SEXUALLY TRANSMITTED DISEASES: DILEMMAS FACING THE YOUTH OF KWAMBONAMBI DISTRICT, IN KWAZULU-NATAL.

By

Mbuyeleni William Xulu

A dissertation submitted for partial fulfillment of the requirements for the Masters degree in Community Work, in the Department of Social Work at University of Zululand

Supervisor: Dr. N.H. Ntombela

January 2008

Declaration

I, Mbuyeleni William Xulu, declare that the work "Sexually Transmitted Diseases: Dilemma facing the youth in KwaMbonambi District, in KwaZulu-Natal" is my own, and that all sources quoted have been acknowledged by complete references.

_____

MW XULU

Dedication

This work is dedicated to my later father M. Xulu and my mother G. Xulu, who supported me during the course of the study, and to my sons Thembinkosi and Wandile Xulu.

Acknowledgements

I wish to express my gratitude and appreciation to everyone who supported me and contributed directly or indirectly to the completion of this study.

I would like to sincerely thank my supervisor DR N.H. Ntombela, for her professional guidance, encouragement and support which made it possible for me to complete the study.

I also wish to thank the following most sincerely.
The academic staff in the Social Work Department at the University of Zululand,
All participants who voluntarily agreed to be interviewed for this study
Lastly, fellow students at the University of Zululand, particularly Miss Thandeka Siyaya, who has been a source of support and encouragement to me throughout this study.

TABLE OF CONTENTS

DECLARATION ii

DEDICATIONS iii

ACCKNOWLEDGEMENTS iv

ABSTRACT ix

CHAPTER I

TABLE OF CONTENTS **PAGE NUMBER**

1. Orientation to the study 1

1.1. Introduction 1

1.2. Statement of a problem 3

1.3. Motivation of the study 4

1.4. Objectives of the study 5

1.5. Literature review 5

1.6. Research methodology 6

1.6.1. Research design 6

1.6.2. Population of the study 6

1.6.3. Sampling 7

1.6.3.1. Sampling procedure 8

1.6.4. Research instrument 8

1.6.5. Procedure of data collection 8

1.6.6. Data analysis and interpretation 9

1.7. The value of the study 9

1.7.1. Dissemination of information 10

1.8. Ethical considerations 10

1.9. Organization of the study 11

1.10. Conclusion 11

CHAPTER 2

LITERATURE REVIEW

2. 1. Introduction 12

2.2. Migratory labor 15

2.3. Prostitution and use of drugs 16

2.4. AIDS and the youth 17

2.5. Health promotion campaign 18

2.6. Young women and AIDS 19
2.7. The role of family in caring for people with STDs 21
2.8. The negative attitudes of health care workers with regards to patients with AIDS 22
2.9. Social development 23
2.9.1. Factors which contribute to HIV/AIDS related stigma 26
2.9.2. The use of condom 29
2.10. Stigma and discrimination related to HIV/AIDS 31
2.11. Factors that increase risks for HIV infection 32
2.12. Cultural analysis and the belief system 34
2.13. Sex education 38
2.14. Forming attitude and beliefs 39
2.15. Conclusion 42

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction 44
3.2. The research design 44
3.3. Data collection 45
3.3.1. Area of the study 45
3.3.2. Some basic statistics of the uThungulu District KwaMbonambi Rural Municipality 46
3.3.2.1. Table 1: Demographic data- 2001 census 47
3.3.2.2. Table 2: Demographic data-2001 census 47
3.3.3. Sample and sampling method 48
3.4. The research instrument 48
3.4.1. The interview 48
3.4.2. Interview schedule 49
3.4.3. Construction of the interview schedule 49
3.4.4. Closed-ended question 50
3.4.5. Personal interview 50
3.5. Data analysis 50
3.6. informed consent 51
3.7. Limitations of the study 51

3.8. Summary 52

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1. Introduction 53

4.2. Descriptive statistics 53

4.3. Classification of respondents according to gender 54

4.4. Levels of education of respondents 55

4.5. Religious beliefs of the respondents 56

4.6. Table of frequency percentage distribution of respondents 57

4.6.1. Table 4.6.1- 4.6.30 58-73

4.7. Conclusion 77

CHAPTER 5

DISCUSSIONS OF FINDINGS

5.1. Introductory remarks 78

5.2. Changes in sexual lifestyles 78

5.3. Safe sex 79

5.4. Discrimination and blame 80

5.5. Youth prostitution 82

5.6. Circumcision 83

5.7. Condoms 84

5.8. AIDS education in schools 84

5.9. Community education 85

5.10. Traditional healers 86

CHAPTER 6

RECOMMENDATIONS AND CONCLUSION

6.1. Introduction 88

6.1.2. Restatement of the objectives of the study 88

6.1.3. Restatement of the key questions of the study 88

6.2. Person to person STDS/AIDS education 90

6.3. The youth help each other 92

6.4. Counselling skills training in youth sexuality 93

6.5. Human development 94

6.6. Conscientisation 95

6.7. Conclusion 96

BIBLIOGRAPHY:

APPENDIX A, informed consent and questionnaires

APPENDIX B, Maps.

Abstract

This study is about the dilemma of sexually transmitted diseases in the youth of kwaMbonambi District, in KwaZulu-Natal. In this community most of the youth are dying as a result of sexually transmitted disease. Even though prevention measures have been implemented on a nation wide basis, but it seems as if it does not reach the youth effectively. This study examines the knowledge the youth have about sexually transmitted diseases and prevention measures as well as barriers that might hinder them from taking prevention measures. It also examines the ignorance of the youth in not taking early treatment of disease that might contribute to the manifestation of HIV.

It is not surprising that some youth with sexually transmitted diseases avoid checkups. Many symptoms of the disease go away by themselves, but the disease does not. One could transmit the disease without having symptoms. The disease may cause severe long-term consequences. According to research findings, the youth know the ways through which persons become infected by sexually transmitted disease. However, the majority of the active youth that have participated in this research project still engage in unprotected sexual intercourse that puts them at risk of infection with HIV.

Condoms have been recommended as one effective method of preventing the transmission of STDs. According to the researcher, condoms are more likely to be used if the peer support the use of condoms and if individuals perceive the benefits of the use of condoms and that outweighs their costs. Education about STD's and AIDS transmission and their prevention, along with training skills in negotiating that should place the youth in responsible sexual behavior. Public health effort must also focus on helping the youth not to contract STDs and to volunteer for AIDS testing.

CHAPTER 1

1. INTRODUCTION TO THE STUDY

1.1. Introduction

Sexually transmitted diseases (STDs) are diseases that are contracted primarily through sexual intercourse as well as through oral-genital and anal-genital sex. There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5 million of these managed by general practitioners (HIV/AIDS/STD strategic plan for South Africa, February 2002). Though worldwide data is incomplete, some experts guess that anywhere from 200 to 400 million people around the globe suffer from STDs. STDs are still associated with significant morbidity and the heavy cost in human lives. These infections are prevalent among youth, especially those between 15 and 25 years (Gennrich, 2004:20). Young people are particularly vulnerable to STDs despite being generally better schooled they still lack adequate levels of knowledge about sexual health risks. The youth are at the age of sexual exploration while at the same time there is still youthful ignorance, often accompanied by the lack of social power in negotiating appropriately in sexual relationship.

Young women who in many instances come from socially deprived circumstances especially economically, are often exposed to the risk. They may partner with older men for "greater protection and support" (*serious exploitation*), or they may give sex favours in return for status items such as cell phones, being driven in nice cars and bought clothes with particular brand names and offered entertainment. This new phenomenon, which has been termed "transactional sex", is a consequence of urbanization and social changes that affect many changes in communities around the world and more particularly in Africa. This behavior among the youth has been steadily showing itself in the last thirty years or so but as Gennrich (2004:11) says it is directly linked to the consumerist society that these young people find themselves in.

A major consequence of this behavior is the direct exposure to the acquisition of sexually transmitted disease (STDs), often with devastating effects on their future lives. Currently these young people and indeed older men involved are in great danger of acquiring HIV/AIDS.

While disease prevention could be brought about by a change in behavior leading to a wide use of the condom, this cannot occur without a better level of two-way communication on the subjects between young people and the adults who are in a position to serve as models (Friedman, 1989:312). The break-up of families increased the number of single parents, the number of men who are alienated from their families and the number of youth taking responsibilities beyond their age, often growing up without a positive parental role model in their "homes". All this deeply affects the relationships between adults and youth, as without clear parental guidance. Further the culture of silence that surrounds sex education in all societies, but which is more prevalent in African communities currently is another contributing factor in the many dilemmas youth face. It means that the youth are exposed to sex in practice before they know much about its consequence or how to protect themselves.

The HIV/AIDS pandemic has become a major challenge in many communities and countries. The spread of the disease comes at a time when many countries are ill-equipped to respond to the AIDS threat adequately. Shortages of resources have made AIDS potentially more serious in Africa than any other continent of the world. There is no known cure for the disease and the only way to avoid the risk of infection is to avoid exposure to AIDS. AIDS is a behavioral illness. To bring about changes in the sexual behavior on a broad scale may be impossible, because specific mores preclude any single educational program. For young people thus affected with these diseases special counselling is essential, not only for them, but also for those who are close to them.

The lack of understanding and suspicions often become a problem too. When the youth fall sick these days, people automatically assume that they are HIV/AIDS affected and unfortunately they will be afraid to seek appropriate help. In fact, the youth are dying from preventable opportunistic conditions that develop as side effects like malaria,

whooping cough, pneumonia, TB and other infections. These days, with little sense of community that might have existed before, in some villages, suspicion, fear and alienation take root in isolating such youth as people fear for the future of their own young as well.

The statement of the problem presents the dilemmas in a nutshell.

1.2. Statement of the Problem

In South Africa, there is a high rate of death among the youth as a result of sexually transmitted diseases. (HIV/AIDS/STD strategic plan for South Africa, February 2002) Also in South Africa the rural communities are the neglected lot. Hence similar negative aspects that get reported, for instance, in townships and like Sabokwe areas the same will not occur in these rural communities and villagers.

The incidence of STD's among the youth has increased in the past few years. Acquiring sexually transmitted diseases during the earliest age of life has many deleterious consequences like causing infertility among the young people in future. It also contributes to a high proportion of pelvic inflammatory diseases, affecting mostly those in the youthful years of their lives. Ectopic pregnancy is another life-threatening sequelae of STD's (Tocci, 2001:28). Genital herpes and AIDS are presently incurable and have very negative psychological effects.

This study is concerned with the apparent void in the lives of many a young person as a result of inevitable changes in their life-circumstances. Often times they lack experience and insight to deal with the harmful effects in their lives timeously like early detection of STD symptoms, discriminatory behavior of people living with HIV/AIDS and the young person's experience when parents have died of HIV/AIDS.

The challenging aspects in dealing with the problem the young people have relate also to their understanding and the processes involved. Hence psychological theories concerned with health-orientated behavioral changes often assume that such changes result from the individual's knowledge of the disease and his or her ability to process the relevant

information and evaluation of the risk to him or herself (Markova, Wilkie and Forbes, 1990:78). The provisions of information about diseases, and the facilitation of comprehension, understanding and memory, are considered to be essential prerequisites of any health-orientated behavioral change.

If the individual does not behave accordingly to this model, it is because of his or her individual characteristics. These include irresponsibility, the denial of the problem and misperception of the risk. Psychological theories and health education programs rarely consider that illness is not just an impairment of the individual's mind but also a social construct with negative connotations.

According to Markova, Wilkie, and Forbes (1990:73), illness and diseases have been constructed as the night-side of life, punishment, social death, destruction, and stigma. Since these constructions are part of our social life, people with illness often develop strategies enabling them to eliminate or at least to reduce the effect of such social construction on themselves.

1.3. Motivation of the Study

The researcher's motivation emanates from being actively involved in monitoring the HIV/AIDS projects in KwaMbonambi District. This District is characterized by factors of under-development as typified by the high rate of illiteracy, unskilled practices and evident poverty in the lives of the majority of the people in the District. Textbooks on sexually transmitted diseases, like Milner, N and Rockwell, R, C, (1988) and especially the recent statistics released by National Minister of the Health Department over the radio, in February 2002 motivated the researcher. The researcher was also motivated by past experience, where the researcher has lost friends, relatives and colleagues as a result of STDs.

1.4. Objectives of the Study

The objectives of the study were conceptualized as follows:

i. To undertake research among the youth of KwaMbonambi District in relation to the problems they have with the spread of STDs and related illnesses;
ii. To examine the social pressures and constraints through which young people negotiate their sexual encounters and how these impinge directly on their ability to make decisions about sexual safety and pleasure;
iii. To increase and improve public information and education regarding the early detection of communicable diseases and
iv. To evaluate the knowledge of the youth in HIV and AIDS as well as their behavior, knowledge, attitudes and practices.

1.5. Literature Review

According to Neuman (2000:445), literature review is based on the assumption that knowledge accumulates and that we learn from and build on what others have done. Scientific research is a collaborative effort of many researchers who share their results with others and pursue knowledge as a community. For the purpose of this study, literature was reviewed from sources such as books, professional journals, conference proceedings and the internet on sexually transmitted diseases. However, information on culturally sensitive aspects of the lives of rural youth in fast changing communities would be collected from those institutions that work in rural communities per se.

1.6. Research Methodology

This section gives a summary of the research methodology, the target population, the sample, and research instruments that have been used in data collection procedure and how the whole research has been conducted.

Research methodology is the broader aspect that deals with methods, techniques, procedures that are employed in the process of implementing the research design or plan

as well as the underlying principles and assumptions that underlie their use (Babbie, 1998:233).

1.6.1. Research Design

The research design is the plan or structured framework of how the researcher intends conducting the research process in order to give adequate attention to the research problem (Welman and Kruger, 1999:46). It addresses the planning of the scientific enquiry, designing strategy for finding out something.

The researcher used the quantitative research methodology of research. According to Newman (1997:20), "quantitative data method refers to the collection of data using numbers of units and measures of things." The qualitative research also examines patterns of similarities and differences across cases and tries to come into terms with their diversity (Neuman, 2000:419). The qualitative approach tends to use narrative description of persons, events and relationships. Qualitative research used content analysis and disclosure analysis. Palmquist (Babbie and Mouton, 2001:98), state that content analysis examines words and phrases within a range of texts, including books, book chapters, essays, interview and speech as well as informal conversation and headings. By examining the pressure or repetition of certain words and phrases in these texts, a researcher is able to make inferences about the philosophical assumptions of a writer, a written piece and even the culture and time in which the text is embedded.

The study used a descriptive design. Descriptive research design is merely interested in the description of the phenomenon (Bless, 2006:43). According to Neuman (1997:20), in descriptive research, the researcher begins with a well defined subject and conducts research to describe the study accurately. Survey research may be used for descriptive, explanatory and exploratory research. Survey research is probably the best method available to the social scientist interested in collecting original data describing a population too large to observe directly (Babbie, 1998:256). Surveys are also excellent vehicles for measuring attitudes and orientations in a large population.

The researcher conducted a survey among the youth population in the area under study using a structured interview schedule that allowed for a face to face interaction. The reason for this, it allowed for building of a rapport essential for understanding some of the sensitive aspects in dealing with personal aspects of understanding and feelings.

1.6.2. Population of the Study

In addition to refining concepts and measurements, the researcher should decide when or what to study. The population used in an interview study is that group about which the researcher is interested in gaining information and drawing conclusions (Babbie, 1998:109). The primary purpose of research is to discover principles that have universal application, but to study a whole population in order to arrive at generalizations would be impracticable. Some populations are so large that their characteristics cannot be measured; as a result, that before the measurement has been completed the population would have changed.

According to Tuckman (1997:201), the term defining the population refers to the boundary conditions that specify who shall be included or excluded from the population. The researcher's target population in this study comprised the youth in Sabokwe Reserve of Kw-Mbonambi District, in Kwa-Zulu Natal along the coastal region. The age range was 18-25 years.

1.6.3. Sampling

Sampling is the process of selecting observations. Specific sampling techniques allow us to determine and control the likelihood of specific individuals being selected for the study (Babbie, 1998:200). In choosing the respondents in the study, the researcher used the probability sampling procedure. According to Babbie (1998:200), a basic principle of probability sampling is that a sample should be a representative of the population from which it is selected if all members of the population have an equal chance of being selected in the sample.

1.6.3.1. Sampling procedure

Simple random sampling is the basic sampling method assumed in the statistical computations of social research Welman and Kruger, 1999:56). Simple random sampling techniques where forty respondents (the youth) were chosen from large population. Once a sampling frame has been established, to use simple random sampling the research assigned a single number to each element in the list. Families were allocated numbers from 1-147. According to Tuckman (1997:201), a sample is comprised of a limited number of elements selected from a population which is representative of that population. It is representative in that the sample is a miniature population. To be representative in the sense requires that all relevant characteristics of the population be included as far as possible. The full description of sampling and sampling procedure would be given in chapter 3.

1.6.4. Research Instruments

When an interviewer poses the questions contained in structured questionnaires to the respondents, whether in a personal interview or over telephone, such a previously compiled questionnaire is known as interview schedule (Welman and Kruger, 1999:165). In this study the interview schedule was used as the instrument for data collection. The interview schedule consisted of closed ended questions was recommended by the researcher to avoid vague answers. The interview schedule was constructed in English but taking into account the level of education, facilitation of adequate communication with respondents even when discussing sensitive matters it was translated into isiZulu. During interview sessions, using isiZulu the researcher ensured that they understood what was asked and also won cooperation of the respondents. In this study, age, gender and religion had been taken into consideration. The interview schedule consisted of the thirty closed ended questions.

1.6.5. Procedure for Data Collection

The data is what is actually recorded by the researcher (David and Sutton, 2004:27). As such, data is not naturally occurring stuff, and it is in a very important to respect what

researchers manufacture in their work as researchers. The interviewer puts a collection of questions from previously compiled questionnaires, known as an interview schedule to a respondent face to face and records the latter's responses (Welman and Kruger, 1999:166). The researcher had used the structured interview. Home visits were carried out and each respondent was given 45 minutes for the interview. However, the researcher had requested for the extension of this time in order to make sure that the schedule was completely filled. The interviewer is restricted to questions, their wording and their order as they appear on the schedule with relatively little freedom to deviate from it (Welman and Kruger, 1999:166). The five interviewers were trained and were familiar with questions in the questionnaires.

1.6.6. Data Analysis and Interpretations

Data have meaning only in terms of appropriate analysis and interpretation made by the researcher according to the scientific procedure (Welman and Kruger, 2003: 213). The researcher might have a large amount of data that must be cleaned and "reduced" to some statistical measures before meaningful interpretations could be made (Welman and Kruger, 1999:212). Data reduction consists of grouping information into a few categories or of computing a small number of statistics to adequately describe the characteristics of the sample. These few statistics were used to communicate the results of the study and to indicate the comparability of the study with others. This is important in order that the researched information can become part of the body of knowledge in the discipline.

The collected data had been analyzed descriptively in order to draw accurate and reliable statistical inferences. Charts, tables, and graphs had been used to present the statistical data using Microsoft word-processor and Microsoft excel.

1.7. The Value of the Research

One important implication of the study is to improve knowledge and dissemination of information and data concerning HIV/AIDS and other communicable disease especially among the youth in the rural KwaMbonambi District. This study would help to increase and improve public information and education regarding the early detection of

communicable diseases. It would possibly assist health educators in planning, implementation and decision-making about programs that are based on STDs and AIDS. The youth as well as community at large will also benefit from the study. The findings would also encourage the health department to take into consideration the traditional African healing systems in fighting against AIDS. This system had been neglected in the past. It would further encourage involvement of the youth in skills development that would assist them in negotiations about safety sex.

1.7.1. Dissemination of findings.

The key to a successful presentation is to select out clearly the objectives that the researcher wishes to achieve in presentation. According to David and Sutton, (2004:353), when undertaking the first presentation it is important to assume that the audience has little or no prior knowledge. The research findings would be disseminated in conferences, workshops and health clinics.

1.8. Ethical considerations

- The names of participants would not be reflected in the interview guide to ensure privacy and confidentiality.
- Informed consent was obtained from the participants of the study after the purpose and objectives of the study was explained to them.
- Participation was voluntary.

1.9. Organization of the Study

In its final form, the report of this study would be organized as follows:

CHAPTER 1. This chapter provides an introduction to the study.

CHAPTER 2. This chapter discusses the literature review that forms the theoretical basis pertinent to this study.

CHAPTER 3. This chapter outlines research methodology that was used in the study.

CHAPTER 4. This chapter provides data analysis and interpretation.

CHAPTER 5. This chapter summarizes an exposition on the findings of the study.

CHAPTER 6. This is the final chapter that concludes and provides recommendations to the study.

1.10. Conclusion

This chapter has outlined the orientation to the study, giving an indication of the core problem under investigation and objectives to be achieved. The next chapter looks at the theoretical background of the study by focusing on previous studies conducted on sexually transmitted diseases.

CHAPTER 2

LITERATURE REVIEW

2. INTRODUCTION TO THE STUDY

2.1. Introduction

Since the beginning of the epidemic, an estimated 60 million of people worldwide have become infected with the STDs, with 40 million people living with HIV at the end of 2001 (National HIV and Syphilis Antenatal Sero-positive Survey in South Africa, 2002: 1). The severity of the epidemic is closely linked to the region's poverty, young women's relative lack of empowerment, high rates of male worker migration and other social and cultural factors. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people and women in poor countrie(HIV&AIDS and STI Strategic plan 2007-2011, page 21). Youth form a large constituency within the population of South Africa, particularly among Africans, is on increase. According to Lehohla (2001:53), twelve per cent of all young females become mothers between 12 and 16 years of age.

A major consequence of unprotected sex in youth is the likelihood of infection from STDs. Included amongst the major STDs are gonorrhea, chamydial infection, syphilis, herpes and HIV/AIDS. Gonorrhea is a bacterial infection that is commonly called "the clap." Early symptoms are common in men than women. In men these symptoms are foul-smelling, cloudy discharge from penis, and burning sensations during urination. If not treated quickly, gonorrhea could produce sterility in both men and women (Tocci, 2001:23). Syphilis also is caused by bacteria. Chamydia, bacteria causes this STD, but acts like a virus growing only within the body's cells.

The most common complication of chamydia for young women is the spread of infection to the upper genital tract, leading to the pelvic inflammatory disease, the major cause of tubal damage resulting in ectopic pregnancy and infertility. AIDS is a sexually

transmitted disease that is caused by the human immunodeficiency virus (HIV), which destroys the body's immune system. A person infected with HIV may not show any manifestation of AIDS for many years, and yet, all this time the person could spread the infection through unprotected sex. The youths are especially vulnerable because of their high-risk behavior. Among the groups that are most vulnerable to STDs are young adults of both sexes who engage in unprotected sexual activities. As the receptive partner, the female naturally, runs a greater biomedical risk to begin with. The risk is magnified in girls because their bodies are still immature. STDs could reduce the risk of infection if appropriate precautions are taken during sexual activity. This includes the use of condoms during penetrative sex.

While the threat of disease as a result of sexual activity has long been with us, it is the advent of AIDS as a global health threat that led to a more active focus on sexual activity. Strictures against unsafe sex have accelerated in recent years with the realization that AIDS is one of the sexually transmitted diseases for which a cure has not been found and which appears to carry with it, ultimately, a sentence of death.

The first cases of AIDS were first recognized and described in 1981. AIDS was first described among homosexual men in 1981 (Tocci, 2001:94). Initially it was thought that newly appearing female Aids cases the were result of IV-drug usage. Soon it was realized that these women had become infected through heterosexual contact with an infected male. More female AIDS cases resulting from heterosexual transmission began to appear in 1983. Clinicians noted that there were persons from Central African countries who were coming to Europe for treatment of unusual illnesses that resembled AIDS. With the discovery of HIV, it is clear now that these cases have the same etiology.

In the 1980s there was no structured response to the South Africa STD, HIV and AIDS epidemics and the period was characterized by uncoordinated, ad hoc reactions to evolving needs (Mckerrow, 1998:1). The state response was the creation of AIDS Training and information centre in the large urban centre s of the country. Each centre was located within local authority structures and, until recent funded at national level by the department of Health. These centres were expected to serve surrounding areas, often

hundreds of kilometers from the base. The major development in the 1990-1994 periods was that of a National AIDS Plan. This formed the basis of the past apartheid response of the state and the HIV/ AIDS and STD Program 1995/6 strategy, Business and Structure Plans. Life skills program targeted at the youth and appropriate treatment and management of patients seeking treatment for STDs, were identified as key strategy. The implementation of programs for the management of patients seeking treatment for STD's began in 1996. The syndromic approach to STD management in which symptoms and not disease are treated was selected, training manuals for primary health care staff developed, training implemented and the program incorporated into all levels of health care (Mackerrow, 1998:8).

STDs has long-term effects on personal relationships, social institutions, and cultural processes. Its effects extend to shape the way individuals and collective groups live and are organized. Social norms and values have also affected the perception of AIDS and the efforts to control the disease (Osei-Hwedie, 1994:41). AIDS is also in the process of reshaping many aspects of societies, its institutions, norms and values, interpersonal relations and cultural processes. Consequently what happens to lifestyles are at the heart of the debate on AIDS concerning transmission and prevention, and this poses a major challenge to societies. The emphasis is on surveillance and containment of the virus. It is argued that the only effective way of prevention is drastic restructuring of attitudes toward intimate social relations. The period of free sex and over indulgence must end and be replaced by careful and responsible living (Osei-Hwedie: 1994:31). Responsible living, in terms of the relationships between the AIDS-infected person and the family and community, is desirable. There are always difficult situations and problems that arise once a person is diagnosed as HIV positive.

AIDS is the pressing health problem in the world today because of its capacity to spread very rapidly and its impact on youth/s. The epidemic is spreading particularly fast in Africa through heterosexual means. Factors such as multiple sex partners and the extent of other underlying factors including urbanization, migrant labor, poverty, population displacement, rapid cultural changes, inadequate social services and inferior status of women influence this rapid heterosexual spread (Gennrich, 2004:). STDs have become a

major public health problem in most countries and account frequently, on the impact and material on the youths' health and on their social consequences, as well as the economic cost in terms health and lost productivity. In KwaZulu-Natal, coastal region, drop, oozing sores near the testicles, cornflower and fish disease are the most frequently diagnosed STDs which constitutes a serious health problem (Green, 1994:6).

2.2. Migratory labor

In South Africa, large numbers of population live in rural areas where arable land is becoming limited and economic growth cannot keep pace with the rapid population increase. Poverty and famine have encouraged massive migration of adolescents to urban and industrial areas in search of work and a more meaningful life. Such movement, particularly in the case of temporal migrant labor, leads to family separation and creates unbalanced sex ratios, resulting in an excess of men in urban and women in rural areas. Returning temporal workers may become sources for the spread of STDs in rural areas.

The massive migration of young people to industrialized centers and urban areas in search of work and education achievement has brought a departure from traditional cultural patterns and adoption of a new set of moral codes arising out of the new environment, interacting with and around the immigrant (Evian, 2003:21). Traditional values such as marriage have become less popular in the face of imported ideas of romantic love and increasing freedom to mix with other young people without the social-control by the family (HIV/AIDS & STI Strategic Plan 2007-2011: 32).

In Africa, heterosexual transmission is the primary route of AIDS transmission. Incidence rates reported are highest in sexually active youths and in-groups with multiple sexual partners. Many people in the highly infected areas of the urban towns are from rural areas. The migration back and forth among the various regions of the country, especially of the adult population, is often quite extensive.

major public health problem in most countries and account frequently, on the impact and material on the youths' health and on their social consequences, as well as the economic cost in terms health and lost productivity. In KwaZulu-Natal, coastal region, drop, oozing sores near the testicles, cornflower and fish disease are the most frequently diagnosed STDs which constitutes a serious health problem (Green, 1994:6).

2.2. Migratory labor

In South Africa, large numbers of population live in rural areas where arable land is becoming limited and economic growth cannot keep pace with the rapid population increase. Poverty and famine have encouraged massive migration of adolescents to urban and industrial areas in search of work and a more meaningful life. Such movement, particularly in the case of temporal migrant labor, leads to family separation and creates unbalanced sex ratios, resulting in an excess of men in urban and women in rural areas. Returning temporal workers may become sources for the spread of STDs in rural areas.

The massive migration of young people to industrialized centers and urban areas in search of work and education achievement has brought a departure from traditional cultural patterns and adoption of a new set of moral codes arising out of the new environment, interacting with and around the immigrant (Evian, 2003:21). Traditional values such as marriage have become less popular in the face of imported ideas of romantic love and increasing freedom to mix with other young people without the social-control by the family (HIV/AIDS & STI Strategic Plan 2007-2011: 32).

In Africa, heterosexual transmission is the primary route of AIDS transmission. Incidence rates reported are highest in sexually active youths and in-groups with multiple sexual partners. Many people in the highly infected areas of the urban towns are from rural areas. The migration back and forth among the various regions of the country, especially of the adult population, is often quite extensive.

2.3. Prostitution and use of drugs

Sex workers have been blamed for contributing to the increase of the HIV-positive status. Prostitution relates to the provision of sexual services for payment. Prostitutes have long been associated with and often "blamed for" the spread of sexually transmitted diseases (HIV/AIDS & STI Strategic Plan 2007-2011:34). In societies where alcohol is legally available, bar room, hotels and other licensed premises are popular for seeking sexual partners. Many of the connections between alcohol, other drugs and sex are attributable to the coalescence of social and cultural patterns, especially those related to leisure.

Most women who regard alcohol as having disinhibiting effects may drink to become sexually freer. Unwanted pregnancies, sexually transmitted diseases, and unprotected sex have all been linked with the disinhibiting effects of alcohol and other drugs (Lehlola, 2001:53). Most of the adolescents who are heavy drinkers are less likely to use condoms. It is apparent that high-risk sexual activities are associated with heavy alcohol and drug use.

There is a well-established link between bar-rooms and casual sexuality. Many bars are used as pick-up places and some clearly defined as single bars. Drugs use is common among prostitutes, and few could say they never use drugs (HIV/AIDS &STI Strategic Plan 2007-2011:38). According to prostitutes, drugs relax them and make their work more bearable. They claim that drugs use takes their minds off what they are doing. Some sex workers used drugs to help them to cope with making contacts with clients. Some sex workers use drugs to compensate for their mixed feelings about their occupation. This is because some dislike their work; they find it stressful. Prostitutes are considered as a reservoir for transmission of certain STDs.

The shortage of resources has made AIDS potentially more serious in Africa than any other continent in the world (Teljeur, 2002:59). AIDS has created a problem of enormous complexity, particularly for developing nations. There is no known cure for the disease and the only way to avoid the disease is to avoid the risk of infection and exposure. AIDS is a behavioral illness. To change sexual behavior on a broad scale may be impossible,

because specific mores preclude any single educational program. Since prostitution was practiced in well developed places, AIDS has been seen as an "urban disease" and perhaps on those who are in the middle income brackets presents a particularly sobering picture for the national leadership (Mckee et al, 2004:139). It is this group of well-trained leaders who have the resources, the money, the cars and leisure time to pursue multiple liaisons, if they are so inclined. Many are part of the "bachelor town syndrome" wherein a man lives in a major city in order to work, while his wife and family maintain the homestead in rural areas.

2.4. AIDS and Youth

Because the infection is concentrated in the young age groups, AIDS attacks the most sexually active and the most productive sectors of African populations. Both the young and the old are heavily dependent on the more productive age group. In African societies with this kind of dependency ratio, there would be a ripple effect as breadwinners become ill, dependent children and the aged would begin to look elsewhere for support. They would not necessarily be ill themselves, but they will surely be impoverished. The dependent ratio does not also change as more and more children become ill and die.

It is not surprising that the theme of young adult's vulnerability has been taken up forcefully by the popular press with anxiety-arousing headlines such as "AIDS message fails to make impression on young adults" and "warning teens of the AIDS risk group" (Moore and Rosenthal, 1993:129). Many young people appear to justify their non-use of condoms with the belief that condoms are unnecessary because their current relationship is monogamous and promise to make the relationship a long-term one. Adolescents who do not believe in the safety of partners do not seem to have understood the danger of sexual relationships. They fail to take into consideration the sexual history of their partners as well their present behavior. Compounding the problem is the fact that most of these young people are aware of campaigns stressing the risk of HIV infection but few considered that the issue is relevant to their own lives. It is clear that most adolescents have not personalized the risk of HIV/AIDS, perceiving the illness as a threat to others, not themselves (Moore and Rosenthal, 1993:129).

The youth who perceive themselves to be at the least risk have a strong stereotype of an AIDS victim. This stereotype is likely to be maintained because few adolescents have ever or even met an AIDS sufferer. Another problem is that adolescents who repeatedly engage in unsafe sex without becoming infected are likely to deny the risk of that behavior. The youth's confidence that they are not at risk may well stem from another myth, namely that "you can tell by looking" whether or not people are affected (Moore and Rosenthal, 1993:130). Most diseases do, in fact, have short incubation periods, it is true that one can tell by looking. Both these possibilities are implausible since young people should have high levels of knowledge about HIV transmission and are unlikely to be ignorant of its long incubator period. It may be that adolescents are merely drawing on the socially constructed equation of beauty with good health, a link reinforced by the media. It is vital that adolescents learn to look beneath the external packing to the realities of transmission of HIV.

One of the most important implications of these studies is the need to tailor AIDS educational programs to children's level of cognitive development, so that the information received matches their ability to comprehend (education and HIV/AIDS. A window of hope, 2002:12). While the information about and transmission of HIV is important, it appears that knowledge is a necessary but not sufficient cause of action. Of considerable concern is the increasing evidence that knowledge is not reflected in these adolescents' behavior.

2.5. Heath promotion campaigns

Some young people have their own ideas about using condoms. They feel using condoms has unpleasant consequences of sexual pleasure by reducing sensation, a view often expressed in vivid comments such as "having shower in raincoats" or "washing your feet with socks on" (Moore and Rosenthal, 1993:144). The difficulties in dealing with condoms may be overcome if young people are taught how to negotiate the use of condoms in every sexual encounter. It is important, then, that adolescents are taught skills, which will enable them to communicate confidently in a climate of mutual acceptance.

It is possible that, as the impact of AIDS in the heterosexual community increases, adolescents' sexual behavior will become more conservative. Fewer partners and more frequent use of condoms are possible options. Alternatively, adolescents may return to the pre-1960 days of premarital chastity, when non-penetrative sex was a preferred and often used substitute for sexual intercourse (Moore and Rosenthal, 1993:144).

There are many adverse socio-economic realities facing the youth that make this difficult. School is not compulsory for African adolescents, and thousands of young people of all ages leave the school system annually. As a result, African adolescents are not easily reached through focused education programs. Poverty, unemployment, and homelessness and inadequate health facilities mark the life for many Africans. All these contribute to the spread of HIV/AIDS. But, we need to ask ourselves whether AIDS education is meeting young people's needs. Their stage of development requires that an understanding be gained by AIDS-educators as to why young people are not assimilating information and acting upon it. This is a special challenge to deal with myths and cultural barriers to knowledge development.

In South Africa, it is women in their capacities as mothers, mothers-in law, sisters, teachers and domestic workers, who are responsible for most of the care and socializing of children. The majority of nurses and community health workers are women. Inevitably the responsibility for much of the burden of caring for the infected and dying will fall on their shoulders, particularly if home-care for HIV/AIDS patients becomes a government policy. This burden will decrease as young women and grandmothers accept the role of caregivers and surrogate parents for the orphans of the AIDS epidemic. If these women become infected themselves, there will be no further human resources to fall back on (Everett, 1994:23).

2.6. Young women and AIDS

The impact of HIV/AIDS on women is particularly acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies, women are

"mistakenly" perceived as the main transmitters of sexually transmitted diseases (Muller, 2005:37). Together with the traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide a basis for the further stigmatizing of women within the context of HIV and AIDS (Evian, 2003:204). HIV-positive women are treated very differently from men in many developing countries. Men are likely to be excused for their behavior that resulted in their infection, whereas women are not. Rejection by wider family members is also common. In some African countries, women, whose husbands have died from AIDS-related infections, have been blamed for their deaths.

Most of the women who die of AIDS leave behind children whose care will at best be taken over by institutions. Young women are made particularly vulnerable to AIDS. Their socialization does not prepare them to negotiate safer sexual practices. Women are unable to refuse male sexual demands, let alone insist on the use of condoms in male hostility. Lack of sexual control is even worse for African women in traditionally patriarchal societies.

The researcher would like to suggest that children and young adults need to be taught life-skills that would enable them to cope with crisis situations, thereby empowering them. Somehow this contrasts strongly with the government's concentration on AIDS awareness and education campaigns, mostly in the form of pamphlets and posters that clearly do not go far enough in some instances. These have not been complemented with appropriate interventions, such as the development of an AIDS program within target communities in a participatory manner; training teachers to use the package or developing peer counselling.

AIDS education and awareness campaigns are vital if prejudice misconception and misunderstanding about AIDS are to be eliminated, broader sex education should also take place at school, aimed at providing life-skills and a framework within which prevention programs could be initiated (Winkler, 2003:66). Such programs must begin at a young age. AIDS campaigns should include assertiveness training for young women. AIDS information must be appropriately communicated and scare tactics avoided. All media channels must be utilized in the fight against AIDS. Education in sex hygiene is

needed to establish better standards; parents could influence adolescents' sexual behavior too. First parental attitudes regarding adolescents' sexual behavior may influence adolescents' attitudes. Second the mental and childbearing behavior of parents, including experience with divorce, remarriage, living arrangements and apparent behaviors toward the opposite sex may provide and support role models for young people. The educational and work experience of the parents may influence attitudes among the youth.

2.7. The role of family in caring for people with STDs

In most parts of Africa, families are the primary caregivers to sick members. There is clear evidence of the importance of the role the family plays in providing support and care for people living with HIV/AIDS (Teljeur, 2002:59). However not all family response is positive. Infected members of the family could find themselves stigmatized and discriminated against within the home.

Major problems of care, including medical needs become acutely apparent, especially when patients must be cared at home. Friends and family members may draw away at a time when people need practical help with a lot of activities such as household chores and emotional support. The extended family members may be so pressured and overwhelmed that they may be unwilling to take care of orphaned children who will need other sources of care. Children and adolescents who may end up as care-givers for dying parents and also for younger siblings may suffer by dropping out of school, and because of inappropriate adult responsibility without adequate emotional and social support (Winkler, 2003:68). Children caring for other children and the very old caring for orphans have become a major characteristic of some African societies despite the popular arguments that there are appropriate members of the extended family to perform such jobs (Teljeur, 2002:59).

Most families and many individuals in Africa are unwilling to share the diagnostic information with friends and relatives due to a sense of guilt associated with AIDS. It is not so much the sense of guilt associated with unfaithfulness and promiscuity. It is rather the fear of community disapproval of the sickness which may lead to stigmatization,

isolation and termination of association with the infected person/s and the entire family. The loss of social support may lead to isolation that may in turn induce depression and difficulties in dealing with issues and tasks.

2.8. The negative attitudes of health care workers with regard to patients with HIV/ AIDS

Many reports reveal the extent to which people are stigmatized and discriminated against by health care systems. Some studies would reveal the unfortunate behavior of withheld treatment, non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. Also fuelling such response are ignorance and lack of knowledge about HIV transmission (Benatar, 2004:572). Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings.

HIV-related stigma and discrimination remains an enormous barrier to effectively fighting the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicity. People with or suspected of having HIV may be turned away from healthcare services, employment, refused entry to foreign countries. In some cases, they may be evicted from home by their families and rejected by their friends and colleagues. According to Fredrickson and Kanabas (2000), the stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on those left behind. Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of the year 2001, 40 million people were living with HIV or AIDS and during the year 3 million died from AIDS-related illness (Fredrickson and Kanabas, 2000). Combating the stigma and discrimination against people who are affected by HIV/AIDS is as important as developing the medical cures in the process of preventing and controlling the global epidemic.

In some countries people who are living with HIV or AIDS lack knowledge of their rights in society. They need to be educated, so they are able to challenge the discrimination, stigma and denial that they meet in society. Institutional and other monitoring mechanisms can enforce the rights of people living with HIV or AIDS and provide powerful means of mitigating the worst effects of discrimination and stigma. However, the reality is that there is no policy or laws that combat HIV/AIDS related discrimination effectively. The fear and prejudice that lies at the core of the HIV/AIDS discrimination needs to be tackled at the community and national levels. A more enabling environment needs to be created to increase the visibility of people with HIV/AIDS as normal part of any society. In the future, the task is to confront the fear based messages and biased social attitudes, in order to reduce the discrimination and stigma of people who are living with HIV (Fredrickson and Kanabas, 2000). Health care workers can play a very positive role in the change of negative attitudes and presenting an objective perspective to eliminate discrimination.

2.9. Social development

The serious repercussions of HIV/AIDS on the South African social development are demonstrated by its possible demographic impact. The epidemic is also notably serious among young adults to some extent middle-age adults. It is argued that with the current nature of the epidemic the number of reproducing women may decline to replace losses due to deaths. Even though these would slow down population growth, the reduction would basically involve young people and workers, the most active part of the population. The basic problem is that the decrease in population would be selective, among the young people and sexually active age groups and would more than offset health and social improvement in life achieved so far (Education and HIV/AIDS: a window of hope, 2002:21). Africa and the Third World in general, are faced with critical shortages of skilled manpower at all levels coupled with expensive training costs (Teljeur, 2002:57). This, loss of skilled labor to AIDS is very costly in terms of wasted training and replacement costs. There is also, close dependence of entire nuclear families in the place of employment. In some agricultural institutions people live in compound schemes and are attached to the place of employment. The loss of the employee means

loss of housing as well as income and often schooling for children. The social cost of AIDS is therefore very substantial and far-reaching.

There is still the vital need to act positively while diagnosing HIV and prescribing the means of alleviation and control which are manifest medical matters, setting limits to acceptance behavior, recommending changes in lifestyles and helping people come to terms with the diseases (Education and HIV/AIDS: a window of hope, 2002:30). This would involve social workers and others in the helping professions. At a personal level, an individual has to confront a range of new and inevitable painful ethical choices. Those in settled monogamy may think they are secure and have nothing to fear. However, where sexual relationships are concerned, no one can be absolutely sure of another person's fidelity.

The youth would normally experiment with sex. Some unsafe experiments are bound to happen. Sex education would have to include detailed and specific technical instruction as a barrier protection that seems desirable for contraceptive purposes alone (Education and HIV/AIDS: a window of hope, 2002:4). The concept of the condom as a normal accompaniment of sexual intercourse must be positively promoted. This is in belief that some protection is better than no protection at all. It is also necessary to avoid promoting random sexual activity in the promotion of condom use. The ethical imperative for the young is to place emphasis on relationship. There is need to increase awareness of the unacceptable risks involved in random sex. Honesty dictates that one needs to know, and this should not be affected by considerations of social and economic consequences (Osei-Hwedie, 1994:39).

The social pressure and constraints through which young women negotiate their sexual encounter impinge directly on their ability to make decisions about sexual safety and pleasure. The power of young women to control sexual practices can then play a key role in the limitation of sexually transmitted diseases. Public health campaigns aimed at women cannot be effective unless they recognize that men and women begin their sexual encounters as unequal partners in the battle against the sexual transmission of HIV (Mackerrow, 1998:11). AIDS is a lethal disease, even if only isolated cases occur in any

segment of a community. That whole community should be educated as if it were at risk. AIDS is the primary cause of death to adolescent women in Africa. The researcher is not suggesting that, on the basis of this evidence, heterosexual women should now be identified as yet another "high risk group."

The AIDS epidemic has challenged our existing knowledge of sexual beliefs, practices and identities. Information on young women's conceptions of personal risk and safety in sexual activities is critical for effective health education. The researcher argues that the way in which young women understand risk, negotiate sexual relationships and develop strategies for safer sex will play a significant part in the limitation of AIDS.

Sexuality also includes people's sexual identities in all their cultural and historical variety. This assumes that while sexuality cannot be divorced from the body, it is also socially constructed. These meanings are inseparable from gender power relations and are active in shaping sexual interaction. Young women are encouraged to attach themselves socially to young men in order to succeed as conventionally feminine women, but they are then inhibited from seeing this desire and expected relationship as a structurally unequal one (HIV/AIDS & STI Strategic Plan 2007-2011:33). There is need for control which young women can exercise over the risks of their notions of sexuality with their expectations of romance, love and caring. Sexual identity for heterosexual women is ideologically constructed in a context which defines sex in terms of men's drives and needs.

The imbalances of power in sexual negotiations coupled with social pressures on young women to guard their reputations, reduces the amount of control which young women have over the practice of safer sex. On the other hand, if fear of pregnancy is a prime concern, she may reject condoms in favour of the pill. Many young women seem to have internalized a negative view of condoms. They argue through their misconceptions that condom use "breaks the flow "and makes you lose the moment', spoils the romance and turns the event into a mechanical physical activity. These views could be understood as a product of a dominant ideology that sex satisfies men's needs for penetration and ejaculation. If, however, young women do make a decision to use condoms in order to

protect themselves from HIV, then she must find a way to negotiate their use with her male sexual partner.

Indeed sex is seen as a means of demonstrating that one loves and trusts someone. As a result of this view there is a tendency to go on the pill as a means of indicating the seriousness of a relationship. As love and trust develop, women may then be safely carried away as far as pregnancy is concerned, but still be engaging in unsafe sex in relation to STD's and HIV. Young women who are already on the pill sometimes conceal this from new partners in order to justify asking for condoms to be used. Condoms tend to be used in situations where partners are not to be trusted.

2.9.1. Factors which contribute to HIV/AIDS-related stigma

Sexually transmitted diseases are well known for triggering strong responses and reactions. In the past, in some epidemics, for example, TB, the real or supposed contiguousness of the disease has resulted in the isolation and exclusion of infected people. From early times in the AIDS epidemic, a series of powerful images were used that reinforced and legitimized stigmatization of HIV/AIDS as punishment (e.g. for immoral behavior), HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims) and HIV/AIDS as horror (e.g. in which infected people are demonized and feared) and HIV/AIDS as the "otherness" (Fredrikson and Kanabas, 2000). Together with the widespread belief that HIV/AIDS is shameful, these images represent ""ready-made" but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes also enable some people to deny that they personally are likely to be infected or affected.

In some societies, laws, rules and policies can increase the stigmatization of people living with HIV/AIDS. Such legislation may include compulsory screening and testing as well as limitations on international travel and migration. In most cases, discriminatory practices such as the compulsory screening of risk groups both furthers the stigmatization of such groups as well as creating a false sense of security among individuals who are not considered at high risk. Laws that insist on the compulsory notification of HIV/AIDS

cases, and the restriction of a person's right to anonymity and confidentiality, as well as the right to movement of those infected, have been justified on the grounds that the disease forms a public health risk.

Perhaps as a response, numerous countries have now enacted legislation to protect the rights and freedoms of people living with HIV and AIDS and to safeguard them from discrimination. Much of this legislation has sought to ensure their right to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support.

Governments and national authorities sometimes cover up and hide cases, or fail to maintain reliable reporting systems. Ignoring the existence of HIV and AIDS, neglecting to respond to the needs of those living with HIV infection, and failing to recognize growing epidemics in the belief that HIV/AIDS can never happen to us are some of the most common forms of denial (Fredrickson and Kanabas, 2000). These denials fuel the AIDS stigma making those individuals who are infected appear abnormal and exceptional.

Stigma and discrimination could arise from community-level responses to HIV/AIDS. The harassing of individuals suspected of being infected or belonging to a particular group has been widely reported. It is often motivated by the need to blame and punish and in extreme circumstances can extend to acts of violence and murder. In December 1998, a person by the name of Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status (Fredrickson and Kanabas, 2000).

Some people with AIDS have been abandoned alone in their homes. In public transportation, some people have forced out a person suspected of having AIDS to vacate the premises (Kisseka, 1990:40). These discriminatory behaviors have extended to funeral ceremonies whereby a person who has died of AIDS is hurriedly buried without observing the traditional sharing of his personal effects. In Uganda according to Kisseka (1990:41), individuals of slim physical statures are stereotyped as having AIDS. Men feel

more secure with plump girls for casual sexual companionship. But that line of defense has been gradually broken these days. Another problem is that prostitutes have salvaged their livelihood by impersonating schoolgirls and thus escaping the stereotype of high-risk group.

Stereotyping related to HIV/AIDS has meant that young women are blamed for the spread or not recognized as potential patients with diseases. The consequences could be delaying diagnosis and treatment, stigmatization and violations of human rights. Women are at an increased risk of exposure to HIV infection for reasons related directly to their gender. Women's lower socio-economic status and lack of power makes it difficult for them to undertake prevention measures (Muller, 2005:32).

Since prevention depends upon behavior change, lack of attention to socio-economic and cultural issues may contribute to the spread of HIV. There is a danger that cultural explanations may serve to excuse failures by policy makers in the international health arena to support effective prevention strategies (Schoepf, 1992:226).

Another stereotype is that AIDS is regarded as a prostitute's disease. This is currently more widespread and appears have a sound epidemiological basis. Traditional ideas about disease with which AIDS is identifying women as those who spread it. Stigmatizing depictions of them as sinful and deviant reinforces the blaming of prostitutes. As a result of such blaming, some young women who are engaged in sex for pay would avoid condoms use so that they do not become identified as prostitutes. Another problem is that people visit hospitals regularly but do not conduct tests for HIV, but for some other diseases. Another problem is that the majority of pregnant women do not attend pre-natal clinics to be diagnosed early for the problem and others do not deliver in maternity wards to benefit from treatment programs. HIV is transmitted to approximately one third of babies of HIV-positive mothers if there is no medical intervention. Use of antiretroviral drugs, obstetric practices including caesarean delivery, and safe infant feeding practices can reduce transmission to very low levels (HIV/ AIDS & STI Strategic plan 2007-20011:29). It is advisable for pregnant women to attend antenatal clinics regularly so that their health and their babies can be carefully monitored. HIV is thought to have

contributed to an increase of 42% in under-five mortality in this country in 2004 (HIV/ AIDS & STI Strategic plan 2007-20011:34). Children usually do not have sufficient access to AIDS treatment because available services are mostly designed for adults. Serious challenges around the skills of health workers and capacity to manage and treat children with AIDS, including lack of appropriate ART formulations for treating children, remain (HIV/ AIDS & STI Strategic plan 2007-20011:34).

2.9.2. Condom use

Many people do not accept that they should use condoms for all sexual encounters including relations with regular partners. Most contacts with regular partners continue to be unprotected even among those whose risk is quite high. Many men who are at risk apparently have not yet come to terms with the full extent of the behavioral changes needed to prevent Aids (Schoepf, 1992:230). Social legitimization of regular condom use is likely to be more effective than restrictive moralistic exhortation. Other scholars have thought that some cultural norms could be used to provoke prevention measures. In many cultures grandmothers and aunts traditionally educated and advised the young people. This role has diminished especially in urban areas. Training in home care and for cottage and rural industry projects with which they can earn an income would help older women cope with the patients and children left their in charge. They should be targeted more specifically as educators and counselors. Young women from elite families in ethnic groups need to legitimate a "return to a tradition" as a means to resist male pressure to have sex.

The first objection stated by many women is that condom usage is "not natural." This appears to be a metaphor for the widespread belief that repeated contributions of semen are needed to form the growing foetus (Schoepf, 1992:231). Since condoms have been associated with prostitution and diseases, proposing the use of condoms signifies mistrust of the partner and is experienced as insulting. Condom use is a particularly sensitive issue among minorities. Using condoms sometimes threatens the minority sense of masculinity. The position of some Christian churches on condoms also has influenced some minority group members' views. In South Africa the use of condoms has been interpreted by some

among some groups of female sex workers, it would be logical to emphasize that these women are a potential source of transmission. In some cases, it is not only prostitutes who are blamed but also women in general.

Traditional ideas about diseases with AIDS might provide a predisposition to identify young women as those who spread it. In South Africa, among the Zulu, sexually transmitted diseases are women's diseases. In Botwana, AIDS is sometimes classified as a pollution disease originating in the female body, which can be transferred to men via sexual intercourse during a culturally prescribed period, after birth, abortion and initial period of widowhood before purification rituals have taken place (Van Dyk, 2005:119). Similar beliefs have been documented in Swaziland, where AIDS has been associated with sexual intercourse with women who are menstruating, and who have had abortions.

Stigmatizing depictions of the disease as sinful and deviant behavior reinforces the blaming of prostitutes. The researcher argues that the stigmatizing nature of metaphor that surround diseases such as AIDS has a direct effect on practices, for people feel inhibited and frightened to seek diagnosis and early treatment. STD's and AIDS are represented as punishment for living unhealthy lives, for taking health risks and lifestyle risks. These choices of metaphors give meaning to AIDS and throw light upon the stigmatized nature of the disease and discriminatory attitudes towards people living with AIDS and those who are believed to be a high risk of HIV infection (Gennrich, 2004:15). All these views, perceptions as well as myths and imaginative conceptions pose serious challenges to education programs and development of appropriate understanding among youth.

2.10. Stigma and discrimination related to HIV/AIDS

From the moment scientists identified HIV/AIDS, social response of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination has spread rapidly, fuelling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS. It goes without saying that HIV and AIDS are as much about social phenomena as they are about biological and medical concerns. Across the world the

global epidemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities (Mckee et al, 2004:101). But the disease is also associated with stigma, repression and discrimination, as individuals affected by HIV have been rejected by their families, their loved ones and their communities. This rejection holds as true in the rich countries of the north as it does in the poorer south (Mckee et al, 2004:102).

Stigma is a powerful tool for social control. Stigma could be used to marginalize, exclude and exercise power over individuals who show certain characteristics. While the societal rejection of certain social groups (e.g. many cases reinforced this stigma) by blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such populations. This is seen not only in the manner in which outside groups are often blamed for bringing HIV into a country, but also in how such groups are denied access to the services and treatment they need (Pelser et al, 2004:293).

In many societies people living with HIV and AIDS are often seen as shameful. In some societies the infection is associated with minority groups or behaviors, for example, homosexuality. In some cases HIV/AIDS may be linked to perversion and those infected will be punished. Also, in some societies HIV/AIDS is seen as the result of personal irresponsibility. Sometimes, HIV/AIDS is believed to bring shame upon the family or community. Whilst negative responses to HIV/AIDS unfortunately widely exist, they often feed upon and reinforce dominant ideas of good and bad with respect to sex and illness, and proper and improper behaviors.

2.11. Factors that increase the risk for HIV infection

Another problem facing youth is the lack of access to information, biological and health-related factors and some sexual practices. This is because the educational level and literacy rate of many adolescents in South Africa is low. They are reached less effectively by anti-AIDS campaigns relying only on printed material such as pamphlets, posters, and brochures. Youth living in rural areas have less access to the radio and television, whereby these communication channels largely pass them by (Muller, 2005:49).

Insufficient knowledge concerning HIV transmission naturally means that perceptions of risk and knowledge of prevention methods would also be low and inadequate.

With AIDS, the social system is under strain. The process through which the virus spreads is seen as a threat to the dominant values of society and also as a moral threat. A biological threat is attached to the moral one due to transfer of the virus from the so-called "guilty" to "innocent people." This has resulted in moral panic that has forced societies and individuals to resort to discrimination and the creation of social and physical distance between themselves and sufferers. However, as people come to understand HIV/AIDS the panic is reduced and the infected are becoming more and more accepted by both societies (Pelser et al, 2004:279).

The social nature of humans underlies the critical importance of social support in facilitating adjustment to stressful life events, and in decreasing vulnerability to stress-related disorders. Social support helps in adapting to stress and decreasing the emotional effects on the individual. Social support is, therefore, a coping assistance that is necessary in the context of the levels of stress associated with HIV/AIDS and the need to help sufferers re-gain their self-esteem (Van Dyk, 2005:247). It is with respect to social supports that indigenous societies are supposed to have advantage over western industrialized societies.

AIDS has an extensive impact on the social as well as the economic status of those affected. Also the psychological distress sometimes leads to vague somatic symptoms which do not respond to medical treatment, thereby increasing the patients' fear and anxiety. Social support must therefore be a primary concern of all HIV-infected individuals and groups. It is supposed to be the network that has the capacity to sustain socio-psychological support and hence provide the justification for the necessary care for those affected.

The ulcers and sores caused by STD's make it easier for HIV to enter the bloodstream. As the ulcers and inflammation are often initially internal in women, they remain unaware of a STD for some time and cannot seek early treatment. In many countries, a

women's social position depends on her status as a mother; her fertility is highly valued as good. Childless women may seek various sexual partners in an effort to become pregnant. Infertility may cause a husband to divorce his wife, if she is unable to remarry, she may eventually have to resort to sexual liaisons to obtain an income (Campbell, 2003:129). Sexual contacts undertaken in these contexts could expose women to seropositive sexual partners.

The importance of seeing AIDS as a disease that affects humans not merely biologically, but also socially, in terms of their conceptions of sexual behavior and belief systems of diseases, illness and sickness. According to Pelser et al (2004:287), individual behavior is a product of complex traditional socio-cultural systems. How people conceive of and interpret their behavior differs widely (Pelser et al, 2004:287). Research in AIDS dictates sensitivity to the socio-cultural dimensions of disease and sickness to a very high degree.

2.12. Cultural analysis and belief system

In the analysis of cultural factors, the first is the conceptualization held by the local people. The second is their belief systems about disease, sickness and death as these relate to AIDS. Since AIDS in Africa is reputed to be a disease affecting wealthy persons and prostitutes, many working class and poor men believe that they are not at risk although they do engage in the same behavior.

The belief systems of a society about disease, illness and sickness are areas of immense importance to AIDS victims. The systems greatly influence the individual and societal response patterns to new diseases. The ethnomedical systems of belief, knowledge and practices in Africa show that all cultures provide their peoples with particular ways of viewing disease, illness and sickness. Kleinman calls this set of beliefs "as explanatory models" (Pretorius, 2004:536). This is because he argues, medicine in that context is part of an ideology wherein "human beings and their experiences are contracted as dehistorized objects in themselves." Medicines as an ideological practice therefore deny the social relation embodied in sickness and does not invest in such relations with great

import for coping. Traditional societies have not stripped ethnomedical practices of their social content but continue to give primacy to social relations (Pretorius, 2004:536).

The interpretation by Ugandans of the cause of AIDS reveals this close association of belief systems with the social context and proclivity of a people to socialize medicine. Ugandans believed that AIDS was caused by witchcraft, which was resorted to by the Tanzanians who were cheated by the fishermen who smuggled goods across Lake Victoria into Tanzania (Van Dyk, 2005:118). Local residents believed that the fish-trading centers, too, had been bewitched.

Many AIDS patients and individuals afflicted with typhoid and other debilitating conditions suspected to be AIDS are increasingly returning to their small communities to the support of their kinship networks. Many others, because the infection have been imported into villages from towns, never come into contact with each other than with the traditional health system before they die. Knowledge of the content of evolving beliefs is important in anticipating the coping response and formulating plans for prevention action.

Most African countries suffer from STD's, because of the link between the presence of STD's and the heterosexual transmission of AIDS. According to Green (1994:7), there is now an additional and urgent reason to treat and prevent STD's, to curtail the spread of HIV infection. Another problem is how actually to lower the incidence of STD's cases in Africa. This appears not to be presented at biomedical health facilities; they are taken to traditional healers. STD's are often regarded as an area of particular competence by African healers. The clients of traditional healers, the majority of Africans also seem to believe that traditional medicine is especially effective in treating STD's (Green (1994:7).

AIDS programs need the active cooperation of traditional healers in order to treat and prevent STDs such as gonorrhea, syphilis and Chlamydia. Traditional healers can also do much to help promote condoms, safer sex practices and restriction of the number of sexual partners (Green, 1994:3). Prevalence figures of specific STD's are unreliable, because a country lacks a functioning STD control system, many STD victims do not know they are infected, and STDs are often treated outside the orthodox health care

system. According to a recent review, STDs are among the top five causes of consultation at health services in many African countries and ranking would be even higher for adolescence (Green, 1994:8).

Social scientists have advised that in Africa traditional healers have an important role to play in caring for persons with AIDS. Some healers have suggested that healer knowledge of medical conditions is useful. Including them in prevention campaigns could expand the number of people actively involved in disseminating information and participating in counseling. Traditional healers could make the number of people available for providing care to AIDS patients larger since healers could help to treat opportunistic infections and to eliminate other fears that contact with AIDS patients are dangerous (Van Dyk, 2005:125).

In selecting indigenous healers for inclusion in HIV/AIDS prevention programs, it is probably best to find out who is currently being consulted for STDs and AIDS treatment. Specialists in treating various locally recognized sexually transmitted diseases are found throughout Africa, since STD's are epidemic in most regions. In addition to indigenous healers and their role in providing health care, indigenous knowledge systems are important in their own right. Indigenous knowledge system refers to that body of accumulated wisdom that has evolved from years of experience and trial-and-error problem solving by groups of people working to meet the challenges they face in local environment, drawing upon the resources they have at hand (Green, 1994:20).

Society's creativity and genius is embodied in its indigenous knowledge system. The indigenous knowledge system forms the basis for local decisions (Green, 1994:21). An understanding of health-related indigenous knowledge is also essential for health planners and program implementers, if plans and programs are to be culturally appropriate and therefore effective. Cross-cultural transmissions should be sensitive in developing helping programs. Basic prevention advice must be given, such as remaining faithful to one's partner, "following traditional values of keeping your virginity until marriage" and if your strength falters, an acceptable premarital sex such as "**ukusoma**" (thigh sex) could keep you from getting the disease.

Western development planners and other professionals tend to think of traditional systems, whether related to health care, land tenure, communal ownership, and kinship obligations, as archaic and dysfunctional, not as a way of life to overcome if there is to be progress and development. African healers do not belong to a "formalized medical system" based on knowledge that is shared through writing. Because of this, the practitioners of non-formalized traditional medicine are not linked by any theory and cooperation between them is rare. Their knowledge is transmitted from one person to another, not taught in special institutions. However such traditional medical knowledge is not recorded in books, it is therefore regarded as of less value.

Lack of circumcision in young males could increase the incidence of STDs. Traditional healers could be used to advise their clients to become circumcised as a way to prevent STDs (HIV/AIDS & STI Strategic Plan 2007-2011:38). Many people believed that there is a relationship between lack of male circumcision and STDs, including possibly AIDS. Traditional healers noticed that male patients who repeatedly become infected with STD have tended to be uncircumcised (Green, 1994:185). Such patients were said to have rash infection under their foreskins. Some healers claim they have convinced parents from non-circumcising societies to have their children circumcised in order to protect them in later life.

In South Africa, Xhosa and Sotho men practice circumcision traditionally, and it is healers from these groups who are seen to be advising men to become circumcised. No doubt cultural values and traditional attitudes toward circumcision groups play a significant part in their decisions to advise on circumcision. Healers believe that circumcision helps to protect one against STD's long before the advent of AIDS. The traditional way involves a ritual circumciser who may not be a traditional healer. The reason why about half of the boys in circumcising societies do not have the operation done in the traditional way is due to urbanization, modernization, disruption of culture, and the fear of consequences if the operation is not done properly.

2.13. Sex education

Sex education, which is sometimes, called sexuality education or sex and relationship education, is the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationship and intimacy. It is about developing young people's skills so that they make informed choices about their behavior, and feel confident and competent about acting on these choices. It is widely accepted that young people have a right to sex education, partly because it is a means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancies, sexually transmitted diseases and HIV/AIDS (http:www.un.org/rights.hrt.oday).

Sex education seeks both to reduce the risks of potentially negative outcomes from sexual behavior like infection with sexually transmitted diseases, and to enhance the quality of relationships. It is also about developing young people's ability to make decisions over their entire lifetime. Sex education that works, by which the researcher means it is effective is sex education that contributes to this overall aim.

If sex education is going to be effective it needs to include opportunities for young people to develop skills, as it could be hard for them to act on the basis of only having information (Education and HIV/AIDS: a window of hope 2002:30). The kinds of skills young people develop as part of sex education are linked to more general life-skills. For example, being able to communicate, listen, negotiate, ask for and identify sources of help and advice, are useful life-skills and could be applied in terms of sexual relationships. Effective sex education develops young people's skills in negotiation, decision-making, assertion and listening. Other important skills include being able to recognize pressures from other people and to resist them, deal with and challenge prejudice, seek help from adults, including parents and professionals through the family, community and health and welfare services (http:www.un.org/rights.hrt.oday). Sex education that works, also equips young people with the skills to be able to differentiate between accurate and inaccurate information, discuss a range of moral and social issues and perspectives on sex and sexuality, including different cultural attitudes and sensitive issues like sexuality, abortion and contraception.

2.14. Forming attitudes and beliefs

Young people could be exposed to a wide range of attitudes and beliefs in relation to sex and sexuality. These sometimes appear contradictory and confusing. For example, some health messages emphasize the risks and danger associated with sexual activity makes a person more attractive and mature. Because sex and sexuality are sensitive subjects, young people and sex educators could have strong views on what attitude people should hold and what moral framework should govern people's behavior (Education and HIV/AIDS: a window of hope 2002:30). These too could sometimes seem to be at odds. Young people are very interested in the moral and cultural framework that binds sex and sexuality. They often welcome opportunities to talk about issues where people have strong views, like abortion, sex before marriage, lesbian and gay issues and contraception and birth control. It is important to remember that talking in a balanced way about differences in opinion does not promote one set of views over another, or mean that one agrees with a particular view (http.www.un.org/rights/HRT oday).

People providing sex education have attitudes and beliefs of their own about sex and sexuality and it is important not to let these influence negatively the sex education that they provide. For example, even if a person believes that young people should not have sex until they are married, this does not imply withholding important information about safer sex and contraception. Attempts to impose narrow moralistic views about sex and sexuality on young people through sex education failed (Winkler, 2003:10). Rather than trying to deter or frighten young people away from having sex, effective sex education includes work on attitudes and beliefs coupled with skills development that enables young people to choose whether or not to have a sexual relationship taking into account the potential risks of any sexual activity (Winkler, 2003:10).

Effective sex education also provides young people with an opportunity to explore the reasons why people have sex, and to think about how it involves emotions, respect for one self and other people and their feelings, decisions and bodies (Education and HIV/AIDS: a window of hope 2002:33). Young people should have the chance to explore gender differences and how ethnicity and sexuality could influence people's feelings.

They should be able to decide for themselves what the positive qualities of relationships are. It is important that they understand how bullying, stereotyping, abuse and exploitation could negatively influence relationships.

Providing information through sex education is therefore about finding out what young people already know and add to their existing knowledge and correcting any misinformation they may have. For example, young people may have heard that condoms are not effective against HIV/AIDS or that there is a cure for AIDS. It is important to provide information that corrects mistaken beliefs. Without correct information young people could put themselves at greater risk. Information is also important as the basis of young people could develop well-informed attitudes and views about sex and sexuality.

They need to have information about the physical and emotional changes associated with puberty and sexual reproduction, including HIV/AIDS. They also need to know about contraception and birth control including what contraceptives there are, how they work, how people use them, how they decide what to use or not, and how they could be obtained. In terms of information about relationships they need to know about what kinds of relationships there are, about love, and commitment, marriage and partnership and the law relating to sexual behavior and relationships as well as the range of religious and cultural views on sex and sexuality and sexual diversity (Mackerrow, 1998:18). In addition, young people should be provided with information about abortion, sexuality, and confidentiality, as well as about the range of sources of advice and support that is available in the community and nationally.

Sex education that works starts early, before young people reach puberty, and before they have developed established patterns of behavior. This could be around the age of 11, 12 and 13. The precise age at which information should be provided depends on the physical, emotional and intellectual development of the young people as well as their level of understanding (Education and HIV/AIDS: a window of hope 2002:4). What is covered and also how, depends on who is providing the sex education, when they are providing it, and in what context, as well as what the individual young person wants to know.

It is important not to delay providing information to young people but to begin when they are young. Providing basic information provides the foundation on which more complex knowledge is built up over time. This also means that sex education has to be sustained. For example, when they are very young, children could be informed about how people grow and change over time, how babies become children and then adults, and this provides the basis on which they understand more detailed information about puberty provided in the pre-teenage years (http.www.un.org/righs/HRT oday). They could also, when they are young, be provided with information about viruses and germs that attack the body. This provides the basis for talking to them later about infections that could be caught through sexual contact.

Some people are concerned that providing information about sex and sexuality arouses curiosity and could lead to sexual experimentation. It is important to remember that young people can store up information provided at any time, for a time when they need it later on (Winkler, 2003:10). Sometimes it can be difficult for adults to know when to raise issues, but the important thing is to maintain an open relationship with children which provides them with opportunities to ask questions when they have them. Parents should also be proactive and engage young people in discussions about sex, sexuality and relationships. Naturally, many parents and their children feel embarrassed talking about some aspects of sex and sexuality. Viewing sex education as an on-going conversation about values, attitudes and issues as well as providing facts could be helpful. The best basis to proceed on is a sound relationship in which a young person feels able to ask a question or raise an issue if they feel they need to.

The role of many parents as sex educators changes as young people get older and young people are provided with more opportunities to receive formal sex education through schools and community-settings. However, it does not get any less important. Because sex education in school tends to take place in blocks of time, it could not always address issues relevant to young people at a particular time, and parents could fulfill a particularly important role in providing information and opportunities to discuss things as they arise (http.www.un.org/rights/HRT oday).

Different settings provide contexts and opportunities for sex education. At home, young people could easily have one-to-one discussions with parents who focus on specific issues, questions or concerns. They could have a dialogue about their attitudes and views. Sex education at home tends to take place over a long time, and involves lots of short interactions between parents and children. There may be times when young people seem reluctant to talk, but it is important not to interpret any differences as meaning that there is nothing left to talk about. As young people get older advantage could be taken of opportunities provided by things seen on television for example, an opportunity to initiate conversation. It is also important not to defer dealing with a question or issue for too long as it could suggest that you are unwilling to talk about it.

It is not as well suited to advising the individual as it is to providing information from an impartial point of view. The most effective sex education acknowledges the different contributions each setting can make. Schools' programs that involve parents, notifying them what is being taught and when, could support the initiation of dialogue at home.

2.15. Conclusion

Let the researcher conclude that individuals and communities require open minds about STDs and HIV/AIDS that would allow for responsible safer sex education and practices. Community education is necessary to enable the fearful to understand and confront the source of the fear including the pain of the disease, of being rejected by a partner, family, friends and relatives. The fear of being disabled and disfigured physically, the fear of losing control of one's mind and life's. This also includes the fear of the common knowledge that one is dying of a sexually transmitted disease.

Families, groups and communities also need to come to terms with, and address the anxieties, shock and sense of helplessness when a member is infected with AIDS. AIDS, therefore, calls for special education and community programs. Most infected people have no symptoms and yet could transmit the virus to others. The challenge is to persuade them not to spread an infection they may not even know they have. People must be sincerely convinced that someone who appears perfectly healthy could transmit a deadly

virus. It is also evident that some of those involved could be in the high risk group. Male and female prostitutes and people with several sexual partners are difficult to reach with conventional methods of communication. Social norms and other barriers may separate them from community organizations and institutions and hence make them difficult to reach (Osei-Hwedie, 1994:54). Educational messages must, therefore, focus on behavior instead of groups.

AIDS is associated with practices often regarded as immoral, for example, prostitution, infidelity and homosexuality. This results in refusal of some policy-makers to support educational and service-delivery programs. At the same time some groups consider discussion of risk factors or preventive measures unacceptable. It is, therefore, important to find educational language, concepts and images that are inoffensive and acceptable beyond the targeted groups.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

The main aim of the study has been stated in Chapter One. In Chapter Two the researcher discussed the theoretical tenets of the challenging factors, health-wise confronting the youth mainly in African communities (rural areas), that are subjected to extremes of social changes. In this chapter the researcher explains the field survey undertaken to collect data in terms of the objectives of the study, that is, the description of the research methods and procedures used in the research exercise. Also the target population from which the sample is drawn is indicated as well as the method used in collecting data.

3.2. The Research Design

Scientifically by research design it means a plan or structured framework of how the researcher intends conducting the research process in order to solve the research problem that has been identified in a particular field (Babbie and Mouton, 2003:176). The plan defines, for example, the participants in the research process, the inter-relationships and methods for instance, used in the sample, measurements and analysis that constitute the piece of research.

In this research a descriptive survey was undertaken to ascertain the correlation that exists between the youth, target of the research, their behavior and exposure to risks and consequences of the health problems they eventually suffer. That is, to enable the researcher to gain insight and increase knowledge about social phenomenon under study to be able to make appropriate description and analysis. Sayner (1986:66) argues that a descriptive survey demonstrates correlation between two or more variables and may predict behavior on the basis of what is known about one or more other variables. Descriptive research also presents a picture of specific details of a situation, social setting and also has the ability to provide an accurate profile of a group. In doing all these, the

researcher attempted to find answers on specific questions in order to contribute to comprehensive and in depth knowledge in sexual transmitted diseases.

3.3. DATA COLLECTION

3.3.1. *Area of Study*

In Chapter one it was indicated that the area of the study was conceptually presented in two perspectives that was, geographic and target population under study.

The Sabokwe rural community under study is part of the KwaMbonambi Municipality, which itself is in the rural Municipality of the Uthungulu District, North East of KwaZulu-Natal Province. KwaMbonambi Municipality is fifteen (15) kilometers west of Richards Bay Town. The KwaMbonambi Municipality with its seat in the KwaMbonambi Village is an area made up of three tribal communities Sokhulu, KwaThethwa and Nhlabane and Sabokwe. These last two are under iNkosi Mtholephi Mbuyazi. Almost all these communities share similar socio-economic characteristics. The Sabokwe tribal community is ten kilometers from the KwaMbonambi Village. The 2001 census gives the population of the KwaMbonambi Municipality as 106,924, spread among the three tribal communities.

Sabokwe although a rural community, is transforming in physical accommodation, with most houses built in semi-substantial types of buildings, different from the small thatched huts of the past. This development has enabled Eskom to agree to connect most houses with electricity. However, road infra-structure is poor and there is no portable water supply to houses and also along the "public roads" The area is planned but not yet developed in most cases.

The Mbonambi area is close to the World Heritage Site of St. Lucia and to popular fishing spots along the North East Indian Ocean. It is also merely an hour away from the world-renowned Hhluhluwe-Umfolozi Game Reserve which is home to the Big Five. The timber giants of Mondi and Sappi and global mineral giant Richards Bay Minerals (RBM) are situated within the municipal borders of Mbonambi, as well as Star-Bio-Mass,

a wood-product company exporting to Europe. Rural Mbonambi boasts thirty nine (39) mayoral development projects which range from chicken farms to block-making. The Eskom Development Foundation, which is geared towards the development of rural women, has continued to finance a number of projects including gardening, sewing, craftwork and poultry farms. The Owen Sithole College of Agriculture, within Kwa Mbonambi Municipality, also contributes to the advancement of agricultural research and training (Annual Report, 2004/2005).

The population is mixed in terms of economic engagement. There are three rural shops in the area, a bottle store and a tavern. The large majority of those employed work outside the community. There is also a high incidence of unemployment. There are two schools in the area, a Primary and a High School. Attendance is good at Primary level but tends to level off as the grades go higher at High School level. Although there are some local youth who have been through high school the majority did not pass a grade that would allow them to go for tertiary education, e.g. grade 12 with exemption. Hence, a number of young adults are not in any form of post school engagement, such as training for skills for the job market. There is a dire shortage of recreational facilities for the youth.

3.3.2. Some basic statistics of the uThungulu Municipality District with kwaMbonambi Rural Municipality.

For ease of reference the area of kwaMbonambi Rural Municipality under which Sabokwe community falls is presented within the broader Municipal District. The target population for this study is the youth of Sabokwe Township in kwaMbonambi District The target population refers to the specific pool of cases that the researcher wants to study. The researcher states that the characteristics of the youth at Sabokwe are similar to the youth in the whole of kwaMbonambi Municipality. Some reference statistics in respect of the population are presented below.

3.3.2.1. TABLE 1: DEMOGRAPHIC DATA: 2001 CENSUS

MUNICIPALITY	AREA(km2)	POPULATION	%	MALE	FEMALE	0-19	20-64	65+
Mbonambi	**1208**	**106924**	**12.1**	**46.6**	**53.4**	**53.2**	**42.4**	**4.4**
Mhlathuze	795	289175	32.6	48.4	51.6	44.5	52.7	2.8
Ntambanana	1083	84746	9.6	46.4	53.6	54.6	40.8	4.7
Umlalazi	2214	221066	25.0	45.3	54.7	52.8	42.0	5.2
Mthonjaneni	1086	50372	5.7	45.8	54.2	51.2	44.0	4.7
Nkandla	1827	133589	15.1	43.0	57.0	57.5	36.4	6.1
Uthungulu	**8213**	**885872**	**100. 0**	**46.3**	**53.7**	**50.9**	**44.7**	**4.4**

Source:Census 2001 Uthungulu IDP Review, 2005

The employment situation at the whole of uThungulu District Munipality is presented below for reference.

3.3.2.2. TABLE 2: Employment levels

MUNICIPLITY	H/HOLDS WITH NO MEMBER/S GAINFULLY EMPLOYED	DEPENDENTS PER NUMBER OF MEMBER EMPLOYED
Mbonambi	**51,22%**	**8**
Umhlathuze	34.87%	35
Ntambanana	76.15%	22
Umlalazi	55.04%	19
Mthonjaneni	83.64%	4
Nkandla	79.26%	9
Uthungulu	**59.02%**	**9**

Source : Uthungulu IDP Review, 2005

From the above figures it is clear that the three municipalities where unemployment is at critical levels are Ntambanana, Mthonjaneni and Nkandla. Mbonambi, Umlalazi and

Mthonjaneni have the highest number of households where a pensioner is the head of the family.

3.3.3. Sample and Sampling Method

The study focused on the youth of the area under study. The researcher engaged the services of five young people from the community to visit a number of homesteads and to note particulars where there was a young person/s. From a visual point of view the researcher decided to divide the area into five parts and allocated each to one of the five assistants engaged as part of the preliminary data collection team. Altogether one hundred and forty seven (147) families were recorded. In each one of these there was a young person between the ages of 18-24 years, either at school or not. Those were all given numbers from 1 to 147.

In choosing the respondents in the study, the researcher used the probability sampling procedure. Simple random sampling where 40 respondents (youth) were chosen from the larger population. The figure one hundred and forty seven (147) provided for replacement in case no contact could be made with the youth chosen from an earlier identified household. The procedure involved choosing every third name in a systematic sampling fashion and each element had an equal chance of being included in the study (Babbie and Mouton, 2003: 190). According to Mark (1996:106), by introducing randomness into the selection of elements for the sample, we minimize biases and other systematic factors that might make the sample different from the population where it was drawn. A representative sample is the one that is very similar to the population from which it is drawn, on those variables relevant to the study. On a gender basis, eighteen (18) youths were females and twenty two (22) were males.

3.4. The Research Instrument

3.4.1. The interview

Interview is a face to face situation in which an interviewer asks questions to one or more interviewees. The initial task for the interview is to create an atmosphere that would put

the respondent at ease, after introducing himself in a friendly way. The interview should briefly state the purpose of the investigation but should avoid giving a lot of information about the study, which could bias the respondent.

3.4.2. Interview Schedule

In this study structured interviews were used to collect data from the respondents. The interviewer is trained in using an interview schedule, which consists of a list of questions. The specific wording and order of questions are predetermined and standard for all interviewees. In the interview schedule, questions addressed the description of experience, and the behavior involved. Value questions which were asked addressed what participants thought of the phenomena under study. These variables are considered important because they have implications for decision-making. The researcher decided to interview the forty (40) respondents personally.

3.4.3. Construction of the Interview Schedule

The interview schedule design is an activity that should not take place in isolation. The researcher consulted and sought advice from the supervisors and colleagues at all times during the construction of the interview schedule. Questions to be taken in the interview schedule should be tested on people to eliminate possible errors. This means that the researcher tested the initial questions in a **pilot study**, thereby establishing validity of the measure. Thereafter all the questions were cleaned before final administration to the target respondents. The researcher endeavoured to follow the basic guidelines that must be taken into consideration when designing questionnaire.

The construction of the interview schedule for this investigation was to present the questions in a simple and straightforward a manner as possible. Questions were phrased in such a way that every respondent could understand. The vocabulary used was non-technical and geared also to the least educated respondent level. The researcher avoided choosing words that sound patronizing. The reasons of this were that not all members of the target population under investigation were adequately educated to interpret questions correctly as they were firstly prepared in English. Hence all the questions were translated

into isiZulu language. However, from a scientific point of view respondents should and /or need to be competent to understand what there were involved in (Babbie and Mouton, 2003: 236). The aim of the interview schedule was to obtain information from the youth regarding sexually transmitted diseases. The interview schedule consisted of thirty closed questions to which the youth were requested to indicate their response to the statements based on their understanding and reaction to the knowledge of STD's, HIV/AIDS.

3.4.4. Closed-ended Questions

A closed-ended questionnaire was used for the purpose of this study. The respondents were presented with three alternatives by the interviewer. They were asked to choose one of the allocated alternatives. The time of each respondent was forty-five minutes. Although closed-ended questions are not always the best way to collect data, they have their own shortcomings; however, in the hands of a skilful interviewer they can improve the researcher's frame of reference on the respondents. Close-ended questions are very popular because they provide a greater uniformity of responses and are more easily processed as they can often be transferred directly into a computer format (Babbie and Mouton, 2003: 233-234).

3.4.4. Personal Interview

In a personal interview, the interviewer (researcher) read questions to the respondent in a face to face setting and recorded the answers. One of the most important aspects of the interview was its flexibility. The interviewer had the opportunity to observe the subject and the total situation in which she/he was responding. In this interview format, the response rates were very high. Personal contact increased the likelihood for the individual respondents to participate and provide the desired information in a non-threatening environment.

3.5. Informed Consent

The researcher informed each respondent on the purpose of the research and asked if she/he will be willing to participate in the interview voluntarily and willingly. Only after that exercise was the interview commenced with. The respondent was thanked after the interview. (Letter attached in appendix).

3.6. Data Analysis and Interpretation

After the field process the researcher cleaned all the data collected with the assistance of the other colleagues. The data collected from our instruments was raw data. In order to get the idea of trends in the data, the researcher started the process of reducing the numbers into a smaller set of units that would ensure the research questions have been answered correctly.

According to Mark (1996:301), when we conduct a research study, we need a data analysis plan. This plan should be formulated as soon as the researcher has finalized the data collection instrument. The information gathered was analyzed using Microsoft Excel to organize quantitative data into charts, tables and to perform statistical calculation. The chart and table allowed seeing the evidence collected by the researcher and learn what was in it. Data analysis and interpretation involved a synthesis of the separate data points collected by the researcher into a unified statement about the research problem.

3.7. Limitations of the study

Limitations within the study were noted during various levels, and can be summarized as follows:

- The research only focused on the youth in KwaMbonambi district, therefore, the findings drawn cannot be generalized to all youth in KwaZulu-Natal.
- The cultural and beliefs system also limited the respondents to be open to express their feelings.

- The research was conducted on the youth. Sometimes it became difficult for the researcher to get them on the first day. It required him to return to the same place for about three times.

3.8. Summary

This chapter has presented a full description of the research methodology that was employed in the study. The description was done with explanations on sampling and the data collection method.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION.

4.1. Introduction

The data, which was collected from the completed interview schedule, was analyzed and certain comments were offered. Forty-interview schedules were completed with the youth of Sabokwe proposed Township in Kwa-Mbonambi. Eighteen females and twenty-two males contributed to this study.

4.2. Presentation of data and descriptive statistics

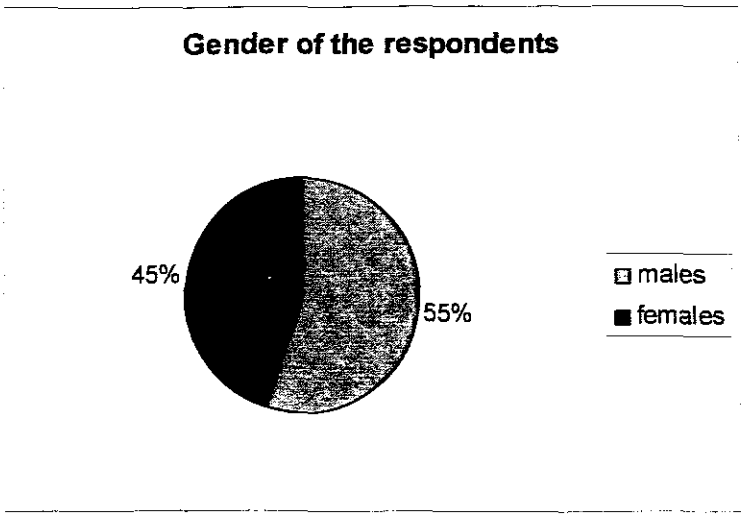
According to Ary, Jacobs and Razavieh (1996:91), statistical procedures are basically methods of handling quantitative information in such a way as to make that information meaningful. This procedure has two principal advantages for the researcher. They enable a researcher to determine how to read and infer from the phenomena observed in the sample.

Descriptive research is the method of research used to youth scientifically in a specific situation (Welman and Kruger, 1999:19). In this study descriptive research was employed with the aim of describing the views of youth regarding their knowledge of how STDs are spread, their behavior in handling sexual relationship and consequences that arise from behavior that is their responsibility when engaging in such activities.

The researcher was seriously concerned with the nature and degree of existing situations in the community selected for the research. As indicated in the motivation of the study, the researcher had been involved in the monitoring of some HIV/AIDS projects around all those areas including the one under study. The impact of the killer diseases had created a social situation where there were children who were responsibility of the elderly in the community who had no alternatives, but to look after the whole family including those whose parents have died.

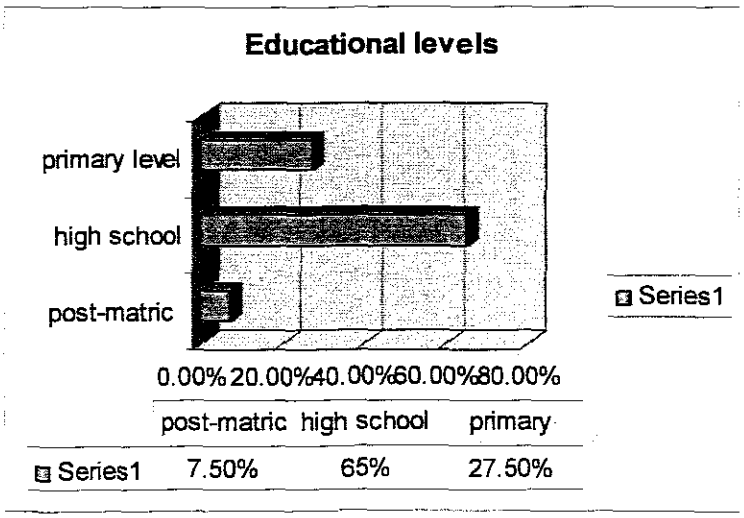
The format of data presentation, firstly dealt with statistical information and secondly the broad presentation as per research instruments used.

4.3. Classification of respondents according to gender



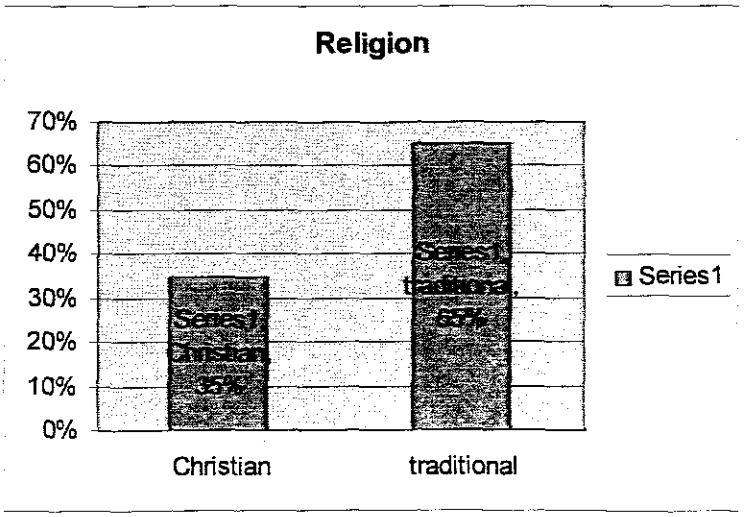
The sample was composed of fifty five percent (22), males and forty five percent (18) females, totaling 40 respondents. The statistics imply that more males were interviewed during the study. The pie chart was used graphically to display the proportion of cases that are in each category of a single categorical variable. Each segment represents one category in the variable. The size of the segment is calculated according to the number of cases that fall in the category (David and Sutton, 2004:283).

4.4. Levels of education of the respondents



The analysis indicated that the sixty five percent (65%) of the respondents, both male and female had been through high school education, in fact 7, 5% had attained some form of post-matriculation education and training. Only 27.5% of respondents had attained primary education. This situation should by right have a positive spin off towards understanding the health problems. In bar charts each category in the variable is represented by a bar, however, since each category is discrete, the bars do not touch (David and Sutton, 2004:281).

4.5. Religious beliefs of the respondents



According to the above column chart it is illustrated that the religious beliefs of respondents are indicated as 65% traditional religious beliefs and 35% Christian denominations. It is important to take into consideration the impact of religious beliefs of respondents, if the study is interested in implementing effective prevention measures. Each and every religious belief provides the adherent with a set of values which are critical in explaining a problem situation, in addition to cognitive knowledge, in which individuals finds himself or herself (Huysamen 1998:15).

4.6. Illustration of frequency percentage distribution of respondents

The original data obtained in social research frequently consist of a list of individuals' names or their identification numbers, and their dependent variables scores. Such lists of raw data contain all information originally collected. According to Huysamen (1998:15), frequency distribution is a table showing various possible measurement categories or classes, together with the number of cases falling into these classes. Frequency distribution shows the manner in which the scores on a variable are distributed. Frequencies are indicated by means of entries in a table

Formula used: percentage (%) = f/n x 100

F=frequency

N=number of respondents

Here below the researcher decided to present frequency distribution of the respondents in terms of the thirty questions asked of them.

1. Table. 4.6.1. Youth perceive themselves to be at risk of sexually transmitted diseases.

Risk of sexually transmitted diseases	Numbers	Percentages
Agree	33	82.5
Uncertain	2	5
Disagree	5	2.5
Total	40	100

The youth perceived themselves to be at risk of sexually transmitted diseases, 82.5% agreed, 5% were uncertain and 2.5% disagreed. This expresses the view that the youth perceive themselves to be at the risk of STDs. Even though, they do not use condoms occasionally. In Sabokwe as in the rest of South Africa there is high rate of youth pregnancy which tends to suggest that condoms are not being consistently used (Lehlola, 2001:53). According to Campbell (2003:7), people often fail to present themselves at STD treatment facilities at the first signs of infection, despite knowing

that the presence of other STDs increases their vulnerability to HIV. It can be concluded that the acquisition of STDs and eventually AIDS would also be consequence of non-preventative measures. This clearly indicates that it is essential that they should be informed about prevention measures and encouraged to use them if they are sexually active.

Table 4.6.2. Youth can be persuaded to change unsafe sex practices that may leave them at risk of contracting sexually transmitted diseases.

Persuasion of the youth to change from unsafe sex practices	Numbers	Percentages
Agree	17	42.5
Uncertain	0	0
Disagree	23	57.5
Total	40	100

In the question based on persuasion of the youth to change from unsafe sex practices, 57.5% disagreed and 42, 5% agreed. This according to the researcher's point of view that the two- way communication is important to ensure that the youth views about STDs are taken into consideration. Young people often engage in high risk sex, despite knowing about the danger of STD and HIV infection. Informing young people about health risks is not enough for behavioral change (Campbell, 2003:122). Ignorance about STD, HIV and AIDS remains profound and is considered a crucial reason why epidemic has run out of control (Pelser et al, 2004:293). Many South African are becoming aware of STD and AIDS, they do not think the risk applies to them. Despite awareness of the dangers of HIV, 55-65% of the African population still holds misperceptions and, as a result, demonstrates behavior that exposes them to severe risk (SAIRR 2001b).

Table 4.6.3. Many sexually active young people engage in behavior which would to place them at risk of HIV infection.

The behavior that places the youth at risk of STDs	Numbers	Percentages
Agree	33	82.5
Uncertain	3	7.5
Disagree	4	10
Total	40	100

The question that dealt with the behavior that places the youth at risk of STDs elicited an, 82.5% agreement, while only 10% were not, the remaining 7.5% were uncertain. Most of the respondents complained that their boyfriends did not like to use condoms. Somehow it appeared that they were referring to casual relationships where a partner did not take responsibility for consequential behavior. This study showed that people often knowingly engage in sexual behavior that places their health at risk. With full knowledge of the dangers of the epidemic, many people continue to have unprotected sex, often with multiple partners (Education and HIV/AIDS a window of hope, 2002:4). An important requirement for translating knowledge into behavior change is a feeling of personal vulnerability to HIV infection. According to Campbell (2003: 123), both local and internationally, there has been a tendency to characterize HIV/AIDS as a diseases of "others".

Table 4.6.4. Youth have changed their behavior as a result of STD/ HIV/AIDS.

Behavioral change as a result of HIV and AIDS	Numbers	Percentages
Agree	16	40
Uncertain	5	12.5
Disagree	19	47.5
Total	40	100

With regard to the question on behavioral change as a result of HIV and AIDS, 47. 5% disagreed, 40% agreed and 12.5% were uncertain. This is because the number of people with HIV/AIDS is increasing. The AIDS deaths would fundamentally change the characteristics of South Africa's population. It is predicated that in the next ten years, the average life expectancy would drop to forty years and the proportion of people in economically active age groups, those responsible to care for the aged and children, will shrink dramatically (Full report of the joint health and treasury task team charged with examining treatment options to supplement comprehensive care for HIV/AIDS in the public health sector, 2003:9). Orphans eligible for support from the departments of social welfare and similar institution would increase.

Table 4.6.5. Having sex with people from cities may increase a chance of getting STD/HIV/AIDS.

Having sex with people from cities	Numbers	Percentages
Agree	27	67
Uncertain	4	10
Disagree	9	22.5
Total	40	100

Having sex with people from cities may increase a chance of getting HIV/AIDS. 67.5% agreed, while 22.5% disagreed and 10% were uncertain. According to the respondents most of their friends are working in the mines and other urban areas, where as they assumed they might have had commercial sex. Many of the people in

the highly infected areas of the urban towns are from rural areas. According to the conducted Dladla et al (2001:80), in KwaHlabisa District, KwaZulu-Natal, 60% of the adult men are migrants. It was found to be common that both male and female do have more than one sexual partner. Women in the above mentioned area are able to have many sexual partners who go unnoticed in the absence of the immigrant husbands and male partners. The reason cited for having multiple sexual partner include the need for financial support and the need for sexual gratification. According to the researcher the circular migration patterns in Southern Africa clearly put people at risk of STD, HIV and AIDS at both ends of the migration movement. According to Pelser et al, (2004:292), if successful intervention programs are to be implemented, it is necessary to understand the underlying process in order to determine the direction and extent of the flow of infection.

Table 4.6.6. For youth, having sex with people they do not know very well may increase chances of becoming HIV positive.

Youth having sex with people they do not know very well	Numbers	Percentages
Agree	35	87.5
Uncertain	3	7.5
Disagree	2	5
Total	40	100

In the question of youth having sex with people they do not know very well. 87.5% agreed, 7.5% were uncertain and 5% disagreed. The large numbers of youth enjoy casual/leisure life such as taverns and shebeens where they meet with strange people while they are under the influence of alcohol and drugs. Dimension immigration and its association with STD and AIDS relates to the growing issue of illegal immigration in South Africa. The largest propotion of these people comes from Mozambique. The rest originate from countries such as Zimbabwe, Nigeria, Burundi, Rwanda, India and Eastern Europe. Several studies have suggested a casual link between illegal immigration and the spread of the STD and HIV virus in the country, as well as

region (Pelser et al, 2004:292). Many illegal immigrants end up in urban areas without their families; sexual services are thus often purchased. Some illegal immigrants find themselves in situations where prostitution becomes their only source of income. According to Pelser et al (2004:293), if the refugee number in South Africa increases in future, mechanisms should be put in place to ensure that refugees have greater access to appropriate information and reproductive health programs and services. Early sexual activity has been found to be associated with use of alcohol and marijuana. The youth are heavy drinkers and use drugs and are more likely to be involved in unprotected sexual intercourse.

Table 4.6.7. For youth, having sex with prostitutes can lead in getting STD/AIDS.

Youth having sex with prostitutes	Numbers	Percentages
Agree	29	72.5
Uncertain	2	5
Disagree	9	22.5
Total	40	100

In the question that was based on the youth having sex with prostitutes, 72.5% agreed, 22.5% disagreed and 5% were uncertain. Because of stereotype-STD/AIDS is viewed as a prostitute's disease. This stereotype appears to have a sound epidemiological basis (Muller, 2005:37). This is because of the given high incidences of HIV infection among some groups of sex workers. Prostitutes are blamed for the spread of disease. The tendency emanates from women's inferior position in their communities as well as from the initial focus in relation to HIV transmission on female prostitutes and male truck drivers (Muller, 2005:37).

Table 4.6.8. The number of young people with AIDS in the country will increase, if condoms are used on every sexual basis?

Use of condoms in every sexual encounter	Numbers	Percentages
Agree	14	35
Uncertain	5	12.5
Disagree	21	52.5
Total	40	100

The number of young people with STD/AIDS in this country would increase even if condoms are used on every sexual encounter, 52.5% disagreed, 35% agreed and 12.5% were uncertain. According to my respondents they said it is difficult to introduce condoms in a long-time relationship. Others believed that condoms have AIDS, although most of them were obtained from hospitals. They are influenced by the radio that says "nothing for **mahhala**" which means that there is nothing for free or without payment. The use of condoms ignores the fact that it is difficult for most female youths to convince male partners to use condoms, thus, the prevention message is lost (Muller, 2005:26). Even though, female condoms are available on market, few individuals manage to buy them. Young people argue that condoms are only worth bothering about if one of the partner is known to have STD. It is clear that peer norms undermined the likelihood of condoms consistent use. According to Campbell, (2003:125), both young women and men said that condoms were generally unnecessary in "steady" relationship but they should be used in casual encounters.

Table 4.6.9. STDs/ AIDS is something for only homosexuals and drugs users; the youth need not to worry about it.

Homosexuality and drugs users	Numbers	Percentages
Agree	4	10
Uncertain	0	0
Disagree	36	90

With regard to the question based on homosexuality and drugs users, the youth need not worry about STD/AIDS. 90% disagreed and10% agreed. According to the

respondents HIV/AIDS is a social disease like cancer and TB. All people must take into cognizance that their life is secure rather than projecting it to certain groups. The association of this disease with homosexuality, promiscuous sexual behavior and the use of drugs laid the foundation for severe discrimination and for apportioning the blame on people and groups affected with AIDS. Traditionally homosexuality, drug usage and prostitution have been criminalized and stigmatized by society at large. Alcohol and drugs have a disinhibiting effect on safer sex as a product of diminishing rational decision-making. Alcohol use has been associated with higher risk of HIV infection, with heavy alcohol consumption being linked to higher likelihood of having unprotected sex with a non-monogamous partners, having multiple partner, and paying for or selling sex(HIV/AIDS& STIs Strategic Plan 2007-2011, page 38).

Table 4.6.10. To stop the spread of STD/HIV, sex education in schools should be introduced.

Introduction of sex education in schools	Numbers	Percentages
Agree	37	92.5
Uncertain	0	0
Disagree	3	7.5
Total	40	100

The question based on the introduction of sex education in schools, 92.5% agreed, 7.5 % disagreed. According to my respondents, introducing sex education might be beneficial to the youth, because most of their parents spent much time outside the family. Those who disagreed believed that introducing sex education in schools might motivate a child to engage in sexuality. According to the researcher, school-based programs have strong potential. When teachers are trained and used as a role model, they can effectively reach large numbers of young people. However, teachers who engage in risky sexual behavior with their students put programs in jeopardy (Mckee et al, 2004:118). Such teachers can no longer be viewed as credible authorities, nor can they command the respect of their students and the communities they serve. In addition, schools may often be the only place where youth can obtain accurate information on reproductive health. Programs could include one or more of these

elements: life skills education, sex education, STD and HIV/AIDS education and school-based health services (Education and HIV/AIDS a window of hope, 2002:30).

Table 4.6.11. Young people must be encouraged for "no sex, before marriage."

No sex before marriage	Numbers	Percentages
Agree	35	87.5
Uncertain	1	2.5
Disagree	4	10
Total	40	100

With regard to the question based on "no sex before marriage," 87% agreed, 2.5% were uncertain and 10% disagreed. Delaying of sexual debut is central to the promotion of abstinence, and a number of countries have developed communication programs that encourage youth to wait (Mckee et al, 2004:95). Youth often experience conflicting emotions about sexual debut, including sexual relations before marriage. Many young people recognize that in today's world, their best protection is to delay or avoid sex during the adolescent years (Mckee et al, 2004:95). Equipping young people with information and particularly the life skills they need to negotiate and maintain a positive approach to reproductive health is essential in the fight against STD and HIV.

Table 4.6.12. AIDS is warning from God that levels of sexual behavior in society are too high.

AIDS as a punishment from God	Numbers	Percentages
Agree	16	40
Uncertain	6	15
Disagree	18	45
Total	40	100

AIDS is a warning from God that levels of sexual behavior in our society are too high, 45% disagreed, 40% agreed and 15% were uncertain. Insofar as AIDS is a sickness is concerned, all sickness is not from God. But it is much deeper than that,

because STDs and AIDS is merely symptomatic of a deeper underlying sin. According to Gennrich (2004:41), this sin is related to a belief system in our society that offers "salvation" of sorts through doing what you like, a false belief in satisfaction in the immediate gratification of desire. This has resulted in debasing of sexuality, abuse of the environment, massive contrast between the rich and poor, and a breakdown of relationship. It is in such a context that HIV/AIDS has thrived, and HIV/AIDS has exposed this social sin by deepening the social inequalities and the suffering that exists as a result of it. So STD and AIDS can be seen as a symptom of the sickness of our society although individual people, who are mostly the poorest and vulnerable, cannot be blamed for this sickness-they are merely the ones who suffer most (Gennrich, 4004:41).

Table 4.6.13. If young people live normally, socially and responsibly, problems like AIDS would never arise.

Normal and responsible life	Numbers	Percentages
Agree	36	90
Uncertain	0	0
Disagree	4	10
Total	40	100

If the youth lived normally, socially and responsibly, problems like STDs/AIDS would never arise, 90% agreed and 10% disagreed. Those who disagreed were worried about their partners who might carry the disease. According to the researcher's point of view, people need to be educated on the transmission of STDs/AIDS. To live a socially normal life, commendable as it is, it is not the only best solution, but the effective use of one or more prevention measures would be a best investment (Education and HIV/AIDS. A window of hope, 2002:10). When condoms are used consistently and correctly, male and female condoms prevent STDS AND HIV infection. Male latex condoms are widely distributed in South Africa including via the public sectors, social marketing programs and commercial sales. Quality control and related logistics for public is managed by the Department of Health and over 350 million condoms annually distributed on a demand basis in recent year (HIV& AIDS and STI strategic plan 2007-2011:38). The public

prevent the development of HIV/AIDS, because HIV/AIDS is the disease that is transmitted to one another through flesh contact and semen. Although male circumcision reduces the risk of HIV infection of male through female-to-male transmission, it is not clear whether it reduces male to female transmission, although there are likely to be long-term epidemiological benefits (HIV/AIDS & STIs Strategic Plan 2007-2011:38). So the only effective method for prevention is the use of condoms.

Table 4.6.16. Because of AIDS it is better to stick on one sexual partner.

Having one sexual partner	Numbers	Percentages
Agree	40	100
Uncertain	0	0
Disagree	0	0
Total	40	100

On the question based on one sexual partner, 100% agreed as a result of the "killer diseases" even though it is against our customs. They raised the concern about the high death rate of women than men in this country. The notion of limiting one's number of partners has an epidemiological truth, but it is not helpful in securing the protection of individual youth. Being faithful to one known and trusted partner or at least reducing the number of sexual partners are usually messages aimed at unmarried but sexually active individuals and to married couples (Mckee et al. 4004:96). It should be clear that youth should know their partners' status and use condoms consistently if they have more than one known and trusted partner. In other words, reducing sexual partner alone may not be an effective HIV –prevention strategy.

Table 4.6.17. It is right to have sex with someone once you have been going out with him or her for a few weeks without the use of condoms.

Having sex without using a condom	Numbers	Percentages
Agree	3	7.5
Uncertain	1	2.5
Disagree	36	90
Total	40	100

On the question of having sex with someone they did not know much about within few weeks without the use of condom, 90% disagreed, 7.5% agreed and 2.5% were uncertain. The argument is based on choice; the risk factors depend on how carefully they select their partners and their choice of sexual activity. To know a person for a long period of time does not guarantee that a person is unaffected. It would be recommended if both have blood tests before involving themselves in sexual intercourse. The economic imbalances amongst the states in region, as well as improvements transport and communication infrastructure, have contributed to easy movements of people, who, among other reasons, are in search for better employment and economic opportunities (Managing the impact of HIV/AIDS in SADC, 200:11). Within the borders of the individual member states, there is evidence of rural –urban migration. The results of this is poverty, lack of educational opportunities, prostitution, crime and substance abuse which are all predisposing factors to contraction and spread of the STD and HIV/AIDS.

Table 4.6.18. The involvement of different sectors in the struggle against STD and AIDS.

Involvement of different sectors	Numbers	Percentages
Agree	19	47.5
Uncertain	11	27.5
Disagree	10	25
Total	4040	100

On the question based on the involvement of different sectors in the struggle against STD and Aids, 47.5% agreed, 27.5% were uncertain and 25% disagreed.

Government, in partnership with community and sectoral organizations, including labor and private sector, has implemented various outreach projects designed to facilitate access to services for groups whose lifestyle puts them at risk of STI and HIV infection (Full report of the joint health and treasury task team charged with examining treatment options to supplement comprehensive care for HIV/AIDS in the public health sector, 2003:15). These groups, which are more prone to casual and multiple sexual relations as well as unprotected sex, including sex workers, migrant labor and long distance truck drivers. Outreach projects normally include an educational component, condom distribution, STI treatment and voluntary counselling and testing for HIV. It is desirable to broaden and expand the number of sectors participating in the response and to considerably scale up the interventions (Managing the impact of HIV/AIDS in SADC, 200:11). This would have the effect of improving and widening coverages-both in terms of geography and in relation to populations and clients served.

Table 4.6.19. If I did get the STD/AIDS virus, it would be because of my behavior.

Personal behavior	Numbers	Percentages
Agree	30	75
Uncertain	0	0
Disagree	10	25
Total	40	100

With regard to a question based on getting AIDS virus, as a result of personal behavior, 75% agreed and 25% disagreed. Those who disagreed believed that a partner might affect them. For example, long distance drivers and mine workers might relay the disease. Women face a greater risk of HIV AIDS infection than men, because their diminished socio-economic and cultural status compromises their ability to choose safer and health life style (Pelser et al, 2004:287). These types of jobs are dominant in most rural areas. Factors enhancing the vulnerability of girls and young women to HIV include social norms that deny women sexual health knowledge, as well as cultural practices that prevent them from controlling their bodies or deciding the terms on which they have sex. In many cases, it is not

uncommon for men to beat their female partner when the latter refuse intercourse or request a condom. Eve when women know their husbands are at high risk of HIV, many do not raise the issue of condoms, because it is believed that doing would impunge their husband's manhood (Pelser et al, 2004:287).

Table 4.6.20. It is unfair to blame women for the spread of STD/AIDS.

Blaming of women as the spreaders of STD and AIDS	Numbers	Percentages
Agree	33	82.5
Uncertain	1	2.5
Disagree	6	15
Total	40	100

On the question of the blame on women as the spreaders of STD/AIDS, 82.5% agreed, 2.5% were uncertain and 15% disagreed. There is no justification for discriminating against and blaming women for the AIDS epidemic. Traditional ideas with which AIDS is associated might provide a predisposition to identify women as those who spread it. In South Africa sexually transmitted diseases are viewed as "women diseases." This is because of some women who had sex with Whites and other ship traders who came with new diseases in this country (Managing the impact of HIV/AIDS in SADC, 200:11). To justify this most of foreign traders are males that have been in ships for a long period of time without their wives.

Table 4.6.21. People with AIDS should be taken away from family members.

Isolation of people with STD and AIDS	Numbers	Percentages
Agree	2	5
Uncertain	0	0
Disagree	38	95
Total	40	100

People with STD/AIDS should be taken away from their families, 95% disagreed and 5% agreed. This shows that people are knowledgeable about AIDS and its transmission, even though AIDS suffers are stigmatized by society and isolated from public gatherings. For people with HIV/AIDS, colleagues and friends as well as family members frequently reject affected people. A feeling of despair and alienation compounds the already difficult problem of coping with the disease in general. People with HIV/AIDS usually feel a need to keep their disease a secret, and fear disclosing the condition to anyone except their closest family (Managing the impact of HIV/AIDS in SADC, 200:15).

Table 4.6.22. Traditional healers should be included in campaigns against STD/AIDS.

Inclusion of traditional healers in AIDS awareness campaigns	Numbers	Percentages
Agree	37	92.5
Uncertain	2	5
Disagree	1	2.5
Total	40	

On the question based on the inclusion of traditional healers in AIDS campaign, 95% agreed, 5% were uncertain and 2.5% disagreed. According to my respondents, traditional healers are regarded as people with expertise and authority. They are not only sought out for curative treatments but also for advice. Including them in the prevention campaign for advice could expand the number of people actively involved in disseminating information and participating in counseling (Van Dyk, 2005:213).

Table 4.6.23. It is immoral to discharge semen in a container.

Discharge semen in a container	Numbers	Percentages
Agree	20	50
Uncertain	5	12.5
Disagree	15	37.5
Total	40	100

On the question relating to the discharge of semen in a container, 50% agreed, 12.5% were uncertain and 37.5% disagreed of it as immoral. Respondents still believed that condoms are unnatural. If you use condoms on a daily basis, it means that the family would decrease in its size since Africans believe in extended families. One of the objections often raised against condoms is that condoms are "not natural"-not only because they inhibit pleasure, but also because they interfere in the process of natural fetal development (Van Dyk, 2005:123). It is also believed that semen contains important nutrients necessary for the continued physical and mental health, beauty and future fertility of women.

Table 4.6.24. Patterns of sexual behavior in our society would not change quickly enough to avoid further spread of AIDS virus.

Sexual behavior in our society	Numbers	Percentages
Agree	29	72.5
Uncertain	6	15
Disagree	5	12.5
Total	40	100

On the patterns of sexual behavior in our society would not change quickly enough to avoid further spread of STD/AIDS virus, 72.5% agreed, 15% were uncertain and 12.5% disagreed. Those who agreed raised a serious concern that STD and AIDS goes together with the high rate of illiteracy in our country. The effectiveness of AIDS awareness campaign raised a serious concern about gender biases on this campaign. In general these campaigns have had little effect either because they have been national campaigns carrying messages which are often insensitive to many local cultures, ignore available resources as well as the status of the local epidemic or as in the Sarafina debacle, have been factually inaccurate, provide limited coverage of the population or have been surrounded by controversy (Mackerrow, 1998:8). In contrast campaigns developed to target local communities have tended to be more culturally sensitive, have recognized local resources and local epidemic profiles and have consequently shown greater success (Mckerrow, 1998:8).

More recently, these AIDS scandals have been followed by various forms of presidential denial. The president of the country refused to visit the dying 12-year old activist Nkosi Johnson, despite the child's publicized desire to meet him (Campbell, 2003:158). The Mpumalanga Health Department closed down the Nelspruit Rape Intervention National Project which provided the AIDS Drugs AZT to rape survivors on the ground that it was breaching government policy.

Non-governmental programs such as "Soul City" which is factually correct, incorporates an AIDS message into a wide spectrum of primary health care issues and has achieved an extremely high coverage of the entire population, especially rural black communities, have been equally successful.

Table 4.6.25. Condoms are associated with prostitution; in any case, they are used only for extramarital sex.

Condoms association with prostitution	Numbers	Percentages
Agree	16	40
Uncertain	0	0
Disagree	24	60
Total	40	100

Condoms are associated with prostitution, in any case, they are used for extramarital sex, 40% agreed and 60% disagreed. Acknowledgement of the use of condoms showed that their use is acceptable to the people. This suggests that although knowledge is high among the youth concerning the transmission of HIV, few youth view themselves at the risk for contracting HIV. For the youth who are sexually active, few use effective methods to reduce the risk of contracting the virus. Young people may be negative about the contraceptive implications of condoms in contexts where having children provides young men with proof of their masculinity, and gives young women a role in contexts where opportunities to finish school of find valued work are few (Campbell, 2003:125). Condoms are available from a number of sources in KwaMbonambi, both free from government clinics and social marketing programs

Another factor deterring many young women form using condoms was their fear of getting a bad reputation. They believed that women who carry condoms risked being labeled as promiscuous or as a "bitch".

Table 4.6.26. Anyone who has more than one sexual partner runs some risk of catching the AIDS virus.

Risk of catching AIDS	Numbers	Percentages
Agree	29	72.5
Uncertain	1	15
Disagree	10	12.5
Total	40	100

Anyone who has more than one sexual partner runs some risk of catching the AIDS virus, 72.5% agreed, 2.5% were uncertain and 25% disagreed. Most of the respondents showed that they are concerned about their own life and as a result of AIDS polygamous families is no longer important. Among people, the risk factors depend on how carefully they select their partners and their choice of sexual activities. Having multiple partners or having just one partner who is sexually active with other people increases the possibility of exposure to STDs. Learning about these infections, knowing what to ask potential lovers and understanding safer-sex techniques could minimize this risk (Managing the impact of HIV/AIDS in SADC, 200:11). Having an active sex life that is both satisfying and healthy involves issues of choice and responsibility.

Table 4.6.27. Anyone who knows they have AIDS virus and engages in sexual activity with more than one partner is being irresponsibility

Having more than one partner while HIV positive	Numbers	Percentages
Agree	36	90
Uncertain	0	0
Disagree	4	10
Total	40	100

Anyone who knows they have AIDS virus and engages in that sexual activity with more than one partner is irresponsible, 90% agreed and 10% disagreed. It shows that people are afraid of AIDS and persons who have AIDS must reveal their status so that when they are engaged in sexual activity, they could ensure that they use condoms.

Table 4.6.28. Education on how to avoid catching the STD/HIV/AIDS should be given to societies.

Sex education	Numbers	Percentages
Agree	40	100
Uncertain	0	0
Disagree	0	0
Total	40	100

With regard to the question based on sex education to all members in a community, 100% agreed is important to all people in the community without specifying certain groups. All categories of people in a community should be informed of the essential facts about AIDS. The seriousness of the disease and the real risk of infection to all individuals needs to conveyed, as well as the means for preventing this condition. A review of South Africa programs targeted at young people shows that there is vast range of programs reaching out to young people in South Africa (Kelly, 2002:111). Besides youth development initiative and school based education approaches, there are numerous forms of workplace initiatives, peer education programs and niche education both soul city and love life, which are the highest budget mass media produces in South Africa, which includes outreach programs into specific contexts where individuals and groups of people can be reached in a closer and more interactive way (Kelly, 2002:109). Rural areas are often hard to be reached by STD, HIV &HIV campaigns. Recent studies in other countries shows that young people are the most likely sector of the population to be involved in activities associated with HIV/AIDS risk, yet remain largely ignored in prevention and awareness campaigns (Pelser et al, 2004:286).

Table 4.6.29. Africans have continued to consult traditional healers, even when biomedical practitioners are available and free.

Consultation of traditional healers	Numbers	Percentages
Agree	35	87.5
Uncertain	1	2.5
Disagree	4	10
Total	40	100

Africans have continued to consult traditional healers, even when biomedical practitioners are available and free, 87.5% agreed, 2.5% were uncertain and 10% disagreed. According to Campbell (2003:26), traditional societies have not stripped their ethnomedical practices of their social content but continue to give primacy to social relatives. Many patients are admitted to hospital, but when they do not get better, and while the doctors are doing laboratory investigations to find what germ ails the patient, the patient asks for a "passout" giving some laudable reasons such as collecting his salary to justify a "passout". He immediately visits an "inyanga", states his illness and asks for help. The inyanga listens carefully and takes a patient history. By the time the patient gets the rest of the medicines to take home the patient is in an excellent frame of mind to recover.

30. Table 4.6.30. AIDS programs need the active cooperation of traditional healers in order to treat and prevent STDs.

Co-operation of traditional healers	Numbers	Percentages
Agree	35	87.5
Uncertain	0	0
Disagree	5	12.5
Total	40	100

AIDS programs need the active cooperation of traditional healers in order to treat and prevent STDs, 87.5% agreed and 12.5% disagreed. According to Van Dyk (2005:125), no AIDS program could succeed in Africa without the help of traditional healers. Traditional

healers are effective agents of change because of they have authority in the communities. According to Campbell (2003:11), the mobilization of local people is necessary but also as a strategy for limiting the destruction of lives and families by limiting STD and HIV transmission. According to Pretorius (2004:548), collaborative health programs involving traditional healers are under way in many African countries, and indicators are that traditional healers could effectively be involved in STD/HIV prevention programs. The willingness of traditional medical practitioners to receive training from biomedical personnel also serves to indicate their readiness to adapt to changing circumstances. According to Van Dyk (2005:125), traditional healers should promote the use of condoms and safer sex practices and to counsel their clients on the prevention of STIs and HIV.

4.8. Conclusion

In this chapter the researcher's aim was to find out how knowledgeable the youth are with regard to sexually transmitted diseases. The researcher believed that effective education on STDs/ AIDS should start from where the youth are and also examine the cultural impact in considering prevention measures. The next chapter of the research is on the discussion of findings.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1. Introduction remarks

It is common knowledge that young people are highly vulnerable to AIDS and sexually transmitted diseases. According to this study, the youth have shown that they are aware of the issues related to sex and by large act accordingly. Most of the respondents said HIV/AIDS has proven to be the biggest challenge facing the country in recent times. Even though the youth admit to the enormity of the challenge the country is facing, most of them believe they are not vulnerable. The increase in teenage pregnancies could be an indication that the youth do not practice safe sex and this could more than ever before place them at risk of contracting HIV/AIDS and other sexually transmitted diseases (Lehohla, 2001:53). This highlights the seriousness of the problem of unwanted and unplanned pregnancy, particularly among teenagers of school-going age. A related problem is the inaccessibility of proper health care facilities and education on reproductive health and contraceptives.

Condom usage has proven to be a popular trend among the youth. But the researcher observes that most young people are either too embarrassed or afraid to go to clinics and their homes also act as a disincentive. Even though the youth are aware of AIDS, most of them still follow the old trend of multiple partnerships, which exposes them to sexually transmitted diseases.

5.2. Changes in sexual lifestyles

Considerable energy has been devoted to educating the youth to adopt safer sex practices in spite of the likely difficulties in persuading them to change their behavior. According to the study in relation to the statistics shown above, many people have not eliminated the risk of STD/HIV infection. While these youth viewed the condom as an effective prevention measure and believed that it is important to avoid sexually transmitted diseases, very few used condoms on a daily basis. Many people are unaware that they

should use condoms for all sexual encounters including relations with regular partners (Campbell, 2003:125). Most contacts with regular partners continue to be unprotected even among those whose risk is quite high. Some people prefer to be faithful to their own partners. According to the researcher many youth know that they are at risk but have not yet come to terms with the full extent of the behavioral changes needed to prevent AIDS.

The most important way to prevent the spread of STDs and HIV is for people to ensure that their sexual behavior does not put themselves at risk. According to Willis (2005:74), two major changes in sexual behavior are needed; the reduction in the number of sexual partners and the move from high risk to low risk sexual activities. Restricting the number of sex partners would not guarantee avoiding AIDS. You could not tell from appearance whether your partner is carrying the HIV virus. Some youth believe that individuals of slim physical structures are having AIDS. Some of them feel more secure with plump girls, for casual sexual companionship.

But a person may have contracted the virus from a single sexual encounter a few years ago. The most effective way of ensuring that one partner does not have HIV would be for each of them to have a test for HIV. Complete abstinence from sex is unrealistic and even reducing the number of sex partners does not guarantee avoidance of HIV. Even if one adopts the message of one partner for life your partner may not and thus one could still be at risk of catching HIV.

5.3. Safe sex

Some youth responses to HIV/AIDS are influenced by misconceptions about themselves and their partners. Adolescents' sexual behavior has been conceptualized as rising out of a rational decision-making. According to Benatar (2004:588), adolescents who have good levels of knowledge about HIV transmission would avoid unsafe behavior; the adolescent who perceives that there are high costs in using condoms is less likely to use condoms than, the ones whose attitudes are positive.

Some people may be forced by the term "safe sex" that is used by both AIDS prevention and family planning programs. Methods that are effective at preventing conception such as the pill would not prevent STDs and HIV transmission. The only family planning that would prevent HIV transmission is the use of condoms. According to Benatar (2004:589), some people are very critical of basing AIDS prevention programs on safer sex and condom distribution. They see these actions as no substitute for messages such as "no sex before marriage" or "one partner for life."

There are many people for whom messages of faithfulness are unrealistic and for whom safe sex including the use of condoms would a more realistic advice. These might include young people beginning adult life who may not get married for many years, men and women away from home and sex workers for whom sex is a vital source for earnings.

Long term changes in sexual behaviors are very important and should be the main emphasis for educational programs. These should be combined with the promotion of safe sexual practices that could immediately reduce the risk of the transmission of HIV. Guidance should be given to individuals to make the best choice for meeting their own special needs.

5.4. Discrimination and blame

In the early days, AIDS was portrayed as a new disease predominantly of gay men, drug users and commercial sex workers. According to Gennrich (2004:15), the association of this disease with homosexuality, promiscuous sexual behavior and the use of drugs laid the foundation for severe discrimination and for apportioning blame on the people and groups affected by AIDS. Traditionally, homosexuals, drug users and prostitution have been criminalized and seen as undesirables by society at large. According to the study by the researcher, these discriminatory behaviors of homosexuality and prostitution have gradually been eroded.

The coming of AIDS has led to a greater willingness to talk about homosexuality. It is now generally accepted that homosexuality is more widespread than had been realized. According to Mckee et al (2004:101), there are many men who see themselves as heterosexual, are married and with children, but who occasionally have sex with fellow men. Homosexual sex is also practiced by heterosexuals away from their families in institutional settings such as prisons and hostels. This study shows that AIDS is not only associated with the above so-called "high risk groups". In Africa AIDS is predominantly a disease of heterosexuals' orientated people. According to the researcher, social forces acting on society determine human behavior. There are many reasons why sexual promiscuity is a feature of South African society at the present time. Factors such as poverty, overcrowding, single sex hostels, migrant labor, low educational standards and the general destabilization of the lives of South African Black people, all of which have played a significant role in the disintegration of traditional values and norms (Full report on the joint health and Treasury Task Team charged with examining treatment options to supplement Comprehensive care for HIV/AIDS in the public heath sector, page15).

There are so many socio-economic reasons why people resort to drugs taking and alcohol, and why women resort to selling sex. According to Campbell (2003:76), the paths to prostitution vary, but a common characteristic is that the young is living in an environment that is unhappy and hostile. These young girls may have to cope with problems of family stress, poverty, crime and substance abuse. All these are likely to lead to prostitution as a means of survival. Some other times, young women voluntarily enter the profession as a consequence of "passive" neglect. The cause for this includes educational failure in the classroom, dead-end employment and the absence of family support structures. For these young women, prostitution may provide a sense of adventure, as well as money to satisfy their needs.

5.5. Youth prostitution

According to the study conducted by the researcher, sex workers are increasingly seen to have played a major role in the spread of AIDS. On other hand, the sex worker is both at risk of becoming infected with AIDS and spreading it to others. According to Van Dyk (2005:142), addicted prostitutes may buy drugs rather than condoms with what little money they earn. They might not always remember to use condoms because of the drugs and their effects. An additional problem is that they are not in a strong position to enforce the use of condoms with customers. Prostitutes are at a risk of becoming infected with HIV from their clients who are sometimes drug users and who generally do not use condoms (Muller, 2005:142). Another problem we are facing in our communities is that they are no resources that exist for prostitutes who want to leave prostitution. There are those who have sex in exchange for cash on an occasional basis. At the other end of the spectrum are sex workers who could have as many as 100 partners in a year.

Educational programs should include sex workers. These programs should involve providing regular health checks and treatment for any sexually transmitted disease. It is possible to identify and work with the full-time sex workers especially if they are based at well-defined locations and have their own associations (Mckee et al, 2004:145). In most parts of South Africa, it is difficult to develop effective educational programs where a sex worker is driven underground. It is difficult to contact women who meet their clients in the street or involved in sex work on an occasional basis. According to Muller (2005:35), young women are forced into sex work through the need for money to maintain their families and children. So it is unrealistic to expect them to stop work unless alternative sources of income are provided.

The issue of sex workers is one where double standards exist with a tendency to blame the women rather than the men who use them. On the other hand, clients of sex workers have been virtually ignored by education and prevention projects.

5.6. Circumcision

According to the study, circumcision may provide young males, some protection against STDs, which assist in the sexual transmission of HIV. In South Africa, circumcision is still practiced by certain ethnic groups. Circumcision is carried out as a traditional ceremony where a group of boys are circumcised together. There is evidence from studies that a circumcised male is less likely to acquire sexually transmitted disease from sexual intercourse (McKee et al, 2004:292). According to the researcher's point of view circumcision could not help in prevention of AIDS, because HIV is transmitted from one another through semen and the discharge of fluid from female body. Circumcision only helps in transmission of STDs if proper caution is taken.

But what is important is that those who conduct circumcision need to be educated about health measures, to ensure the safety of young boys. These involve some risk of infection if the blade is not sterilized. Medical doctors should be involved in the ceremonies to ensure that circumcised boys are still in good condition. It remains necessary for men to practice consistent condom use, as well as maintaining other prevention strategies such as limiting numbers of sexual partners, whether or not they are circumcised (HIV/AIDS &STI Strategic plan 2007-20011, page 38). According to Van Dyk (2005:26), circumcision should not be promoted as a way of preventing HIV, because circumcision does not prevent infection. In addition, the belief that it is a way of preventing infection may cause ignorant people to abandon safer sex practices such as using condoms.

5.7. Condoms

According to the study conducted by the researcher, this shows that people understand that the only way to avoid the transmission of HIV is the use of condoms. But few individuals indicate that they misunderstood the use of condoms. According to HIV & AIDS AND STI Strategic plan 2007-2011 page 37, many young people appear to justify their non-use of condoms with the belief that condoms are unnecessary because their current relationship is monogamous and promises to be a long term one. Young women have been seen to harbor a negative view of condoms. As a result of this there is a

tendency to go on the pill as a means of indicating the seriousness of a relationship. As love and trust develops, women may then be safely carried away as far as pregnancy is concerned, but still be engaging in unsafe sex in relation to STD and HIV. Some people still believe that condoms tend to be used in situations where partners are not to be trusted.

According to this study, it is obvious that condoms are still used depending on the men's willingness and ability to use them properly. In South Africa, female condoms are available on sale. According to study conducted by Mckee et al (2004:138), sex workers have responded to female condoms particularly well because they can put it on themselves and do not risk losing their clients by insisting that they wear a condom. Unfortunately the female condom is more expensive than the male condom and most of young women cannot afford to buy it.

5.8. AIDS education in schools

This study proves that, it is important to carry out health education with school children. Young adults are a section of the community who are normally free from STDs and HIV and it is important to ensure that they do not become infected. This period of life normally free from infection has been called "window of opportunity". Many youth begin experimenting with sex while still at school with "sugar daddies" in exchange for money. Most of sugar daddies are taxi drivers, bus drivers, government employees and commercial workers (Campbell, 2003:123).

By introducing health education, children could learn about AIDS from sessions in the classroom. Some important decisions must be taken when to introduce AIDS and STDs lessons to the youth, where in the syllabus, it should be included and who teaches it. It is tempting to leave AIDS and STDs until children are over 14 years old. This is too late, as some pupils would have already started sexual activities. It is best if education on AIDS is not treated separately but is carried out as part of a general health education program including STDs and personal relationships. This should begin at the primary school level with basic concepts of health and disease as well as human relationships and then

progress to more detailed treatment as children get older (Education and HIV/AIDS.A window period of hope, 2002:5). According to the study conducted by the researcher, it shows that people are willing to allow sex education in schools. It is a good idea to hold meetings with teachers and parents and tell them what one wishes to do in the school on AIDS education.

Some parents are concerned that informing young people about safer sex including condoms is likely to encourage them to experiment with sex. There is no evidence to suggest that this occurs. We must remember that young people would already know something about sex but that their information is likely to be incomplete. It is better that they should get correct information from a responsible adult rather than rely on gossip from friends (Campbell, 2003:123). Sex education could help young people to make sensible decisions such as the delaying of sexual activity and taking the necessary precautions to avoid pregnancy and STDs. AIDS prevention education must also recognize the impact of cultural attitudes toward gender roles.

5.9. Community education

AIDS education should be given to all members of a community. It is important to find out who are the people with influence and respected in the community. It is important to spend much time talking to them and finding out what they think about AIDS and the safer sex messages, rather than imposing things on them or inviting them to participate in planning and carrying out health education activity (Van Dyk, 2005:2005).

It is important to include traditional healers, grandmothers and aunts who are traditionally educated to advise the young. Training in home-care and for cottage and rural industry projects with which they could earn an income would help older women cope with the patients and children in charge. They should be targeted more specifically as educators and consellors. Another group who should be involved is sex workers. According to Campbell (2003:63), sex workers are in a good position to advise on the best way of reaching other sex workers in their community.

It is important to ensure that educational messages are relevant and effective. People would usually be more easily reached and convinced by a trusted member of their own group than an outsider (Education and HIV/AIDS.A window period of hope, 2002:5). It is also important to know the local myths and customs that may effect the spread of AIDS and STDs. With the expansion of public education programs, most people may accept that AIDS is sexually transmitted.

5.10. Traditional healers

According to the study conducted on the youth about the incorporation of traditional healers in AIDS programs, many people go to traditional healers first if they fall ill. Most people made use of both doctors and traditional healers for the treatment of STDs. These includes practitioners of western biomedicine , including hospitals and general practitioners in private practice and traditional healers including sangomas (diviners), inyanga (herbalists) and umProfithi (faith healers) (Campbell, 2003:27). Some people go to a traditional healer and get preventive medicine, which would "block" these diseases from entering the person. According to the researcher's experience, reliable practitioners of traditional medicine do not claim to be able to cure AIDS, but they do help people come to terms with illness by giving spiritual comfort. In many African cultures, illness is blamed on disharmony among ancestral spirits. Rituals that appease those spirits may not cure the illness, but would satisfy patients and their families that the correct measures have been taken, allowing acceptance and support for the patient by the family (Pretorius, 2004:592).

On the other hand western medicine focuses on the individual patient and leaves the social content of his illness. The traditional healer approach is holistic medicine. The traditional healer treats patient within his environment, physical, and spiritual, past and present.

Traditional healers could give health and hygiene education, recommend the use of condoms and give preparations that may help someone to feel better psychologically. They could also encourage anyone with symptoms of HIV infection to see a doctor.

Cooperation between traditional healers and health services would greatly benefit the people with HIV who rely on both, as with other illnesses. Traditional healers should be involved in STD/HIV programs and encouraged to refer patients with STDs/HIV to clinics. According to Schoepf (1992:231), including healers in prevention campaigns could expand the number of people actively involved in disseminating information and participating in counseling. In some districts of Botwana, healers do not only provide information but are also distributors of condoms. In Brazil, religious leaders took 20 hours courses on AIDS and they use videos and posters to educate their followers and attend monthly meetings to discuss and evaluate their programs (Schoepf, 1992:231).

The following chapter draws the conclusion and makes recommendations on the study.

CHAPTER 6

CONCLUSSION AND RECOMMENDATIONS

6.1. Introduction

In this chapter the researcher draws conclusions and makes recommendations. The objectives and the key questions of the study are also restated.

6.1.1. Restatement of the objectives of the Study

The objectives of the study are as follows.

i. To undertake research among the youth of KwaMbonambi District in relation to the problems they have with the spread of STDs and related illnesses;
ii. To examine the social pressures and constraints through which young people negotiate their sexual encounters and how these impinge directly on their ability to make decisions about sexual safety and pleasure;
iii. To increase and improve public information and education regarding the early detection of communicable diseases and
iv. To evaluate the knowledge of the youth in HIV and AIDS as well as their behavior, knowledge, attitudes and practices.

As shown in the literature review the presence of STDs such as syphilis, gonorrhea and drops greatly increases the risk of HIV transmission through sexual intercourse. Activities that would reduce the extent of sexually transmitted diseases in community would also control AIDS. In South Africa, the level of HIV infection is increasing on a yearly basis. STD control is one of the most effective ways of preventing the increase of AIDS.

What is exacerbating the problem is that most of the youth delay in receiving treatment because they do not recognize the symptoms. Education programs should, therefore, promote awareness of symptoms and the importance of early diagnosis and treatment. Even with improved STD services, effort is needed both to ensure that the services are

properly used and also to reach infected persons who do not have symptoms (Kelly, 2002:110). The longer a person with an STD delay going to a health practitioner, the more chance there is of developing serious complications.

The youth may delay to use STD services for different reasons. They may feel shy about going to a health center and believe that someone they know would find out about their health status. Women may be reluctant to be examined by men. People may feel going to government health services is a waste of time because they do not stick to the necessary medicine to treat STDs. People then go directly to traditional healers and buy medicines without consulting a trained health worker.

The development of improved STD service has to be accompanied by educational programs to tell people about these new services and encourage them to come for treatment. Young people, especially women may delay going for treatment simply because they do not have any visible symptoms and are not aware that they are infected (Kelly, 2002:111). One way of reaching these women is to screen persons who are attending health services for other diseases. These clinic-based methods need to be supplemented by public education to increase awareness of STDs. The promotion of safer sexual practices including the use of condoms for prevention of STDs/HIV should be encouraged. The researcher **recommends** the following strategies:

6.2. Person to person STDs/ AIDS education

Radio and television programs are appropriate ways of reaching large sections of the population quickly with simple messages. However, the important tasks of explaining the details of STDs and AIDS, providing advice on behavior change, helping people to acquire skills, attitudes change and empowerment could be carried out at a personal level.

Another form of **person to person education** is through small groups. The facilitator should provide specific information where necessary, by promoting discussion and sharing of ideas between participants (Kelly, 2002:111). It is important to start any group teaching by finding out what one's audience already knows and whether one has to meet special needs. People may be shy about asking questions in public. On could overcome

this by putting them in pairs at the beginning to identify questions and concerns. Once they have discovered that others have similar questions and anxieties they would feel more confident about voicing these to the whole group.

The group discussion should use active learning methods, including small group discussions and structured group processing to demonstrate to participants the ability to reduce the risk of STDs. The facilitator should not give advice. They should promote the search for solutions appropriate to the participants' personal power. In the case of young women, and especially in the case of sex workers who have experienced social stigma, feelings of powerlessness, and low self-worth, telling people how they should act is tantamount to blaming them for their predicament (Van Dyk, 2006:173). Instead of focusing on behavior that could not be altered in present circumstances, experiential training on self-empowerment could be used to initiate and sustain other types of socially transformative change (Campbell, 2003:42). There is a need of increasing feelings of personal competence and to maximize anxiety and guilt.

According to the researcher's point of view the youth should be empowered, so that they could be able to take preventive measures. According to Potgieter (1998:216), **empowerment** is a process of increasing personal, interpersonal and collective power that allows individuals, groups and communities to maximize their quality of life. Empowerment assumes that people have options available to them and that they can unlock the necessary resources to ensure maximum control over their own life. The researcher believes that youth have many competencies, skills and knowledge available within themselves and accept that they can achieve even more if they focus on their strengths rather than on their weaknesses. Empowerment encompasses the development and stimulation of another person's capabilities, a professional skill on the one hand, and the struggle of power and control by youth themselves (Van Dyk, 2005:184).

Another valuable technique that has been suggested for use when using an empowerment strategy is work focused on reduction of self-blame. The youth needs to be helped to see that the problems they are facing often have their source in the functioning of systems in their environment. Tied to the reduction of self-blame is the assistance needed to help

youth take responsibility for changing the impacting environment. It is important that the youth accept major responsibility; a feeling of personal incapacity may be further reinforced (Van Dyk, 2005:185).

By virtue of their numbers, young people are not only tremendous resources for health care activities in the community, they are also a potentially influential group whose cooperation and goodwill would be essential to cultivate. In most parts of the world, young people contribute their labor to the family economic unit at the early stage. They may take care of young brothers and sisters while their parents died of STDs/HIV. Young people also help members of the extended family and their community in tasks that are undertaken cooperatively, such as harvesting. All these contributions are important to the life of the community, though care must be taken to ensure that the youth are not exploited and that they receive STD/HIV education and recreation necessary for health development (Campbell, 2003:42).

6.3. Youth helps each other

Although not generally part of their traditional role, young people helping other young is rapidly becoming the strategy of choice in health promotion and particularly in primary prevention of the most common health problems among the young such as risk-taking behavior and problems related to unprotected sexual activity (Van Dyk, 2005:174). It has been amply demonstrated that young people are often far more receptive to information communicated to them by peers than by adult authority figures and are more likely to be influenced to modify the behavior that leads to health problems.

Moore et al, (1996:112), define **peer education** as program of education that is at least in part, devised and delivered by young people for the young people. Rather than being targeted as victims of problems, young people could advocate and amplify health behavior to their peers, and indeed to the adults around them, in a most constructive and powerful way.

Peer education is a strategy that embedded education for behavior change in the fabric of the local community, and readily seen as the most useful approach for developing

countries with limited resources (Campbell, 2003:42). The interest in using peer education for STD/AIDS prevention with young people arose readily in this climate, but also because the well-established role of peer influence in youth development had already been recognized by health promoters. Peer education in its various forms has been one of the most widely used means of influencing adolescent behavior in the era of AIDS. It is certainly a major approach used with difficult to-reach young people outside schools, and by clubs and organizations such as young people's health services (Van Dyk, 2005:173).

Young people should be involved in educating others on the prevention of STDs and AIDS. Peer leaders are credible role models and have a role to play in dissemination of information and they speak the same language as their peer members. Peer leadership appears to be the most promising approach to prevention of HIV/AIDS across a variety of settings and cultures. An important development is the involvement of the youth in baseline research, particularly in regard to patterns of behavior and relationships.

For effective participation of young people in the provision of health care it is recommended that, a two-way channel of communication should be set up to permit full access by young people to relevant information and give them the opportunity to contribute their own ideas (Mckee et al, 2004:254). Young people should have a say in decisions about objectives, policies, and the allocation of resources in government and non-governmental organizations at the local and national levels in all matters relating to their health. Governments should support the involvement of young people in the promotion and protection of their own health, particularly in such areas as family life, sex education and the avoidance of risk-taking behavior.

To achieve these goals, professional workers who are inviting the young to join their activities should be sensitive to their feelings and views and careful not to underestimate their potential. If young people are trusted, they would be more responsible, to everyone's benefit.

6.4. Counselling skills training in youth sexuality

Human interaction is an intrinstic and extremely important component of any profession. Yet formal instruction in effective communication with other people is rarely included in the training of these that may provide services to the young. Young people tend to underutilize existing services, often because they expect a lack of understanding, an unwillingness to listen and a negative attitude, especially if sexual behavior is involved (Mckee et al, 2004:254).

When young people need help, counselling services could be of great value; however, those providing the service must be trained in communication skills that enhance the youth's ability to make decisions and choices. A workshop model was developed to strengthen interpersonal communication for behavior change and to desensitize the participants to the subject of adolescent sexuality. The model should focus on counselling as a technique that helps youth strengthening their self-understanding and powers of decision-making, rather than simply providing service (Van Dyk, 2005:175).

6.5. Human development

Many, although not all, youth have a low opinion of themselves and of their own ability to change their situation for the better. Because of this low opinion, and perhaps also out of fear, the youth do not assert themselves. They remain shy, passive and withdrawn. Their dependency relationship with others who are stronger diminishes their self-confidence and initiative.

The youth, if not oppressed by the more powerful, are oppressed by their own limited knowledge. Their lack of knowledge and information prevents them from effectively utilizing the few resources that they do control (Mckee et al, 2004:254). The researcher strongly believes that no STD and AIDS activities, whether initiated by experts or by the youth themselves, could hope to succeed unless it contains a strong element of human development. Human development involves the strengthening of the personality and the acquisition and internalization of knowledge and information.

If the youth are to manage and control their own STD and AIDS awareness programs, they must gain self-confidence, learn to be assertive and have faith in their own abilities to succeed (Education and HIV/AIDS: A window of hope.2002). They must build on their present knowledge, replace false beliefs with new knowledge and develop new skills and abilities.

As part of the planning for any STDs and AIDS activity, the youth must learn to discuss among themselves and with others especially community workers. This is what they already know about the activity, what skills individual group members have and how these could most productively be utilized. The researcher recommends that the youth set up and carry out their own personal STD and AIDS campaign plan. Community workers should help them considerably with this during the early phases of their development, but in terms of their own long-term development effort, this process must become internal. Equally important is the acquisition of new skills and new knowledge and the ability to judge oneself on what one needs to learn, and to find ways of doing this (Education and HIV/AIDS: A window of hope.2002).

Equally important also are skills in communication, organization and management. People must learn how to express themselves in public, analyze and verify information, make decisions and resolve conflicts. Constructive participation also requires a certain minimum of mutual trust, honesty and concern for others.

6.6. Conscientization

According to the researcher, HIV/AIDS intellectuals have prevented us from building on what people know. Their knowledge, unlike much of our own, is based on personal experience and the accumulated experiences of their forebearers. This knowledge, if wisely used, could provide a foundation for wise and successful development, and when given prior respect, could provide the basis for acquisition of modern scientific knowledge as a complement to their experiential learning.

This process of problem-solving education is often called conscientization. **Conscientisation** as formulated by Paulo Freire means the stimulation of self-reflected

critical awareness in people of their social reality and of their ability to transform that reality by their collective action (Gran, 1983:157). A self-reflected critical awareness is achieved by "looking into one's self" and using what others hear, see and experience to understand what is happening in one's own life. It is important to realize that conscientization means something which occurs within a person. It could not be imposed from outside. Conscientization is a process in which the people try to understand their present situation in terms of the prevailing social, economic and political relationships in which they find themselves. This analysis of reality must be undertaken by the youth that could decide what their important needs and experiences are, and not by expert. Lastly, the problems of the youth could not be solved by anyone but themselves, and all solidarity efforts must be aimed at strengthening their own capacity for independent action.

A valuable approach is to select non-medical persons from the community with the right personal qualities and provide a basic training in STD/AIDS and counselling. People generally respond better to a person of similar background and these needs to be considered when selecting for a particular group such as the youth (Education and HIV/AIDS: A window of hope.2002).

The researcher recommends the following strategies:

i. Life skills programs targeted at the youth;
ii. Appropriate treatment and management of patients seeking treatment for STDs;
iii. Full community participation in prevention and care should be developed and fostered and
iv. All sectors of government should be involved in the fight against STD and HIV/AIDS education, prevention and care should be viewed in a broad context.

6.7. Conclusion

Let the researcher conclude by stating categorically that African countries are affected by AIDS. This is, however, not only Africa but all over the world, where millions of people are living with HIV related diseases. As most people lie in the hospital, those ill from

AIDS-related diseases, should awaken everyone to the scientific facts that there are thousands if not millions of other faceless and nameless people, whose plight we do not know about. It should give us reason to step back and review our current campaign strategies against AIDS, which have come to rely heavily on expensive but ineffective television, radio and newspaper advertisements.

As a result many public messages about and warnings against the danger of STDs and AIDS continue to miss their target population. It is, therefore, vital for African governments to review their AIDS campaign, which rely considerably on modern, expensive materials that are not reaching all young people. It is time for us to utilize alternative traditional means of communication among our communities.

Most of television and radio messages are designed for the urban areas, where health care facilities and information dissemination are fairly adequate. It should be taken into consideration that the literacy level in South Africa is still low. This means that many people do not read newspapers. Because of poverty and unemployment, many poor households do not have access to television sets, which leaves radio as the only practical medium for conveying public health warnings and campaigns about STDs and AIDS. A fairly large number of our rural areas like Kwambonambi District still do have communities and people who are not reached by communication techniques used. Yet these people suffer as much from these conditions.

If only political parties in South Africa could take STD/AIDS as seriously as they take elections, by regularly flooding the country with poster warnings against the danger of STD/AIDS and unsafe sex, we would be miles ahead in our awareness campaigns.

Bibliography

Ary, D. Jacobs, L. C. and Razavieh, A. 1996. **Introduction to Research in Education.** New York: Holt, Rinehart and Winston, Inc.

Babbie, E. **The practice of Social Research.** Beltmont C. A: Wadsworth Publishing company.

Babbie, E. and Mouton, J. 2003. **The Practice of Social Research.** Cape Town. Oxford University Press.

Babbie, E. and Mouton, J. 2001. **The Practice of Social Research.** Cape Town. Oxford University Press.

Berer, M. and Ray, S. 1993. **Women and HIV/AIDS. An international resources book. Information, action and resources on women and HI/AIDS, reproductive health and sexual relationships.** London: Harper Collins Publishers

Benatar, S. R. 2004. **Ethical challenges for health care in South Africa. Heath Care in South Africa.** Pretoria: Van Schaik Publishers, page 561-599.

Bless, C. Highson-Smith and Ashraf Kagee. 2006. **Social Research methods.** Cape Town: Juta and Co LTD.

Campbell, C. 2003. **"Letting them die" why HIV/AIDS Prevention Programmes fail.** Cape Town: Double Storey/ A Juta Company.

Dladla, A.N, Heiner,C.A, Qwana, E. & Lurie, M. 2001. **Speaking to rural women: the sexual partnership of rural South African women whose partners are migrants.** Society in transition, 32. Page 79-82.

David, M. and Sutton, C. D. 2004. **Social Research: The basics.** London: Sage Publication.

EDUCATION AND HIV/AIDS: A WINDOW OF HOPE.2002. Washington, DC 202433: the World Bank.

Everett, D. 1994. **Creating a future: Youth policy for South Africa**. Johannesburg: Ravan Press.

Evian, C. 2003. **Primary HIV/AIDS Care. A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS.** Durban: Double Storey/ a Juta Company.

Equal Treatment action campaign, June 2006.

Fredriksson, J. and Kanabus, A. UNAIDS, HIV and AIDS-related stigmatization, discrimination and denial: forms contexts and determinants, June **2000**

Friedman, H. L. 1989. **The health of adolescents: Belief and behavior**. Switzerland: Pergamon Press PLC. Soc. Sci. Med. Vol 29. No 3, pp 301-315.

Full report of the joint health and treasury task team charged with examining treatment options to supplement comprehensive care for HIV/AIDS in the public health sector, 8 August 2003.

Gennrich, D. 2004. **The Church in an HIV+ World: A Practical handbook**. Pietermaritzburg: Cluster Publication.

Gran, G. 1983. **Development by people. Citizen construction of a trust world**. New York: Praeger Publishers.

Green, E. D. 1994. **AIDS and STD's in Africa: Bridging the gap between traditional healing and Modern Medicine**. Durban: University of Natal Press.

Health Systems Trust, South Africa Health Review, 2000.

HIV/AIDS/ STDs strategic plan for South Africa, February 2002.

HIV/AIDS/ STDs strategic plan 2007-20011, 31 March 2007.

Hogstel, M. D. and Sayner, N. C. 1986. **Nursing Research: an introduction**. New York: McGraw-Hill Book Co.

Holland, J. Ramazonogli, C. Scott, S. Sharpe, S. and Thomson, R. 1990. **Sex, gender and power: young women sexuality in the shadow of AIDS. Sociology of Health and Illness**. Vol 12. No. 3. pp. 336-348.

Hook, D. and Eagle, A. **Psychopathology and Social Prejudice**. Cape Town: UCT Press 2002.

Huysamen G, K. 1998. **Descriptive Statistics for the Social and Behavioral Sciences.** Pretoria: J.L. van Schaik Publishers.

Kelly, K. 2002. **HIV/AIDS, economic and Governance in South Africa: key issues in understanding response**. A review 2002. Johannesburg: USAID.

Kisseka, M. N. 1990. **Women's mental health in Africa**. New York: Hawarth Press.

Lehohla, P, L. **The Youth of South Africa. Selected findings from Census 96**. Pretoria: Statistics South Africa.

Managing the impact of HIV/AIDS in SADC, August 200.

Mark, R. 1996. **Research made simple. A handbook for Social workers**. Thousands Oaks, London and New Delhi: Sage Publications, Inc.

Markova, P. A. Wilkie, S. A. and Forbes, C. D. 1990. **Self-and-awareness of the risk of HIV in people with haemophilia and implications for behavioral change**. Scotland: Pergamon Press PLC. Vol. 31, no 1. Pp. 73-79.

Mackerrow, N. 1998. **The South African Response to the HIV/AIDS epidemic. An input paper to the report on the elimination of poverty and inequality in South Africa.**

Mckee, N. Bertrend, J. T, AND Becker-Benton, A. 2004. **Strategic Communication in the HIV/AIDS Epidemic**: New Delhi: Sage Publications.

Moore, S. and Rosenthal, D. 1993. **Sexuality in adolescence**. London and New York: Routledge.

Moore, S. Rosenthal, D. and Mitchel, A. 1996. **Youth, AIDS and sexually transmitted diseases**. London and New York: Routledge.

Muller, T.J. 2005. **HIV/AIDS, gender and rural livelihoods in Sub-Saharan Africa.** Nertherlands:Wageningon Academic publishers.

Neuman, W. L. 1997. **Research Methods: Quantitative and Qualitative approaches**. London: Allyn and Bacon.

Neuman, W. L. 2000. **Research Methods: Quantitative and Qualitative approaches**. London: Allyn and Bacon.

Osei-Hwedie, K. 1994. **AIDS, the individual, family and community: Psychosocial issues. Journal of social development in Africa**. Vol. 9. No. 2. 31-43.

Pelser, A.J. Ngwena, C. S. and Summerton, J. V. 2004. **The HIV/AIDS epidemic in South Africa . Trends impacts and policy responses. Heath Care in South Africa.** Pretoria:Van Schaik Publishers, page 276-311

Potgieter, M. A. 1998. **The Social work process. Development to empower people.** Port Elizabeth: Prentice Hall Ltd.

Pretorius, E. 2004. **Complementary /Alternative and traditional health care in South Africa. Heath Care in South Africa.** Pretoria:Van Schaik Publishers, page 507-607.

PRESIDANTIAL AIDS ADVISORY PANEL REPORT. A synthesis of the deliberations by the panel of experts invited by the President of the Republic of South Africa, the Honourable Mr Thabo Mbeki. March 2001

SAIRR (South African Institute of race relations). 2001b. South Africa survey 2001/2002. Johannesburg: SAIRR

Schoepf, B. G. 1992. **AIDS, sex and condoms.** Publishers SA: Gordon and Breach Science.

Simon, Forrest, Director, **Sex Education Forum**, UK & Annabel Kanabus, Director, AVERT, UK1 United Nations Universal Declaration of Human Rights. http://www.un.org/rights/HRToday/

Teljeur, E. 2002. **Response of non-governmental organization, community based organizations and communities. HIV/AIDS, economic and Governance in South Africa: key issues in understanding response**. A review 2002. Johannesburg: USAID. Page 57-67

Tocci, S. 2001. **Sexually transmitted diseases.** New York: Franklin Watts.

Tuckman, B. W. 1997. **Conducting Educational Research.** New York: Harcourt Brace Jovanovieh, Inc.

UNAIDS. HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts and determinants, June 2000. Jenni Fredriksson and Annabel Kanabus

Uthungulu. **Annual Report 2004/2005**

Uthungulu IDP Review 2005

Van Dyk, A. **HIV/AIDS Care & Counselling. A multidisciplinary Approach. Cape Town: Pearsa Education.**

Welman, J. C. and Kruger, S. J. 1999. **Research methodology for the Business and Administrative Science**. Cape Town: international Thomson Publishing LTD.

Welman, J. C. and Kruger, S. J. 2003. **Research methodology for the Business and Administrative Science**. Cape Town: international Thomson Publishing LTD.

Willis, R. 2005. **The AIDS Pandemic. England**: The Stanborough Press LTD.

Winkler, G. 2003. **Courage to Care. A workbook on HIV/AIDS for schools**. Southdale: Catholic institute of education.

APPENDIX A

Topic: Sexually Transmitted Diseases: Dilemmas facing the youth of KwaMbonambi District, in KwaZulu-Natal.

Registrar of participants

Gender: Male/Female

Education: Primary/ Secondary/ Post-matric level

Religion: Christian/ Traditional

Numbers	Gender	Education	Religion
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

I would like to find out your views about sexually transmitted diseases.

Interview schedule

Youth questionnaires

1.Youth perceive themselves to be at risk of sexually transmitted diseases.

Agree	33
Uncertain	2
Disagree	5

2. Youth can be persuaded to change unsafe sex practices that may leave them at risk of contracting sexually transmitted diseases.

Agree	17
Uncertain	0
Disagree	23

3. Many sexually active young people engage in behavior which would to place them at risk of HIV infection.

Agree	33
Uncertain	3
Disagree	4

4. Youth have changed their behavior as a result of STD/ HIV/AIDS.

Agree	16
Uncertain	5
Disagree	19

5. Having sex with people from cities may increase a chance of getting STD/HIV/AIDS.

Agree	27
Uncertain	4
Disagree	9

6. For youth, having sex with people they do not know very well may increase chances of becoming HIV positive.

Agree	35
Uncertain	3
Disagree	2

7. For youth, having sex with prostitutes can lead in getting STD/AIDS.

Agree	29
Uncertain	2
Disagree	9

8. The number of young people with AIDS in the country will increase, if condoms are used on every sexual basis?

Agree	14
Uncertain	5
Disagree	21

9. STD/AIDS is something only homosexuals and drug users; the youth need not to worry about it.

Agree	4
Uncertain	0
Disagree	36

10. To stop the spread of STD/HIV, sex education in schools should be introduced.

Agree	37
Uncertain	0
Disagree	3

11. Young people must be encouraged for "no sex, before marriage."

Agree	35
Uncertain	1
Disagree	4

12. AIDS is a warning from God that levels of sexual behavior in society are too high.

Agree	16
Uncertain	6
Disagree	18

13. If young people live normally, socially and responsibly, problems like AIDS would never arise.

Agree	36
Uncertain	0
Disagree	4

14. The use of a condom during sexual intercourse should be recommended as a safe sex practice in youth to reduce the risk of catching STDs and AIDS.

Agree	36
Uncertain	0
Disagree	4

15. Circumcision may provide young males some protection against STDs which also assists in the prevention of sexual transmission of HIV.

Agree	17
Uncertain	9
Disagree	14

16. Because of AIDS it is better to stick on one sexual partner.

Agree	40
Uncertain	0
Disagree	0

17. It is right to have sex with someone once you have been going out with him or her for a few weeks without the use of condoms.

Agree	3
Uncertain	1
Disagree	36

18. The involvement of different sectors in the struggle against STD and AIDS.

Agree	19
Uncertain	11
Disagree	10

19. If I did get the STD/AIDS virus, it would be because of my behavior.

Agree	30
Uncertain	0
Disagree	10

20. It is unfair to blame women for the spread of STD/AIDS.

Agree	33
Uncertain	1
Disagree	6

21. People with AIDS should be taken away from family members.

Agree	2
Uncertain	0
Disagree	38

22. Traditional healers should be included in campaigns against STD/AIDS.

Agree	37
Uncertain	2
Disagree	1

23. It is immoral to discharge semen in a container.

Agree	20
Uncertain	5
Disagree	15

24. Patterns of sexual behavior in our society would not change quickly enough to avoid further spread of AIDS virus.

Agree	29
Uncertain	6
Disagree	5

25. Condoms are associated with prostitution; in any case, they are used only for extramarital sex.

Agree	16
Uncertain	0
Disagree	24

26. Anyone who has more than one sexual partner runs some risk of catching the AIDS virus.

Agree	29
Uncertain	1
Disagree	10

27. Anyone who knows they have AIDS virus and engages in sexual activity with more than one partner is being irresponsibility.

Agree	36
Uncertain	0
Disagree	4

28. Education on how to avoid catching the STD/HIV/AIDS should be given to societies

Agree	40
Uncertain	0
Disagree	0

29. Africans have continued to consult traditional healers, even when biomedical practitioners are available and free.

Agree	35
Uncertain	1
Disagree	4

31. AIDS programs need the active cooperation of traditional healers in order to treat and prevent STDs.

Agree	35
Uncertain	0
Disagree	5

CONFIRMATION OF INFORMED CONCERNED

I ..... Age: .....

Address: no: SABOKWE PROPOSED TOWNSHIP

KWAMBONAMBI

3915

STATEMENT

I'm, hereby freely declared without any pressure being exerted on me in any way that: I agreed to participate in this study on STD, HIV AND AIDS.

I know and understand the content of the declaration.

I have no objection in taking the prescribed oath.

I consider the prescribed oath as binding on my conscience.

_____

Signature

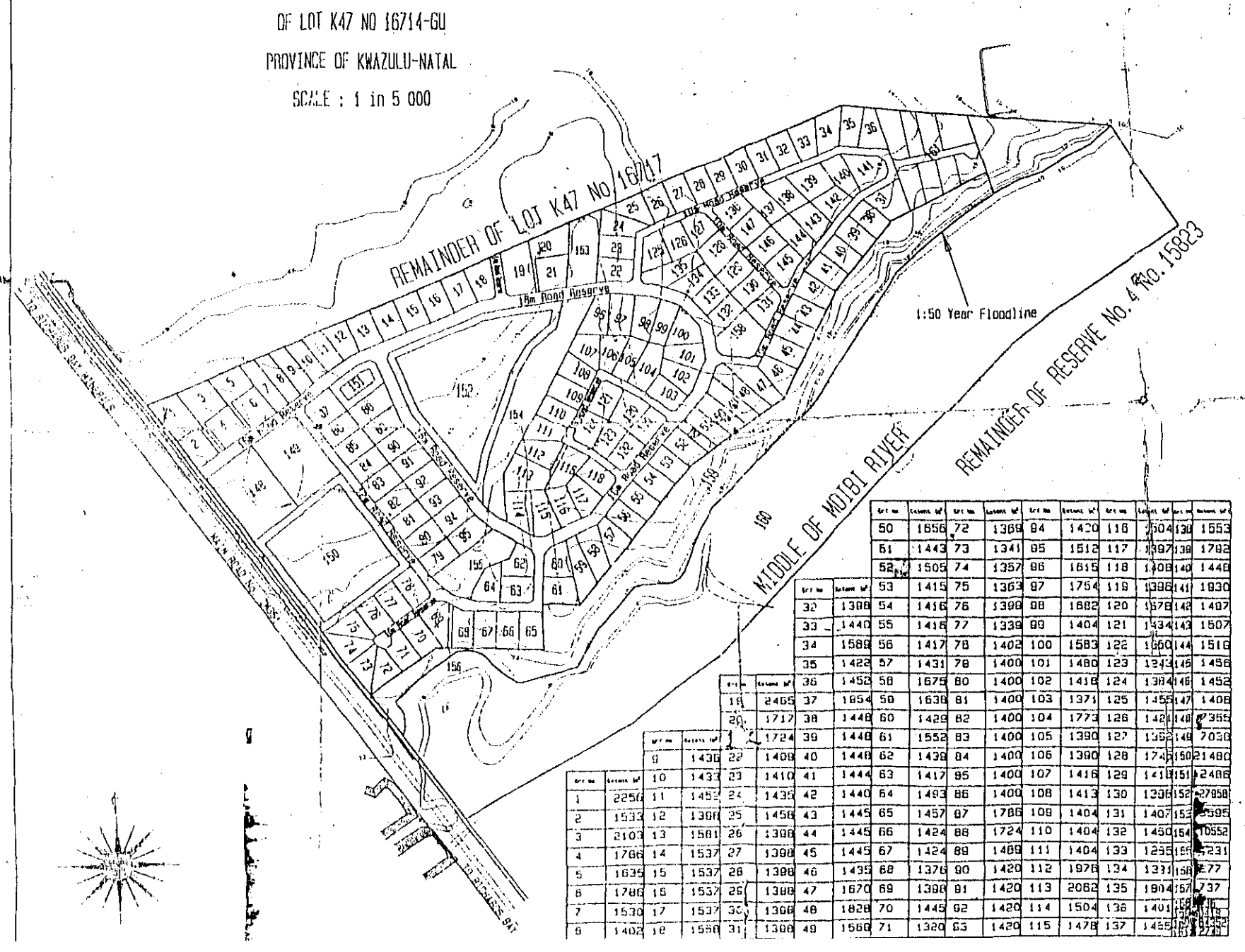
PROPOSED ERVEN 1-161 OF SABOKWE

TOWNSHIP SITUATED ON PORTION 1

OF LOT K47 NO 16714-GU

PROVINCE OF KWAZULU-NATAL

SCALE : 1 in 5 000



Erf no	Extent m²	Erf no	Extent m²	Erf no	Extent m²	Erf no	Extent m²	Erf no	Extent m²
1	2250	37	1954	73	1341	109	1512	145	1397
2	1533	38	1448	74	1357	110	1615	146	1408
3	2103	39	1448	75	1363	111	1754	147	1396
4	1786	40	1448	76	1399	112	1682	148	1578
5	1635	41	1444	77	1339	113	2062	149	1434
6	1786	42	1440	78	1402	114	1504	150	1660
7	1530	43	1445	79	1400	115	1478	151	1343
8	1402	44	1445	80	1400	116	2504	152	27858
9	1436	45	1424	81	1400	117	1597	153	5595
10	1433	46	1424	82	1400	118	1408	154	10552
11	1452	47	1435	83	1400	119	1396	155	5231
12	1398	48	1435	84	1400	120	1578	156	277
13	1581	49	1560	85	1400	121	1434	157	737
14	1537	50	1656	86	1400	122	1660	158	
15	1537	51	1443	87	1400	123	1343	159	
16	1537	52	1505	88	1400	124	1384	160	
17	1537	53	1415	89	1400	125	1455	161	
18	2465	54	1416	90	1400	126	1421		
19	1717	55	1418	91	1400	127	1392		
20	1724	56	1417	92	1400	128	1748		
21	1448	57	1431	93	1400	129	1418		
22	1409	58	1675	94	1400	130	1396		
23	1410	59	1638	95	1400	131	1407		
24	1435	60	1429	96	1400	132	1450		
25	1450	61	1552	97	1400	133	1255		
26	1398	62	1439	98	1400	134	1331		
27	1398	63	1417	99	1400	135	1804		
28	1424	64	1493	100	1400	136	1401		
29	1424	65	1457	101	1400	137	1465		
30	1424	66	1786	102	1416	138	1397		
31	1424	67	1724	103	1371	139	1408		
32	1398	68	1404	104	1773	140	1408		
33	1440	69	1398	105	1390	141	1930		
34	1589	70	1445	106	1400	142	1407		
35	1422	71	1320	107	1416	143	1507		
36	1452	72	1369	108	1404	144	1519		
		73	1341	109	1404	145	1456		
		74	1357	110	1413	146	1452		
		75	1363	111	1400	147	1408		
		76	1399	112	1400	148	2355		
		77	1339	113	1400	149	7036		
		78	1402	114	1400	150	21480		
		79	1400	115	1400	151	12486		
		80	1400	116	1400	152	27858		
		81	1400	117	1400	153	5595		
		82	1400	118	1400	154	10552		
		83	1400	119	1400	155	5231		
		84	1400	120	1400	156	277		
		85	1400	121	1400	157	737		
		86	1400	122	1400	158			
		87	1400	123	1400	159			
		88	1400	124	1400	160			
		89	1400	125	1400	161			
		90	1400	126	1400				
		91	1400	127	1400				
		92	1400	128	1400				
		93	1400	129	1400				
		94	1420	130	1553				
		95	1512	131	1782				
		96	1615	132	1448				
		97	1754	133	1930				
		98	1682	134	1407				
		99	1404	135	1507				
		100	1583	136	1519				
		101	1480	137	1456				
		102	1416	138	1452				
		103	1371	139	1408				
		104	1773	140	2355				
		105	1390	141	7036				
		106	1400	142	21480				
		107	1416	143	12486				
		108	1404	144	27858				
		109	1404	145	5595				
		110	1413	146	10552				
		111	1400	147	5231				
		112	1400	148	277				
		113	1400	149	737				
		114	1400	150					
		115	1400	151					
		116	1400	152					
		117	1400	153					
		118	1400	154					
		119	1400	155					
		120	1400	156					
		121	1400	157					
		122	1400	158					
		123	1400	159					
		124	1400	160					
		125	1400	161					
		126	1400						
		127	1400						
		128	1400						
		129	1400						
		130	1553						
		131	1782						
		132	1448						
		133	1930						
		134	1407						
		135	1507						
		136	1519						
		137	1456						
		138	1452						
		139	1408						
		140	2355						
		141	7036						
		142	21480						
		143	12486						
		144	27858						
		145	5595						
		146	10552						
		147	5231						
		148	277						
		149	737						
		150							
		151							
		152							
		153							
		154							
		155							
		156							
		157							
		158							
		159							
		160							
		161							

NOTES

LAND USE			
DESCRIPTION	NUMBER	EXTENT (ha)	%
RESIDENTIAL	1-147	22.3661	36.4
COMMERCIAL CENTRE	148	0.7356	1.2
COMMUNITY FACILITY	149	0.7029	1.1
PRIVATE OPEN SPACE	150	2.1490	3.5
NURSERY	151	0.2498	0.4
SCHOOL	152	2.7956	4.5
PUBLIC OPEN SPACE	153-158	1.9382	3.2
AGRICULTURE	159	0.5416	0.9
CONSERVATION	160	19.4356	30.0
CEMETERY	161	1.2748	2.1
ROADS		4.8777	8.0
TOTAL		61.4698	100

1. TITLE DEED No. T[illegible]/1996
2. G.S. No. 863/1995
3. ALL MEASUREMENTS ARE APPROXIMATE AND SUBJECT TO FINAL SURVEY
4. AVERAGE STAND DIMENSION 30m x 40.0m (1440m²)
5. MINIMUM STAND SIZE 1440m²
6. CONTOURS AT 1m INTERVALS

THE SETPLAN METROPLAN ASSOCIATION

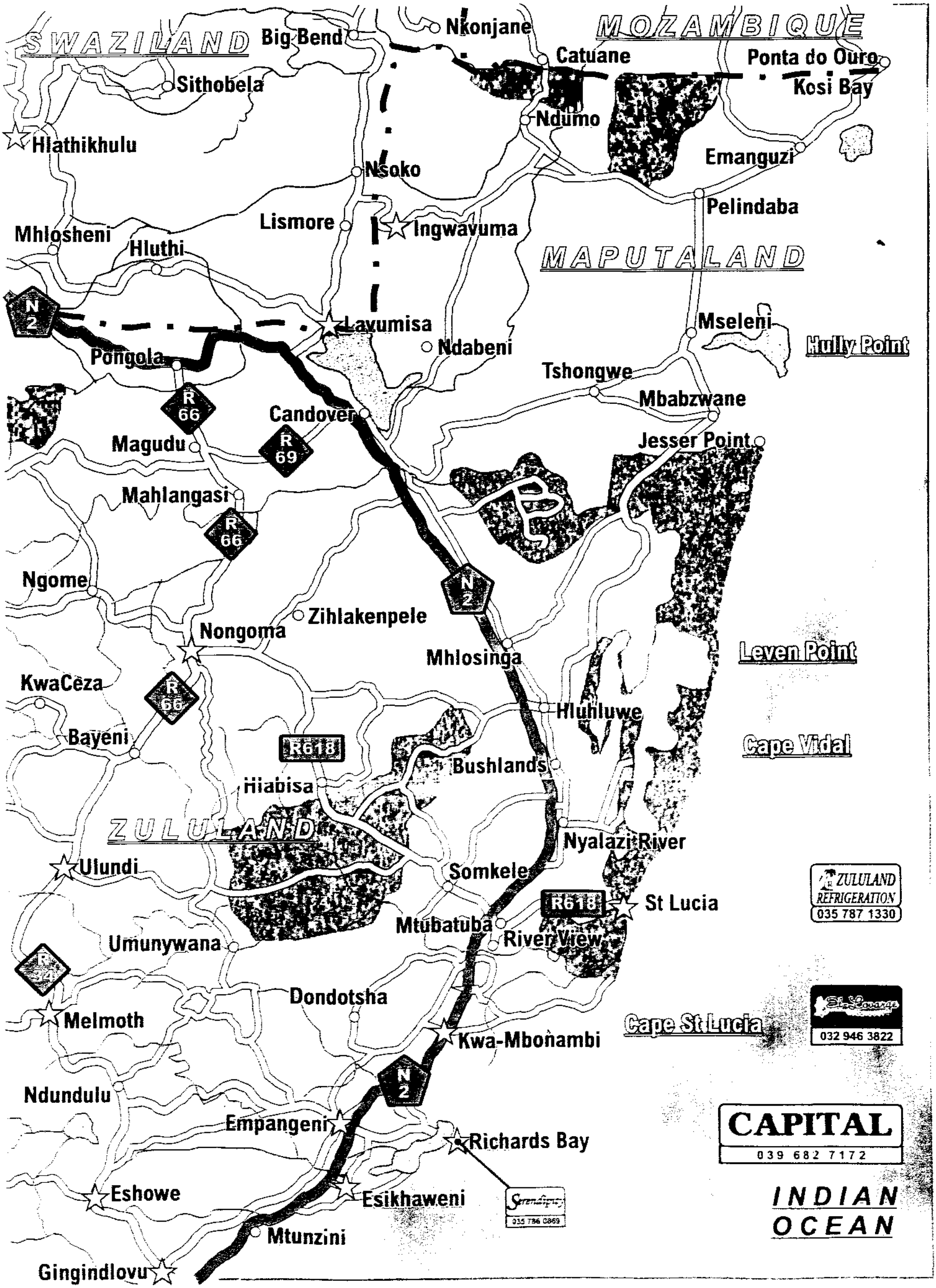
SURVEYED — DRAWN BY
DESIGNED — DATE
CHECKED — DRAWING No.

PROJECT: SABOKWE SUBDIVISION

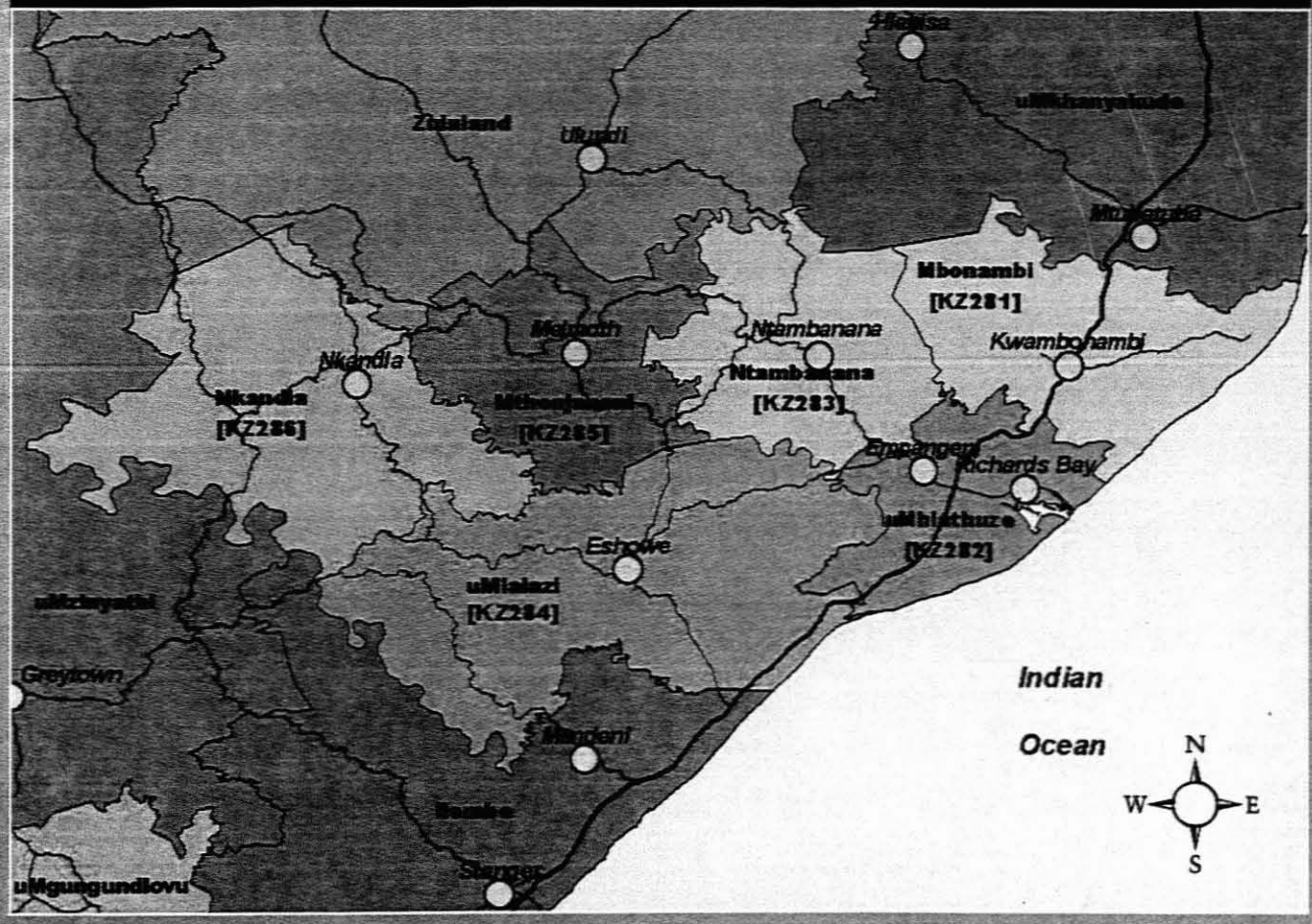
TITLE: PROPOSED PRIVATE RESIDENTIAL TOWNSHIP

SCALE: 1 in 5000 — DATE: MAY 1997

PLAN No: 8066-05-97


SWAZILAND
Big Bend
Nkonjane
MOZAMBIQUE
Catuane
Ponta do Ouro
Kosi Bay
Sithobela
Ndumo
Hlathikhulu
Emanguzi
Nsoko
Pelindaba
Lismore
Ingwavuma
Mhlosheni
Hluthi
MAPUTALAND
N 2
Lavumisa
Mseleni
Ndabeni
Hully Point
Pongola
Tshongwe
R 66
Mbabzwane
Candover
Jesser Point
Magudu
R 69
Mahlangasi
R 66
Ngome
N 2
Zihlakenpele
Nongoma
Mhlosinga
Leven Point
KwaCeza
R 66
Hluhluwe
Bayeni
Cape Vidal
R618
Bushlands
Hlabisa
ZULULAND
Nyalazi River
Ulundi
Somkele
ZULULAND REFRIGERATION
035 787 1330
R618
St Lucia
Mtubatuba
River View
Umunywana
Dondotsha
Melmoth
Cape St Lucia
032 946 3822
Kwa-Mbonambi
N 2
Ndundulu
CAPITAL
039 682 7172
Empangeni
Richards Bay
Eshowe
Esikhaweni
INDIAN OCEAN
Mtunzini
Gingindlovu

The uThungulu District and its six constituent municipalities



The uThungulu District is situated on the east coast of the province of KwaZulu-Natal