-regulative” capabilities in conjunction with the necessary guidance of the adults who represent their Islamic culture in the family and the school (Bandura 1994:2). The Social Cognitive Model advocates that it is possible for people to attain their objectives if they are able to rationally consider their personal abilities and ordeals thus controlling their knowledge and attitudes to avoid pitfalls (Bandura 2001:2). As Bandura (2001:3) puts it, the effectiveness of “functional consciousness” in the regulation of an individual’s actions can be gauged once there is cognitive deliberation. To consider the social cognitive theory and the influence of <sup>10</sup>agentic factors to my study I needed to establish if adolescents too were able to reflect rationally upon their complex socio-educational circumstances in the same way to avoid oversights in their pursuit of survival within the context of HIV/Aids (Bandura 1989:46/65).

#### ***2.12.1.1. What does it entail to be human?***

In terms of Bandura’s Social Cognitive Theory, to be human or a person is to have the ability to take cognizance of physical factors within one and social factors around one while one strives to achieve one’s goals and avoid pitfalls (Bandura 2001:2-4). Bandura (2001:3) considers that “forethoughtful, generative, and reflective capabilities are, therefore, vital for survival and human progress”. According to Bandura (2001:6-11) the vital agencies of intentionality, forethought, self-reactiveness and self-reflectiveness are the nucleus characteristics of what it entails to be human and will therefore form the basis of my study.

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<sup>10</sup> ‘make things happen by one’s actions’... made up of ‘endowments, belief systems, self-regulatory capabilities, distributed structures and functions’ Bandura 2001:2

**a) *Intentionality***

Bandura (2001:6) advocates that “agency refers to acts done intentionally”. Intentionality therefore, is an individual’s cautiously premeditated decision to behave in a particular manner that will impact upon a future endeavor. Hence, according to this theory and the Action Regulation Theory that Jones (2007:2) refers to, a behavioural plan of action revolves around personal intention – what does the individual intend the end product or goal to be. However, it is pertinent to consider that personal agency may not simply assure that the intended result will be achieved since actions can yield certain unintentional consequences that may hinder progress. It is also unrealistic to single-mindedly believe that the mere state of intention is sufficient for the successful execution of an individual’s goal for the reason that the role of other participating agents could be crucial to the result. As far as my investigation is concerned I pursued the line of inquiry that represented the intention of the Muslim adolescent to apply HIV/Aids-knowledge gained from exposure to family and school culture, in order to inculcate certain attitudes that could culminate in responsible behavior.

**b) *Forethought***

The concept of “forethought” allows individuals to be able to confidently engage in goal-directed actions that are more likely to yield positive results while being sensitive to harmful future measures that may frustrate their endeavors (Bandura 2001:7). Forethought caters for the human strength of being able to stay motivated in the design of one’s life eagerly and pragmatically anticipating what lies ahead (Bandura 2001:7). Realistically, forethought sanctions the consideration of exclusive social and environmental contexts for enhanced self-efficacy, guidance and expectations (Bandura 2001:13; Bandura 1989:46/65). Individuals are equipped to be discerning and maneuver their way within their present milieu adapting accordingly in order to conquer desired aspirations. Bandura (1989:13) asserts that a person is able to access invaluable logic from the social agencies within the individual’s sphere of influence. As a consequence, within the framework of the Social Cognitive Theory my research probed the Muslim adolescent’s strength to harness the knowledge provided by the Islamic family and school culture to remain focused on

generating beneficial attitudes anticipating what the future holds when one becomes HIV infected (Bandura: 1989:11-12).

**c) *Self-Reactiveness***

The intention to perform an action precedes the planning as well as the experience of forethought. Once this visualization takes place the role modifies to one of being a motivator and self-regulator in order to unite the initial action of reflection with the carrying out the deed (Bandura 2001:8). During this process of self-reactiveness an individual will resolutely strive towards goals that have emanated from an established value-system. Vicarious learning, a human attribute that is accentuated in social cognitive theory, highlights that individuals learn by example and observation (Bandura 1989:21). The goal-directed process of self-reactiveness is by no means without obstacles and the successful achievement thereof will depend on what Bandura (2001:8) pronounces “the level of challenge and temporal proximity” in conjunction with the mistakes one will make. During the process a person’s actions will also be regulated by the moral agency that impacts upon a moral wisdom, moral logic and moral actions (Bandura 1989:46/65). One of the objectives of my study was to establish the role of the moral astuteness of the Muslim adolescents in utilizing knowledge acquired from the Islamic family and school culture to “resolutely strive towards” unwavering attitudes and actions vis-à-vis HIV/Aids regardless of complications (Bandura 1989:10).

**d) *Self-Reflectiveness***

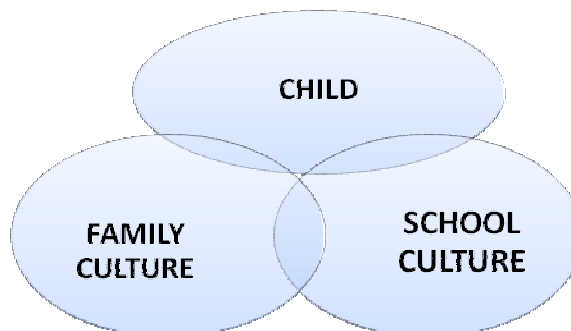
An individual is equipped to meta-cognitively appraise goals and values during the action process, making it possible to be analytical every step as agents of actions (Bandura 2001:10). Having a definite belief in being able to effectively execute an action ought to be accompanied by a controlled search thereof to avoid harmful effects. It is Bandura’s (2001:10) conviction that within the context of the Social Cognitive theory efficacy beliefs is the foundation whereby people are motivated to fulfill their actions. This theory of self efficacy develops the stance that an individual will work at reducing personal vulnerability during the action process and rationally decide which actions are less harmful during the process.

Further, efficacy beliefs dictate the manner in which certain actions and social factors will influence the quest of a person's goals (Bandura 1989:4). The Social Cognitive Theory postulates that the formative years of an individual are a time when social influences (as depicted below in 2.12.2.) are significant as these demands are critical in the ability to handle stress and impediments (Bandura 1989:4). With particular reference to my study, I implemented the theory to consider if the participants (Muslim adolescent) were able to control the influence of goals and values within the environment (Islamic family and school culture) in order to regulate health status-vulnerability in relation to HIV/Aids (Bandura 2001:11 Bandura 1989:12).

### **2.12.2. The Eight Gateways influencing school culture**

Elbot and Fulton's (2008) exposition of the Eight Gateways indicate that the child is at the centre of the interaction between the family and school culture - being influenced by each. With reference to my inquiry about the child's knowledge and attitudes to HIV/Aids the ideology presented by Elbot and Fulton's (2008) Gateways pertaining to school culture per se can be used to explain how the child learns about HIV/Aids and how such knowledge assists to develop certain attitudes and behavior. This exchange of ideas and the impact upon the child is indicated in the following figure:

**Figure 5: Influence of Family and School Culture on the child's HIV/Aids education**  
Adapted from information in Elbot and Fulton (2008)



The above illustration indicates that the child's education about HIV/Aids suggest that there is infiltration of information from the family culture as well as the school culture to the child. There is also evidence that there are aspects of both cultures that overlap. Hence, my study demonstrated that there was a strong correlation and interaction between the Muslim family culture and the Muslim school culture. At the same time it had to be acknowledged that the child too was able to contribute in some way to each cultural component. In terms of HIV/Aids education the above representation depicts that the child is influenced and guided by the culture of the family as well as that of the school. The above figure denoting the Eight Gateways recognizes that the child is the centre of the process of teaching and learning (Elbot and Fulton 2008). While the school culture promotes HIV/Aids education via the curriculum, the family culture influences the child's growth during the family's daily interactions that may include discussion and debate. The "collaborative relationships" pertaining to HIV/Aids allow the child to know more about the disease and to develop holistically in order to prevent HIV infection (Mosia 2009:5; Barth 1990:512-516).

The explanation that follows introduces Elbot and Fulton's (2008:72-105) concept of the Eight Gateways which, according to these writers represents the "entry points" of influence within the culture of a school. Just as Kezar and Eckel (2002), O'Hagan (1999) and Stoll (1998) have communicated in terms of school culture, these factors have a direct impact upon the way a school operates and with time each may transform the very ethos of the school in varying degrees. A detailed discussion of these Eight Gateways is thus central to my study since HIV/Aids may be seen as one concern that the modern South African school encounters. Consequently, this inquiry will benefit from a discussion of how each of these "entry points" influences the Muslim adolescents' knowledge of and attitudes to HIV/Aids:

#### ***2.12.2.1. Teaching, learning and assessment***

In terms of what Elbot and Fulton (2008:75) uphold about school culture, learners will benefit from a basic consensus regarding the nature of "high-quality teaching and learning" and shared goals. Although each teacher will have a different concept regarding the execution of the lessons, the fundamental principle ought to remain the same. Elbot and



Fulton (2008:75) are of the view that the “hidden curriculum” as proposed by Wren (1999:1) who considers that it is “the influential ambiance that affects the teaching and learning of a school” (Chapter 1 p22, paragraph 1.7.2.), is just as powerful as the guides provided by the Department of Education that South African teachers are meant to subscribe to. It is therefore vital that the school is able to co-ordinate the hidden curriculum and Departmental requirements to respond to the learner’s educational needs (Elbot and Fulton 2008:76-77). To extend this ideology to the investigation that I undertook, teachers and parents were questioned in terms of the quality of teaching and the hidden curriculum (e.g. Islamic ideology) at the school.

#### ***2.12.2.2. Relationships***

Elbot and Fulton (2008:78-79) estimate that adults (parents and teachers) who display a caring disposition within the school culture are able to inculcate superior standards of learning and achievement in schools. The Muslim learners’ comments regarding the quality of all relationships within the school were not restricted to just teachers, but extended to parents as well. This is significant in terms of the learner’s educational development within the particular school culture. For that reason, the concept of “caring” in this discussion involves exciting lessons, awareness of the children’s needs, reciprocal relationships of trust and positive feedback. This study explored the relationship between the parents and the teachers and the impact upon the school culture. It also investigated if the school culture included teaching and learning that encompassed a caring disposition which could have influenced the learners’ knowledge of and attitudes to HIV/Aids.

#### ***2.12.2.3. Problem-solving***

All schools will tackle their diverse problems in the unique way prescribed by the culture that pervades the school and community it serves (Elbot and Fulton 2008:81-82). The process of trying to eliminate problems affecting learners might be time-consuming but if all parties (teachers, learners, parents) were able to work together, getting to the source could help eliminate these effectively. If learners were considered as part of the structure of “interdependence” the school would be more successful in its attempts at problem-solving (Elbot and Fulton 2008:83). Learners needed to be taught that respect for the well-being of

the self and of others went hand-in-hand with respect for authority in the constant process of problem-solving. The Muslim adolescent's knowledge of and attitudes to HIV/Aids (a modern crisis), was investigated in respect of the unique guidance provided by the collaborative effort of the parents and the teachers of this independent Islamic institution.

#### ***2.12.2.4. Expectations, trust and accountability***

Generally, the school touchstone conveys the nature of the expectations, trust and accountability within a school culture (Elbot and Fulton 2008:2-4; 85). It is accepted that schools that operate effectively will have superior, yet principled expectations and a definite sense of trustworthiness embodied within the touchstone of choice (Elbot and Fulton 2008:2-4). Barth (2001:78) is of the view that while it is important to assess teachers on the basis of learners' academic results it is also imperative to evaluate how these teachers contribute sincerely to the improvement of general learning within the school culture. Elbot and Fulton (2008:87) contend that the teacher and learner should be familiar with characteristics that represent trust and accountability and which promote the relevant learning expectations. This study explores the expectations, trust and accountability of the parents, teachers and learners who are part of this Islamic school culture noting their accountability regarding the Muslim adolescent's knowledge of and attitudes to HIV/Aids.

#### ***2.12.2.5. Voice***

Learners appreciate being "heard" and knowing that they are a bona fide part of the school culture with the ability to contribute to building "a better school" (Elbot and Fulton 2008:90). While it is of great consequence within a school culture that learners are listened to, it is also as important that the teachers and parents are able to express their views in an attentive environment. Each participant within the school culture will be more secure and "high-performing" if they are noticed (Elbot and Fulton 2008:92). Another aspect of exploration in the study I embarked on was whether the teachers, parents and learners felt that they could contribute to the education and allowed to express their personal attitudes in terms of HIV/Aids within the school culture.

#### ***2.12.2.6. Physical environment***

Elbot and Fulton (2008:92) point out that the physical environment that includes multiple facets of the school does affect all those connected to the school culture. Their opinion is that the school environment must be “safe and clean, inviting and inspiring, and conducive to learning” (Elbot and Fulton 2008:92). Therefore, a constructive partnership within an effective school culture will yield a positive physical environment that includes the neighborhood of that school community as well. Hence, with reference to my research I had to study the circumstances under which the teaching and learning took place and whether it was safe and conducive to learning in the context of HIV/Aids.

#### ***2.12.2.7. Markers, rituals and traditions***

Elbot discovered in his research of important markers that there was a lack of “powerful school-based experiences” among those who had just graduated (Elbot and Fulton 2008:95). The assertion was that schools ought to create indicators representing rituals and prominent times in the learners’ lives. Learners’ lives were constantly changing and they should be given the opportunity to share their treasured moments with others so as to remember these markers always. However, the warning from the researcher was that if the collaborative school culture did not provide the opportunity for the creation of traditions and rituals, learners would create their own which could be as a result of harmful behavior patterns. It was imperative for this research to reveal what noteworthy Islamic rituals and traditions of the family and school culture influenced the Muslim adolescents’ knowledge and attitudes to HIV/Aids.

#### ***2.12.2.8. Leadership***

Leaders within an intentional school culture facilitate the process of establishing ethical standards that guide the members of that community towards an integrated school environment. Dominance in any one facet of the school community or hierarchy will prove that the leadership is ineffective and promote an unstable school culture. Accepting that each culture has strong points and drawbacks leaders can encourage the perception that different cultures can learn from one another in order to transform any one culture while it maintains its “basic integrity” (Elbot and Fulton 2008:102). The contention of intentional school culture promoted by Elbot and Fulton (2008:104-105) is that leadership forms the

mainstay of effective, supportive school cultures often relying on what is borrowed from others in the process of change. This study attempted to investigate whether the leadership in the Islamic school formed an effective, supportive school culture that promoted the awareness of HIV/Aids among the learners.

### **2.13. Conclusion**

It is over two decades into the existence of the AIDS epidemic and countries are still under pressure to provide watertight responses to the pandemic (Parker and Aggleton 2003:13-14). Of particular importance in these responses are the roles of the family and the school to proficiently make adolescents aware of HIV/Aids and the best ways to avoid infections. I argue that education within the life skills and HIV/Aids Education sector and socio-cultural practices can essentially assist to overcome the vulnerability of the youth (UNESCO and IBE 2004:6). The study I undertook was meant to expose advancement within the Muslim family and school culture in the field of HIV/Aids education in order to mitigate the burden of disease. While the importance of the family cannot be denied, Van Wyk and Lemmer (2007: 301-316) advocate that the school and its associated “capital” – i.e. other relevant entities are vital in the mitigation of AIDS within the South African context. It is their theory that communication within all parties involved in the running of the school can be guided by the guidelines provided by the Department of Education to benefit the learner in the fight against AIDS. Adolescents have a basic right to HIV/Aids education and it is essential that school culture with its guiding policies, institutional rules and hidden curriculum provide the crucial protection in order to augment gender equality within the school context (Jerald 2006:1-2; Posser 1999:8).

Alluding to my study, I considered that the above implications were significant as the discussions relate to families and HIV/Aids education. In view of the assertions, this study considered the manner in which the Muslim adolescent’s knowledge of and attitudes towards HIV/Aids were influenced by the communications and relationships within the family that exemplified Islamic Law as well as the Islamic school culture. Cultural factors together with important statistical data made for inspiring and logical research since the findings might in some way contribute to future programmes for all youth, not only those of Islamic descent. While moral values as well as behavioural exemplars progress down



generations within each distinct society and traverse school cultures it is important to ensure that while children accept these values that their basic rights are not violated as a result of their culture.

The following chapter elaborates upon the methodology and data collection procedures that are introduced in Chapter 1.