EXPLORING SOCIO-ECONOMIC, CULTURAL AND ENVIRONMENTAL FACTORS INFLUENCING YOUNG WOMEN'S VULNERABILITY TO HIV: A STUDY IN SUNNYSIDE (PRETORIA)

by

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DECLARATION

EXPLORING SOCIO-ECONOMIC, CULTURAL AND ENVIRONMENTAL FACTORS INFLUENCING YOUNG WOMEN'S VULNERABILITY TO HIV: A STUDY IN SUNNYSIDE PRETORIA is my own work and all the sources that I have used or quoted have been by means of complete references.

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ABSTRACT

Women face a greater risk of HIV infection worldwide than men. This study explored socio-economic, cultural and environmental factors influencing young women's vulnerability to HIV. A quantitative explorative study was conducted among young women in Sunnyside, Pretoria. A sample of 158 young women in the age group 18 to 24 years from all language groups was randomly selected to participate in this study. The findings showed that poverty, peer pressure and multiple sexual partners were the main factors that influenced young women in Sunnyside's vulnerability to HIV. Behavioural change and social change were recommended as long-term processes, which need to be taken into consideration. Findings from the Sexual Relationship Power Scales show that young women between 18 and 21 years experience physical abuse, emotional abuse, sexual abuse and forced sex in their relationships. The study concluded with specific recommendations for the successful implementation of policy makers and planners to protect women.

KEYWORDS: age-cohort 18-24, environmental factors; exploring; risk-taking behaviour; sexual cleansing; socio-cultural status; socio-economic status; vulnerability.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
CEO	Chief Executive Officer
CBD	Central Business District
CDC	Centre for Disease Control
CARe	Centre for Actuarial Research
CWL	Catholic Women's League
FBO	Faith-based Organisation
HIV	Human immunodeficiency virus
HEAIDS	Higher Education HIV/AIDS Programme
ICAP	International Centre for Alcohol Policies
KYE	Know Your Epidemic
NSP	National Strategic Plan
NGO	Non-governmental Organisation
SADC	Southern Africa Development Community
SANAC	South African National AIDS Council
SSA	Sub-Saharan Africa
SES	Socio-economic Status
Stats SA	Statistics South Africa
SRPS	Sexual Relationship Power Subscale
STIs	Sexually Transmitted Infections
SWAASA	Society for Women & Aids in SA
TMPD	Tshwane Metro Police Department
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
UNGASS	United Nations General Assembly Special Session
USPC	United States Peace Corps
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1

1.1 INTRODUCTION

This study explored and described how socio-economic, cultural and environmental factors influenced young women's vulnerability to HIV in Sunnyside, one of the suburbs of Pretoria. It critically discussed recent reviews of the work published on this topic, was explorative and descriptive in nature and used a quantitative analysis of survey to collect data.

This chapter presents a background to the study undertaken. It outlines and explains the research problem; aims and objectives; the research question; the purpose of the study and the key terms.

It is a well-known fact that globally AIDS-related illnesses are the leading cause of death among women of reproductive age (UNAIDS 2011). This is acknowledged by Michel Sidibe, executive director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) when he comments: "This epidemic unfortunately remains an epidemic of women" (UNAIDS 2011:1). The Global AIDS Response Progress Report 2012, however, states that the number of young females aged 15 to 24 years living with HIV decreased in 2012 (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Lambadarios, Onoya 2014:42). But the South African AIDS Council (SAAC) CEO, Dr Fareed Abdulla (in Child 2014:1), disagrees with the statement and argues that South Africans have underestimated a staggering quarter of all new cases which affect people between 15 and 24 years of age.

Dr Fareed Abdulla continues to explain that hundreds of thousands of young people are still dying from the disease (Child 2014:1). The researcher concurs because it is the youth that are most affected, but since the introduction of antiretroviral treatment (ARV) in South Africa, people who are taking it consistently are surviving , which means ARVs

prolong people's lives but there are still new infections. It is difficult to differentiate between those who are receiving antiretroviral therapy and those who are HIV negative. People who are positive often do not disclose their status because of the stigma that still surrounds HIV/AIDS, and thus it is very easy for them to infect others. This situation further spreads the virus especially if condoms are not used.

There is no evidence that the disease is declining in South Africa. The fact that the number of people living with HIV has increased by 10% since 2008 (Child 2014:1) shows that this disease is still a major concern and that people are still practising unsafe behaviour. The question is: What are the contributing factors that cause this number to increase, considering that people are now knowledgeable about this disease and are taking antiretrovals? This study explored the socio-economic, cultural and environmental risk factors that influence young women's vulnerability to HIV.

The problem of HIV/AIDS among young women has long been an interest of the researcher. In 2002, she completed her research article for her honours degree in gender studies, the title being *Youth and HIV/AIDS exploration of perceptions among schoolgirls in South Africa* (Tlhako 2002). The research participants were young girls in a rural village in Limpopo. The researcher was concerned about their views, and realising that there was a difference between rural and urban life, she had for a long time been concerned about the young people who live in Sunnyside especially young women. She was motivated, therefore, to continue the research on HIV/AIDS in an urban area in Pretoria. Another disconcerting issue was that the young rural girls were still afraid of talking about their sexual life even though some of them were sexually active.

The researcher had been visiting Sunnyside for several years and was concerned about the busy fast life of the suburb. People are on the streets day and night. She became inquisitive about the sociological development of people who lived in this area and asked herself how young women survived in this environment. For the purpose of this re

search, Sunnyside was chosen as a research site because most people who live in the area have migrated there and most of them are young. Young women between the ages of 18 to 24 who reside in Sunnyside were selected to participate in this study. Most of these young women were coming from all language groups and were composed of blacks with a few coloureds, whites and Indians. This research was, therefore, motivated by the realisation that current strategies had failed to harness the spread of HIV/AIDS among women, as they were continually avoiding the all-important issues of human sexual behaviour, socio-economic, cultural, and environmental factors that affected behaviour. As a result, all the above factors played an important role in this study.

This research sought to draw on the existing research knowledge and findings on the risk factors that contribute to young women's vulnerability to HIV/AIDS in an urban area. It also attempted to identify possible measures in order to change young women's sexual behaviour. Such insights formed the backdrop to the data gathering which used a survey approach in which a sample of young women living in Sunnyside, Pretoria, were randomly given questionnaires. It was envisaged that the study would provide an understanding of the risk factors that render young women who live in Sunnyside vulnerable to HIV/AIDS. This was important in designing appropriate and targeted health, social and economic development policies and programmes.

1.2 BACKGROUND OF THE STUDY

HIV/AIDS remains one of the biggest challenges of our times. Globally an estimated 35,3 million people were living with HIV in 2012 (UNAIDS 2013:4).The prevalence of HIV/AIDS remains high among young people in many countries around the world, and a significant proportion of new infections continues to be evident among these young people (UNAIDS 2014:3). According to United Nations Entity for Gender Equality 2013, young women worldwide make up more than 60 per cent of young people living with HIV (UN Women 2014). While in most of the Asian, Eastern European and Latin

American countries, young men constitute the majority of young people who are HIV-positive, (about 62% of the youth), people who are 15 to 24 years old living with HIV/AIDS globally are females (UNAIDS 2013:17).

In sub-Saharan Africa, research has shown that about 57% of young women are more likely to be living with HIV/AIDS than young men (UNAIDS 2013:78). In the South African Development Community (SADC) regions, the HIV burden is still heavy with an estimated 12 million people living with HIV (SADC 2009:9). In the entire SADC region, it is estimated that 53% of those living with HIV/AIDS are women, and it is stated in the SADC HIV and AIDS Strategic Framework 2010-2015 that urban populations are more affected than rural and HIV transmission in these regions is mostly heterosexual (SADC 2009:9) .

High rates of HIV/AIDS in sub-Saharan Africa compelled the Department of Health in South Africa to conduct the National Sentinel Surveillance Surveys of Antenatal clinics (ANC) in 1990. These surveillances showed consistent and increasing figures among pregnant women tested up to 2002 (South Africa, Department. of Health 2011:1). A similar increase was observed between 2002 (9.3%) and 2005 (10.3%) by Shisana *et al.,* (2009:6). Today rates of HIV infection and HIV incidence in South Africa continue to decrease but women continue to be the most vulnerable group (AIDS Guide 2009:134). More women than men are facing death because of HIV/AIDS (Gilbert & Selikow 2011:333).

High rates of HIV infection among young people occur mostly in countries where young people represent a high percentage of the population (UNAIDS 2013). In South Africa, for example, about 51% of the population is below the age of 24 years and the highest HIV infection levels are among youth: an estimated 16.6% of those between 15 and 49 are HIV positive (Statistics South Africa 2010:80). The 2010 South Africa Country Progress Report on the Declaration of Commitment on HIV/AIDS states that infections among South African girls, for example, peak at 25 to 29 years. Among boys they peak

at ages 30 to 34 years. The same report indicates that while the overall HIV prevalence in the country has started to stabilise, the prevalence among the youth, and especially young women is still high (South Africa, Department of Health 2010:11).The country's response to the HIV/AIDS epidemic relies on preventative strategies. Information on modes of transmission, counselling and testing, and the availability of antiretroviral treatment is provided to enable people to identify and avoid risky behaviours that could expose them to infection (South Africa, Department of Health 2010:20).

It is important to have accurate HIV/AIDS knowledge about transmission and prevention in order to avoid HIV infection and the resulting stigma and discrimination of infected and affected persons. Shisana *et al.,* (2014:96) believe that knowledge about HIV transmission among all age groups declined in 2012 compared to that in 2008, except among black African women aged 20 to 34 years. Their rate of knowledge was at 27.6% in 2012, which is still low. Similarly, accurate knowledge about prevention of sexual transmission of HIV among the youth remains low; it declined from 29.4% in 2008 to 28.6% in 2012 (Shisana *et al*., 2014:95). This is below the target set in 2001 by the United Nations General Assembly Special Session (UNGASS) to ensure that 90% of young people aged 15 to 24 years worldwide have comprehensive HIV and AIDS knowledge (UNAIDS 2013:14).

The increased HIV prevalence in this country is associated with a number of factors which include unemployment, poverty, violence against women, cultural limitations that promote intergenerational sex and non-condom use (UNAIDS 2014:9)). Unemployed women who depend on men to survive and match the standard of living especially in urban areas are desperate to secure money or gifts (Tigawalana 2010:3). This creates problems for women because they cannot force men to use condoms while depending on them economically. Rapid urbanisation in South Africa has also presented development challenges leading to deteriorating living conditions and growing urban poverty. Poverty comprises many dimensions. It includes low incomes and the inability to acquire the basic goods and services necessary for survival with dignity as

mentioned before (World Bank 2011). Poverty also encompasses low levels of health and education; poor access to clean water and sanitation; inadequate physical security; lack of voice; and insufficient capacity and opportunity to better one's life (Statistics South Africa 2014). Young people form a large proportion of those moving from rural to urban areas in search of livelihood opportunities and better education. Owing to limited livelihood opportunities and the frustrations of unemployment, many young people in these settings, especially women, turn to risky sexual behaviours.They also seek an outlet in prostitution and drug abuse, both of which expose them to HIV infection (Phetoe 2011).

Other behavioural factors that increase young urban women's risk of HIV infection include having older sexual partners, inconsistent condom use, forced sex, and transactional sex (Ochako, Ulwodi, Njagi, Kinetu & Onyango 2011:2). This situation is aggravated by the low social cohesion that often accompanies rapid urbanisation (Ochako *et al*., 2011:2). Jacob (2012) cited in Barnett and Whiteside (2002:65) assert that the epidemic has the "deepest foundations in the normal social and economic life". This means that HIV/AIDS infection affects people in many ways. The infection affects people's lives through the social, cultural and economic relations among groups of human beings. The basis of HIV/AIDS found in these relations and factors motivated the researcher to continue this study. There is a need to observe, describe and explain the factors that render young women in urban areas vulnerable to HIV/AIDS.

This research attempted to add value and contribute towards the Sunnyside social upliftment programmes that aim to increase the health and education of young people. The next section describes the location of the study.

1.3 LOCATION OF STUDY

The Sunnyside area in Pretoria was chosen as a research site because of its youthful population (a high student population) and because it mimics many urban areas in greater South Africa where unemployment is high. Sunnyside is probably the busiest

suburb of Pretoria. It is within walking distance of the Pretoria city centre. In Sunnyside, the majority of households live in flats and their dwellings are close to work areas, good public transport, and other facilities. The major shopping centre is Sunny Park, which was opened in 1970.

Most young people move to this area because they are close to amenities such as schools, hospitals, the city centre and two universities: University of Pretoria and University of South Africa. There is one police station: the Sunnyside Police Station. There are also a few churches such as the Church of Jesus Christ of Latter Day Saints in Leyds Street and the United Apostolic Faith Church in Colliers Street. The nearest services which offer counselling for HIV/AIDS are the Catholic Women's League (CWL) which provides counselling for people who reside in Sunnyside only and the Society for Women & Aids in SA (SWAASA). The last one is the United States Peace Corps that works with civil society and community-based organisations and collaborates with government departments such as the Department of Social Development to improve the lives of people infected with and affected by HIV and AIDS.

1.4 STATEMENT OF THE PROBLEM

The central research problem of the study was to explore the socio-economic, socio-cultural and environmental factors that could influence young women's vulnerability to HIV infection. The problem dealt with an explorative quantitative approach working with young women living in Sunnyside. The details of selecting these young women are explained in chapter 3.

The South African government tried to commit itself to the United Nations Millennium Declaration 2000; the United Nations Declarations of Commitment on HIV Global crisis - Global actions 2001, 2006; the United Nations Political Declaration on HIV/AIDS from 2011 to 2015; UNAIDS Global Report on the global AIDS epidemic 2013 (UNAIDS 2013). According to these declarations, gains were made towards many of the 2015

targets and elimination commitments, but there are still challenges that remain. One of the challenges faced by the UNAIDS Global Report on the global AIDS epidemic 2013 declaration was to eliminate gender inequalities and gender-based violence and increase the capacity of women and girls to protect themselves from HIV (UNAIDS 2013:7). To achieve this, women and girls need attention because they are the most vulnerable and unattended group.

The HIV/AIDS prevention strategies continue to be explored in order to achieve the target action of the United Nations Political Declaration on HIV/AIDS 2011. One of the biggest prevention priorities for South Africa was to reduce new infections among young women and girls between the ages of 15 and 24 (South Africa, National AIDS Council 2011:26). In order to achieve this, more information is needed to understand the underlying factors that increase young women's vulnerability to HIV infection, especially in urban areas. The concern is the reasons for risky behaviour frequently continued among young people despite population awareness of its negative health consequences. Why are young women still the most vulnerable group for HIV/AIDS infection even though the rate of HIV infection has been reduced in South Africa? This research provides a case study of an urban suburb of Pretoria, the Sunnyside suburb, and focuses attention on a section of young women living there.

1.5 RATIONALE

This study addressed the barrier to safe sexual behaviour among young women in Sunnyside, considering socio-economic, socio-cultural and environmental factors affecting their vulnerability to HIV. The study also identified possible measures to change young women's behaviour and assist HIV/AIDS policy makers and planners regarding urban living. It will also serve as a theoretical model for future studies of the same nature if the existing problem continues. The researcher supported this by using the theory of gender and power.

The HIV/AIDS pandemic was articulated by different international meetings with numerous frameworks and protocols for HIV/AIDS. South Africa participated in the meetings and agreed to achieve the goals of these protocols. The government developed the National Strategic Plan (NSP) 2000-2005 as amended by the NSP 2007-2011 to reduce the number of new HIV infections by 50% with a particular emphasis on reducing new infections in the 15- to 24-year-old age group (South Africa, Department of Health 2011:29). Among others, one of the NSP's concerns was to focus on human rights and protect individuals against discrimination. These specifically include provisions for vulnerable populations including the aged, women and the youth (South Africa, Department of Health 2011:53).

The Know Your Epidemic (KYE) report highlights the areas in which the epidemic seems to be concentrated, and some of the major risk factors for HIV infection. Among others is HIV prevalence that is significantly higher in the African black population than in the other race groups (UNAIDS 2011). Young women aged 15 years and above are significantly more likely to be HIV positive than men of the same age. Young women between the ages of 20 and 24 are four times more likely than males of the same age to be infected with HIV (UNAIDS 2011:25). The difference is even higher in teenage girls compared with teenage boys (South Africa, Department of Health 2011:18).

Programmatic experience shows that successful HIV/AIDS prevention requires a comprehensive focus not only on risk-taking behaviours, but also on the environmental and societal factors that influence such actions (UNAIDS 2013:11). Therefore, the purpose of the study was to provide an understanding of and information on the risk factors that render young women who live in Sunnyside vulnerable to HIV/AIDS.

1.6 THE AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to describe the socio-economic, socio-cultural and environmental risk factors that influence young women's vulnerability to HIV infection in an urban setting.

1.6.1 The objectives of the study

From the aim described above, the following specific objectives were derived:

- To describe the socio-economic, cultural and environmental factors that influence young women between the ages of 18 and 24 years who are vulnerable to HIV infection at Sunnyside
- To understand and explain the socio-cultural factors that influence young women's vulnerability to HIV infection
- To explain how all these factors affect young women in Sunnyside
- To find possible measures for changing young women's behaviours

1.7 RESEARCH QUESTIONS

In order to achieve the objectives, the following research questions guided this study:

- What are the socio-economic, cultural and environmental factors that tend to increase the risk of vulnerability and susceptibility to HIV infections among young women between the ages of 18 and 24 years?
- What are the socio-cultural factors that influence young women's vulnerability to HIV infection?
- How do all these factors affect young women in Sunnyside?
- What are possible measures for changing young women's behaviour in Sunnyside?

1.8 LIMITATIONS

The study was limited in that it did not manage to investigate every woman living in Sunnyside. Only young women between 18 and 24 years were randomly given the questionnaires. This created a problem because most of the participants were older than 24. As there were often older women and men living with these young women, they also expected to be given questionnaires but because of the sensitivity of the questionnaire, the study was limited to young women who were between 18 and 24 years of age.

1.9 RESEARCH METHODOLOGY

This study is explorative and descriptive in nature as the researcher endeavoured to understand, from the point of view of young women living in Sunnyside, the factors that influenced their vulnerability to HIV. A quantitative method was used to collect data and describe the socio-cultural, economic, environmental, and individual factors that rendered young women susceptible to HIV/AIDS in Sunnyside. The methodology is discussed in more detail in chapter 3.

1.10 DEFINITIONS OF KEY TERMS

Age cohort 18-24 falls under the age group 18 to 25, which is referred to by Arnett (2000) in his theory of development as “emerging adulthood”. This is neither adolescence nor young adulthood. This is the age of identity explorations that is a period of life when people are moving toward making crucial choices in love and work, based on their judgement of their interests and preferences (Arnett, Zukauskiene & Sugimura 2014:569).

Environmental factors are known characteristics in an environment that affect the survival, operations, and growth of an organisation.

The identifiable elements exist as physical, cultural, demographic, economic, political, regulatory or technological characteristics as mentioned before (Law Dictionary 2014).

Exploring means to examine or investigate a subject or idea carefully (Oxford Dictionary 2012). In this study, the term involves familiarising a researcher with a topic.

Risk-taking behaviour refers to the tendencies that force you to engage in behaviours that have the potential to be harmful or dangerous, yet at the same time provide the opportunity for some kind of outcome that can be perceived as positive (Tull 2009).

Sexual cleansing refers to cleansing rituals involving a sexual act, which is believed to purify the recipient through the semen entering the woman's body (Malache & Day 2011:6). The practice is common for widows. It is also known as widow cleansing in which custom dictates that a widow must undergo a cleansing ritual after the death of her husband (Bond 2011:29).

Socio-cultural refers to knowledge and values shared by society considering a population's characteristics including lifestyles and beliefs as essential references to the creation of action plans (Nyoni 2008:24).

Socio-economic status (SES) refers to a combination of factors including income, level of education and occupation. It is a way of looking at how individuals or families fit into society using economic and social measures to impact an individual's health and well-being (Boskey 2014).

Vulnerability refers to the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment which are beyond the control of a person or particular social group (UNAIDS 2011:30).

1.11 OUTLINE OF CHAPTERS

The next section comprises of the review of all the chapters in order to familiarise the reader with the structure of the dissertation.

Chapter 1 Introduction and background

The first chapter focuses on the introduction and background pertaining to the overview of HIV in South Africa and the gap that still exists caused by socio-economic, socio-cultural and environmental factors influencing young women's vulnerability to HIV/AIDS.

Chapter 2: Literature review

This chapter provides a broad comprehensive, in-depth systematic and critical analysis of the available literature and identifies the gaps in the literature in relation to the title. It provides the information of the risk factors that influence young women's vulnerability to HIV infection. Discussion of theories is also provided in this chapter.

Chapter 3: Research methodology

This chapter outlines the research methodology adopted for this study and looks at why those particular research methodological techniques were followed. It also examines how data was gathered using the identified research tools and how the areas of study were selected. Information is also provided on data analysis and interpretation.

Chapter 4: Study results summary

In this chapter, a discussion of the findings derived from the data collected as well as a description of the statistical methods used to analyse the data is presented. The results of the study are summarised, evaluated, interpreted and discussed in accordance with the research questions.

Chapter 5: Conclusion and recommendation

Chapter 5 summarises all the chapters and provides conclusions and recommendations. The strength of the study, challenges, and limitations of the study are highlighted, while suggestions for further research are given for policy makers and planners.

1.12 CONCLUSION

In this chapter, issues pertaining to socio-economic, socio-cultural, and environmental factors influencing women's vulnerability to HIV/AIDS were introduced and background information was provided. The research problem, the rationale of the study, the aims and objectives of the study and the research question were articulated. The chosen study site, definitions of key terms used throughout this dissertation, the limitations and the research methodology were also provided. The next chapter is the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents an overview of the AIDS epidemic in the world, particularly in sub-Saharan Africa and the South African Development Community (SADC) countries. The South African AIDS epidemic is discussed in relation to the vulnerability of women to HIV/AIDS regarding socio-economic, socio-cultural, environmental, and other factors that impede behavioural change. Gender inequality that results in women participating in risky sexual behaviour and the theories of gender and power implicated in changing this are discussed below.

2.2 WOMEN'S VULNERABILITY TO HIV/AIDS

Women's vulnerability to HIV/AIDS means that more women than men are now HIV positive (Ramjee & Daniels 2013). Globally women comprise 52% of all people living with HIV/AIDS (UNAIDS 2013:78). Around the world, the epidemic is growing fast because of the context of profound gender, class and other inequalities coupled with systems and policies that do not address the needs of young women (UNAIDS 2014:1). The high rate of HIV/AIDS among women started long ago. The World Health Organization (2015) emphasises that it takes ten years from becoming infected with HIV to the development of AIDS. Abdool Karim and Abdool Karim (2010:287) argue: "Women acquire HIV infection at least five to ten years earlier than men". This means that if one examines the people who have AIDS now, one can arrive at the answer of the people who were infected ten years ago. These are mainly women.

HIV/AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of transmission (Kalibala & Mulenga 2011:20). In sub-Saharan Africa, research reveals that about 68% of young women are more likely than young men to be

living with HIV/AIDS (UNAIDS 2013:5). The rate of HIV/AIDS is alarming among young women. A recent nationally representative survey in South Africa found that HIV prevalence was rated 11.4% in young women aged 15 to 24 compared with 2.9% among men (Shisana *et al.,* 2014:42). Approximately 17% of South African women in their reproductive years are HIV positive (Statistics South Africa 2013:2).The above fact is supported by Cullinan (2012:2) who states that the "faces of those newly infected with HIV/AIDS are more often the faces of women and girls".

The South African government through the Department of Health tried to use the National Antenatal HIV and Syphilis Prevalence Surveys as one of the epidemiological tools to monitor the epidemic trend. This survey has been conducted annually since 1990 and reveals that about one quarter of all pregnant women attending antenatal services nationally are HIV infected (South Africa, Department. of Health 2011). The survey provides evidence that South African women are at a high risk of contracting the HIV virus for a number of reasons including gender inequality, high geographic mobility and extensive migrant labour (South Africa, Department. of Health 2011).

. 2.3 DEFINITION OF YOUNG PEOPLE AND THEIR VIEWS ON HIV/AIDS

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This section briefly discusses the definition of "young people" as they represent young women and their rate of infection and the factors that influence young women's vulnerability to HIV. According to the United Nations for statistical purpose, "young people" refers to individuals aged 15 to 24, while "adolescents" are defined as persons between the ages of 10 to 19 (UNAIDS 2013:3). The South African national definition regards persons aged 15 to 34 years as "youth" (Statistics South Africa 2015:4). Youth is the transition between childhood and adulthood (Dekeke & Sandy 2014:1). According to Erikson's developmental stages (1980) this is the stage of recovery in which young adulthood (the 20s) is portrayed as a period of intimacy versus isolation during which people find new friendships and sexual partnerships. People tend to seek companions and also begin to settle down and start families. Young adults seek deep intimacy and

satisfying relationships but if unsuccessful, isolation may occur (Vogel-Scibilia, McNulty, Baxter, Miller, Dine & Frese 2009:412). For the purpose of this study, the researcher used the term “young people” to refer to both groupings.

The researcher chose the age cohort of 18 to 24 years because adolescence and youth have been acknowledged as times of great psychological, physical and social change at the individual level (UNAIDS 2013:6). It is also regarded as a period when behaviours and perceptions of risk, illness and health are shaped in relation to parents, peers and the wider community (UNAIDS 2013:6). The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) identified young people aged 15 to 24 as a priority group in reducing new HIV infections and set a global target of reducing the incidence of HIV in this group by 20% by 2015 (AIDS Guide 2009:134).

Studies in South Africa and other sub-Saharan African countries show that young people often perceive their risk of HIV/AIDS to be low, even if they engage in HIV/AIDS risk behaviours and live in areas with high HIV prevalence rates (Shisana *et al*., 2014:87). This may be because the young people are still at the stage of adolescence and are ignorant of the dangers that may occur. This developmental period is the most dangerous period because it may promote a sexuality behaviour that enhances vulnerability and makes them the best group for new infections. Young people are also regarded as a group whose mainly sexual behaviour is often regarded as premature if not immature; and whose own ideas, experiences, and concerns about sexuality are mostly neglected by society (UNAIDS 2013:4). This group needs to be given much attention in society as they are still influenced by peer group pressure.

According to the report from the Prime Minister Chief Science advisor in 2011, adolescence is defined as the period that extends from entry into puberty until the individual is fully accepted as an adult in the particular societal context. Research shows that peer pressure, socio-cultural norms and expectations influence the process of adolescence enormously (Simons-Morton & Farhat 2012:4). Adolescence is a stage

that needs a great deal of monitoring especially from parents and older people, but because of circumstances such as migration and urbanisation forced by education and employment, parents are frequently unable to live with their children.

In most of the Asian, Eastern European and Latin-American countries, young men constitute the majority of young people who are HIV-positive and the virus is confined to homosexual sexual networks (UNAIDS 2013:22). However, the majority of persons who are 15 to 24 years old living with HIV/AIDS globally are females (UNAIDS 2013). In South Africa, a survey conducted in 2010 indicated that HIV/AIDS infection among pregnant women was the highest in KwaZulu Natal province at 39.5%, followed by Mpumalanga with 35.1%, Free State 30.6% and Gauteng 30.4% (South Africa, Department of Health 2011). Since the arrival of HIV/AIDS in South Africa 1983, the heterosexual HIV epidemic has had a different character and exposure (Ramjee & Daniels 2013:1). It has spread with no sign of diminishing and is more powerful in younger women. This is still a problem, creating a gap that must be researched.

Many studies such as those of Ramjee and Daniels (2013) and Abdool Karim & Abdool Karim (2010) have been carried out in different parts of the world in the area of socio-economic, socio-cultural and environmental factors that influence young women's vulnerability to HIV/AIDS. The South African National HIV Prevalence, Incidence and Behaviour Survey 2012 identifies that there is a high rate of HIV infection among young people in South Africa because of their social behaviour (Shisana *et al.,* 2014:65). This has led to the South African youth gaining a reputation for being one of the highest risk groups for HIV/AIDS in the world. The writer concludes that there is a need to set a research that takes a wider view, one that analyses the normative social, cultural and economic influences that are shaping young people's sexual desires and experiences in rapidly changing communities. The researcher concurs with this survey because although HIV messages have been conveyed to young people in South Africa through the media such as television, radio, billboards and at the clinics and prevention methods have been spread through the distribution of condoms and abstinence, there is still a

high rate of HIV infection among youth because of social behaviour that reflects poor socio-economic factors. The following headings elaborate on the factors that predispose women to HIV infection

2.4 ECONOMIC FACTORS

2.4.1 Poverty

Poverty refers to standards of living and the quality of life; it means a day-to-day struggle for life in which individuals may be unable to afford basic human needs such as food, water, clothing, shelter and health care (Shisana *et al.,* 2014:23). Poverty has many dimensions that include lack of income; lack of education; environmental degradation; and gender inequality (World Bank 2011). One of the challenges faced by communities in urban areas is tackling issues like poverty that increase vulnerability to HIV/AIDS especially among young women because of their demand for high standards of living.

Poverty and lack of parental resources are cited as primary reasons for young women to trade sex for goods or favours or to engage in relationships that involve financial support (Mutinta 2014:153). The views of young women in Sunnyside on their experiences and perceptions of living in an urban area away from parental support were important for this study. It was also important to understand how they dealt with the lack of basic needs in an urban setting. The more confounding factor was that they might be living without adult supervision for the first time in their lives. Such circumstances together with peer group pressure might influence young women to be highly vulnerable to HIV/AIDS.

Some of the young women might also engage in commercial sex. Hove, Gwerume and Muchemwa (2013:6) agree that commercial sex exists in urban settings in order for the women to avoid poverty. In a study of multiple sexual partnership at the University of Kwazulu-Natal, 13% of students declared that poverty influenced their attitude to sexual

intercourse, but they did not explain whether they were involved in commercial sex or not (Mutinta 2014:153).

The study conducted by Thurlow, George and Gow (2009:22) also demonstrates that poverty and unemployment tend to increase the risk of HIV infection among the poor. This is due to poverty-related factors such as financial dependence on partners, as it is evident that women who receive money from their partners are more likely not to use condoms because their partners disapprove (Gilbert & Selikow 2011:329). Naidoo (2008:1) concurs with Thurlow *et al*., (2009:22) in her study conducted in the Winterveld, north of Pretoria, an informal settlement area regarded as densely populated, infrastructurally underdeveloped and extremely poverty ridden. The study highlights factors that compel women to use sex to fight poverty.

The study of Gender and HIV/AIDS in South Africa by Gilbert & Selikow (2011:329) states that for women and mostly unmarried women, sexuality is conceptualised as a resource that can be drawn upon for material or economic advantage. This means that sex may be used to secure a job or to acquire material benefits of various kinds from men. The writer regards this as sexual economy, which may be operated on a scale of benefits. It ranges from trading by women of sexual favours in order to secure basic needs such as food, school fees and rent as well as expensive fashion accessories (for example, clothes). This is not the right way for women to survive. Women must be empowered to be able to work for themselves. This is explained at the end of this chapter by means of the theory of gender and power.

Hajizadeh, Sia, Heymann and Nandi (2014**)** conducted a recent study that attempts to address these issues and examines the relationships among socio-economic status risk factors for HIV infection and HIV status in an urban population with high HIV prevalence in 24 sub-Saharan African (SSA) countries. The authors disaggregate the analysis by age, gender and marital status, using a socio-economic status (SES) measure. They consider that risk of infection indeed differs among these three dimensions and that new

infections may be occurring fastest among young women of lowest socio-economic status.

2.4.2 Inter-generational sex

Inter-generational sex means the practice of age mixing, for example, young women having sex with older males (Shisana *et al*., 2009:2). The international Centre for Alcohol policies (ICAP) (2015:24) reports that relationships between individuals from high risk and from low risk groups (mixing of risk groups) are another driving force of the HIV epidemic. The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2012) also supports the above statement that in South Africa the practice of age mixing or intergenerational sex particularly among young females who have sexual relationships with older males, has been identified as a factor contributing to the spread of HIV (Shisana *et al*., 2014). The same report also indicates that younger people who report having collaborates who are five or more years older than they are have increased, reaching a high rate of 33.6% in 2012.

Nowadays in South African townships and suburbs, older women have sexual relationships with younger males, who are 5 to 10 years younger than they are. They call them “Ben10” and give these young men cars, money and expensive clothes. As a result, this phenomenon of age difference has become popular. Formerly only men practised it by dating young girls; nowadays women have joined them. In one of his speeches on the 14th March 2013 in Mpumalanga province, the Minister of Health, Dr Aaron Motsoaledi, condemned the situation in which South African men act as “sugar daddies” to young girls in order to exploit them sexually (Motsoaledi 2013). He concluded that this would lead to high HIV infection rates. The researcher concurs with him because most of these sugar daddies are married and they infect these young girls with sexual diseases.

Shisana *et al.,* (2009:2) in the South African National HIV, Prevalence, Incidence, Behaviour and Communication Survey (2008) found that 26.7% of females had sexual partners who were five years older than they were. High-risk intergenerational sex may also occur when older men, who know they are infected with HIV, seek unprotected sex with younger women or children. In South Africa there is also a belief that having sex with a virgin is a cure for HIV (Bond 2011:19). Studies such as Transactional Sex amongst Young people (Wamoyi, Wight, Plummer, Mshana & Ross 2010:1) in parts of Africa reveal that older men often help young women's families to meet essential needs such as school fees, transport costs and groceries.

Research on intergenerational sex shows that in all instances in which intergenerational sex is practised, the act is associated with power imbalances, no condom use, manipulation, poverty and the need for economic survival, unemployment and low educational standards (Wamoyi *et al.,* 2010:7). The researcher of this study supports this statement because if a woman can fall in love with an older man who gives her money, there is no way that she is going to force him to use a condom. She will be afraid that he will go away and find someone else and consequently he will usually manipulate her. Many women nowadays desire and compete for material things in order to survive this competitive life. This leads to a situation in which women need partners who can provide all the things they want even if they do not love them (Gilbert & Selikow 2011:329). As a result, this contributes to the social risk behaviour that is discussed in the next section.

2.5 SOCIAL FACTORS

2.5.1 Sexual coercion

Social factors that lead to sexual coercion may be defined as forced sex or rape (World Health Organization [WHO] 2012:1). Sexual violence is any sexual attempt to give unwanted sexual comment, obtain a sexual act, or to traffic against a person's sexuality

using coercion (WHO 2012:149). In South Africa, one of the countries in which the epidemic has increased at the fastest rate, a significant increase in the rape and sexual abuse of girls and women has been reported. For example, interviews conducted in Gauteng in 2010 by Gender Links and the Medical Research Council found that almost one in 12 women had been raped in 2009 (Vetten 2014:3). This shows the extent that South African women are suffering and not being safe in the environment they live in.

Stuijt (2009) acknowledges that rape experts in South Africa believe that about 500,000 rapes occur each year and that this statistic is higher than the rape cases reported to the South African police service. In other words, some of the rape cases are unreported to the police. Cases of rape are unreported in South Africa especially among black people as often the perpetrator is an uncle or cousin (Vetten 2014:3). The families hide this problem and just keep quiet because they do not want the perpetrator to go to jail.

Jewkes in her study (Rape and HIV 2009) argues that it is very difficult to stop rape in South Africa because this country has a patriarchal society. She explains that the intersections of the epidemics of HIV/AIDS and gender-based violence are deeply rooted in the country's gender hierarchy and the dominant construction of South African masculinities around the control of women. The researcher of this study supports Jewkes's statement as men in South Africa are still in control of everything. They are regarded as the heads of the family and have all the power from birth. As a result, it is difficult to find solutions for rape, because women do not have power and are still vulnerable to sexual abuse. The researcher's concern is the consequences of rape for the HIV epidemic.

Some researchers attribute the increase in rape among young women to a belief that has gained credence in some communities that sexual intercourse with a virgin can cleanse a man of HIV or AIDS (Bond 2011:19). These social disorders or anarchy render females, especially young women, susceptible to HIV infections. This has created problems in South Africa as young children are raped every day. A case was

reported on the 28th November 2013 in Northern Cape, Galeshewe Kimberley, in which a man aged 24 raped a 6-week-old baby (News 24 2013). Young women who are inexperienced and in a new environment away from parental guidance and control can be raped or forced into unwanted sex. In Lima, Peru, for instance, WHO (2012:3) documented that the number of young women reporting forced sexual initiation (40%) was four times greater than for men (11%). The study conducted by community-based organisations in Botswana, Namibia, South Africa and Zimbabwe found that 6.6% of women have had an experience of forced sex against their wishes and many viewed sexual coercion as a routine part of a relationship (Vetten 2014:4).

Nowadays there is growing evidence that shows the link between gender-based violence (GBV) and the spread of HIV. Gender-based violence refers to offences committed against a non-consenting person based on normative beliefs about gender (Chiu, Blakenship, Burris 2011:1).

Studies conducted by Chiu *et al*., (2011:3) maintain that there are four mechanisms linking HIV and gender-based violence:

- Violence can increase the risk of HIV infection when a woman is forced to have sexual intercourse.
- Violence may mean that a woman is less able to negotiate the use of preventive measures such as condoms.
- Links have been found between physical and sexual abuse during childhood and high levels of risk-taking behaviour in adolescence and adulthood.
- Women who are infected and disclose their HIV status may be at risk of violence.

As a result, violence is thus both a determinant and potential consequence of HIV infection. In South Africa, women are killed on a daily basis because of violence. There were two cases in the South African High court (April 2014) in which women were killed, and their partners were involved. The environment of our society is no longer a safe place for women because they are victims of violence. Another aspect of sexual

violence in South Africa is gang rape. Woodhams, Cooke, Harkins and Da Silva (2012:729) define gang or group rape as a rape in which one or more victims are subjected against their consent to sexual intercourse with two or more offenders. The study of Violence Against Women in Cape Town, South Africa acknowledges that gang rape is often planned by a group of men or friends (Sawyer-Kurian, Wechsberg & Luseno 2009:20). This violence against women is one of the contributing factors to sexual behaviour and HIV/AIDS. This is discussed in the next section.

2.5.2 Sexual behaviour

According to Abdool Karim and Abdool Karim (2010:311), sexual behaviour describes a set of behaviours and practices that define sexual risk for HIV, and which take into account partnership and sexual networking. Sexual behaviour is described as one of the factors that increase HIV infection among young people. It is the behaviour that puts most females including young women at risk of HIV infection. Shisana *et al*., (2014:115) in their South African National HIV Survey (2012) conclude that it is important to understand the behavioural dynamics driving HIV epidemics in South Africa among the youth because they are considered a highly vulnerable group.

Studies on sexual behaviour among South African youth also reveal the tendency among young people to engage in high risk sexual practices, for example, by having multiple sexual partners and engaging in unprotected sexual intercourse (Mutinta 2014:152). Multiple sexual partnerships and polygamy also contribute to the spread of HIV/AIDS especially in African countries (Mutinta 2014:148). This author further states that there is enough evidence that young people engage with multiple sexual partners. Studies of young people in South Africa such as that of Factors Influencing Sexual Risk Behaviours by Dekeke & Sandy (2014:5) indicate that the lifestyle of having multiple sexual partners is a common phenomenon in a segment of the population. Multiple sexual partnerships were previously practised by young men in their efforts to secure

more women and the men were called “isoka” in Zulu, which means “womaniser” (Aggleton, Parker & Thomas 2015:38).

Aggleton *et al*., (2015:39) assert that even though traditional informal polygamy has declined, multiple partnerships for men continue, and men still consider one legitimate wife and multiple sexual partners as acceptable. Many young people still follow the tradition of polygamy in a different way as they are involved in multiple relationships without fearing the outcome of infection, which may occur. Shisana *et al*., (2009:41) assert that where people or groups are linked in sexual networks, a new infection has the potential to move rapidly as a product of high viral load. Mutinta (2014:148) refers to sexual networks as a set of people who are linked directly or indirectly through sexual contact; every partner one has ever had. The pattern of linkages can negatively influence health outcomes in a population such as the transmission of HIV and other STIs.

The ICAP Blue Book (2012:24.9) maintains that the tendency to have multiple sexual partners is a factor that is encouraged by poor economic situations in developing countries. Maintaining relationships with more than one partner concurrently is viewed as a modern activity as women are also practising it nowadays. Similarly, concurrent sexual partnerships (defined as having two or more partnerships that overlap in time) has been identified as a driver in the spread of HIV (Xu, Luke, Zulu 2009:1). The study of Measuring Concurrent Sexual Partnership argues that once a concurrent partner acquires infection, transmission to a third person can occur without the delay involved in completing the first partnership and beginning the next (USAIDS 2012:18).

In the survey conducted by the Higher Education HIV and AIDS Programme (HEAIDS), Higher Education Sector Study in South Africa 2008-2009, it was found that 19% of male students and 6% of female students reported that they had had more than one partner in the past month (Higher Education HIV & AIDS Programme 2009). Studies also show that the sexual behaviour of friends (peer group pressure) influences young

people's own sexual behaviour (Dekeke *et al*., 2014:4). For example, when adolescents believe that their peers think unprotected sex is not risky, they are more likely to have unprotected sex as well.

2.6 SOCIO-CULTURAL CONSTRUCTION OF GENDER

Nyoni (2008) describes "socio-cultural" as the knowledge and values shared by a society, considering a population's characteristics including lifestyles and beliefs as essential references to the creation of action plans. WHO (2015:17) defines "gender" as commonly shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles. Rabe (2014:561) argues that gender is a social construction of what it means to be male or female. She continues to emphasise that the social and cultural constructs differentiating women from men define the way they interact with each other, and the different expectations that they have in relation to their sexual conduct (Rabe 2014:157).

In their study, Farrar and Mc Gilvray (2009:6) reveal that sexual relationships are negotiated within a context in which dominant social norms and masculinity portray young men as macho and conquering heroes in the sexual arena. Rakgoasi and Odimegwu (2013) support the above statement in their study of Masculinities and HIV/AIDS in Botswana. They observed that traditionally men enjoy higher socio-cultural status compared with women and as a result they dominate decision-making in the home and private consensual relationship (Rakgoasi & Odimegwu 2013:167). Farrar and McGilvray (2009:6) also acknowledge that the social construction of femininity predisposes women to use the responses of passivity or fruitless resistance in the face of male advances. For example, it is socially acceptable that men must initiate and control sexual interactions and decision making, which has implications for women's vulnerability to HIV infection. This construction of male and female sexuality reflects the inequalities of the social and economic sphere of life (Connell 2009:78).

Farrar and Mc Gilvray (2009:277) maintain that social and community norms remain important to young people such as conflict between social norms and sexual feeling; gendered power imbalances within young people's relationships; aspects of male sexuality; and peer norms and values. Gender inequality continues to be a major concern surrounding HIV infection (Higgins, Hoffman & Dworkins 2010:436). Many researchers acknowledge that women are more vulnerable to HIV than men because of biological and socio-cultural aspects (Abdool Karim & Abdool Karim 2010; Higgins *et al*., 2010; Ramjee & Daniels 2013:1). Higgins et al (2010: 436) state that the feminisation of the AIDS epidemic is fuelled by both biological and socio-cultural factors, which put women more at risk of HIV infection than men. They further argue that women's vulnerability to HIV is increased by systems of oppression and subjugation that legitimate male domination.

Gilbert and Selikow (2011:332) in their study of Gender and HIV/AIDS in South Africa conclude that sustainable change needs to challenge gender-based power inequalities at both the macroeconomic level as well as socio-cultural level. As a result, some researchers argue that gender-based factors do affect the ability of women to engage in self-protective behaviours (Higgins *et al.,* 2010:441). The socio-cultural construction of gender guided the researcher in answering the research question, which examines how socio-cultural factors influence young women's vulnerability to HIV infection. Theories of gender and power, which are relevant to this study, are discussed in the next section.

2.7 THEORETICAL FRAMEWORK

In this study, the researcher used the theory of gender and power. This is an old theory that was conceptualised by Connell (1987). This theory proposes that inequities arise from three overlapping social structures, which interact to generate different exposures and risk factors for HIV/AIDS: namely, the sexual division of labour, the sexual division of power, and structure of cathexis (Wingood & DiClemente 2000:540). Through the sexual division of labour, men have more access to wealth and opportunities and

consequently women become dependent upon their partners in order to meet their financial and social needs (Conroy 2010:4). This imbalance of power may constrain a woman's ability to negotiate condom use. To support this theory the researcher also used the Sexual Relationship Power Scale (SRPS) to measure power relationships. Pulerwitz, Gortmaker and De Jong (2000) developed the SRPS as a theoretically based, rigorously tested measure of power in intimate relationships. The authors conceptualise relationship power as "the relative ability of one partner to act independently, to dominate decision-making, to engage in behavior against the other person's wishes and to control a partner's actions" (Conroy 2010:5).

2.7.1 Relevance of the theory of gender and power to the study

a. Sexual division of labour

According to the sexual division of labour, there is still a differential allocation of jobs and income for men and women. Women are often delegated the responsibility of women's work which limits their economic potential and confines their career paths (Wingood & Diclemente 2000:543). Most women are responsible for caring for the sick and elderly, childcare and housework. In South Africa, very few women have better jobs than men do (South Africa, Department of Women 2015:9). As a result, this creates an economic imbalance in which women have to rely on men financially to support them and this reduces women's power to have safer sex and gives men more control.

Poverty is the driving force in the formation of relationships (Mutinta 2014:148). Most women depend on their partners to pay their rent. These partners may not only pay rent, they may even go further and buy expensive clothes and jewellery to satisfy the women. As a result, poverty may fuel risky behaviours that expose women to HIV infection. This theory guided this study in seeking the answer to the socio-economic and environmental factors, which tend to increase the risk of vulnerability and susceptibility to HIV infections among young women and how they are affected.

b. Sexual division of power

Power means having the capacity to influence the actions of others, often against their will (Stewart & Zaaiman 2014:568). This conceptualises power in terms of power over others. This ability resides primarily at the interpersonal level and occasionally at the institutional level (Wingood & Diclemente 2000:543). At the institutional level, the sexual division of power is maintained by social mechanisms such as the abuse of authority and control in relationships (Wingood & Diclemente 2000: 543). As said previously, men are still in control in many relationships. Historically, they have also been granted privileges in terms of guardianship, educational and employment opportunities (South Africa, Dept of Women 2015:10). Women in power-imbalanced relationships tend to depend on their male partners because men usually bring more financial assets (money, status) to the relationship.

Women having more adverse physical exposures and behavioural risk factors are more burdened by the sexual division of power and subsequently experience poorer health outcomes (Wingood & Diclemente 2000:543). The physical exposures may be defined as women who have a history of sexual or physical abuse; a high-risk steady partner; and a partner who disapproves of practising safer sex (Wingood & Diclemente 2000:544). Women who are in an abusive relationship tend to be powerless. Power determines whose pleasure is given priority and when, how, and with whom sex takes place (Wingood & Diclemente 2000). This imbalance of power creates a situation in which violence against women contributes both directly and indirectly to women's vulnerability to HIV. Behavioural risk factors may be defined as women who have a history of alcohol or drug use; poor condom use skills; low self-efficacy to avoid HIV; and limited perceived control in their relationships (DePadilla, Windle, Wingood, Cooper, Diclemente 2012:9).

c. Structure of Cathexis (psychoanalysis)

The structure of cathexis is referred to as the structure of affective attachments and social norms (Wingood & Diclemente 2000). At the societal level, this structure dictates appropriate sexual behaviour for women and is characterised by the emotional and sexual attachment that women have with men (Wingood & Diclemente 2000:544). At the institutional level, the structure of social norms and affective attachments is maintained by social mechanisms such as preferences people have with regard to how women and men should express their sexuality (Wingood & Diclemente 2000:544). These biases produce cultural norms, the enforcement of strict gender roles and stereotypical beliefs such as believing that women should have sex only for procreation, thus creating taboos with regard to female sexuality (Wingood & Diclemente 2000:544). For example, women are labelled as bad girls if they have premarital sex, as opposed to having multiple partners, which is an accepted norm for men but not for women.

In many societies worldwide, it is believed that variety in sexual partners is essential to men's nature and that men will seek multiple partners for sexual release (Rakgoasi & Odimegwu 2013:180). This seriously challenges the effectiveness of prevention messages that call for reduction in the number of sexual partners. Women who have exposures that are more social and have risk factors that are more personal are more affected by the structure of social norms and affective attachment (Wingood & DiClemente 2000:544). In South Africa in most cultures, men are the decision makers (Rissik 2011:99). As a result, women are compelled to discuss with their partners if they want to test, or visit HIV voluntary counselling and testing services, while men make their own decisions about whether to seek voluntary counselling and testing independent of others. It is also difficult in this country for women to use condoms because only male condoms are distributed freely all over, while women's condoms are difficult to find and are expensive.

In this study, social exposures are defined as women who have older partners and conservative cultural and gender norms. The personal risk factors are defined as women having limited knowledge of HIV prevention; and negative attitudes and beliefs about condoms. There are also the prevailing masculinity norms that expect men to be more knowledgeable and experienced about sex (Wingood & DiClemente 2000:555). This norm puts young men at the risk of infection because it prevents the youths from seeking information or admitting their lack of knowledge about sex. These norms coerce them into experimenting with sex in unsafe ways at a young age to prove their manhood.

According to the structure of cathexis (social norms and affective attachments), women who are more accepting of conventional social norms and beliefs are more likely to experience diverse health outcomes (Wingood & DiClemente 2000:554). As a result, this theory guided the researcher to answer the second research question, which examines how socio-cultural factors influence young women's vulnerability to HIV infection. This theory shows that all three structures reflect patterns of social norms and affective attachments and are related as they show the manner in which women depend on men and how they are oppressed**.**

2.8 Conclusion

In this chapter, women's vulnerability to HIV/AIDS and the definition of young women were discussed. A review of the literature on factors influencing women's vulnerability to HIV/AIDS was also provided and theories that gave guidance to the study were discussed. The next chapter deals with the research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the preceding chapter, the researcher reviewed literature concerning factors that influence young women's vulnerability to HIV. This chapter gives a description of the methods used to answer the main research questions. Research methods are diverse methods of investigation used to gather empirical or factual material (Giddens 2009:1130). According to Gilbert (2006:64), research methods describe how the data is obtained and analysed. The researcher used the quantitative analysis method as Babbie (2010:422) asserts that quantitative analysis is the numerical representation and manipulation of observation for the purpose of describing and explaining the phenomena that those observations reflect. In this study, 158 young women between the ages of 18 and 24 and living in Sunnyside, Pretoria, were coming from all language groups, participated in the survey and a questionnaire was used to obtain the data. Participants of this study were black Africans, whites, coloureds and Indians.

According to Dornyei & Csizer (2012:84), data analysis involves two steps: first reducing to manageable proportions the wealth of data that one has collected and second identifying patterns of themes in the data. Specific techniques used to gather data on socio-economic, socio-cultural and environmental factors that influence young women's vulnerability to HIV/AIDS are discussed.

The important components of research methodology included in this study are:

- Chosen research design
- Study population and study site
- Sampling design and procedure
- Data collection procedures
- Permission to access the study population
- Measurement of variables
- Data analysis
- Ethical consideration

3.1.1 Chosen research design

Babbie (2010:117) describes a research design as a process that involves a set of decisions regarding what topic is to be studied among what population with what research methods for what purpose. This study was designed to be quantitative in nature. Neuman (2011) states that the aim of quantitative research is to determine how one thing (a variable) affects another in a population. In this study, the aim was to describe the risk factors that influenced young women's vulnerability to HIV infection. What were those factors affecting young women's vulnerability to HIV infections? The factors that affected the population were the variables in this study, and this was the reason for a quantitative methodology being chosen. Quantitative research is all about quantifying the relationships between variables. In this study the researcher utilised survey questionnaires given to young women living in Sunnyside flats and other forms of housing.

Social research can serve many purposes, three of the most common and useful purposes being exploration, description and explanation (Babbie 2010:92). The reasons for this study follow.

3.1.2. Descriptive study

The researcher chose a descriptive non-experimental research design. Babbie (2010:121) asserts that a descriptive research design is the precise measurement and reporting characteristics of some population or phenomenon under study. According to Babbie (2014), descriptive quantitative research involves either identifying the characteristics of an observed phenomenon or exploring possible correlations among two or more phenomena, and it examines a situation as it is. In this study the researcher explored and described socio-economic, cultural, environmental and other factors influencing young women's vulnerability to HIV in Sunnyside Pretoria.

3.2. THE STUDY POPULATION

"Population" is defined as a collection of persons alive at a specific time who meet certain criteria; the people who are the focus of a study or survey (Stewart & Zaaiman 2014). The target population for this study comprised of young women meeting the following eligibility criteria for the survey:

- Participants were between 18 and 24 years of age.
- Participants were all randomly selected in this study.
- Participants had to reside within the catchment area of Sunnyside.

The reason for choosing young women between 18 and 24 years was that women in this age group are vulnerable to diseases such as HIV and AIDS. Dellar, Dlamini and Abdool Karim (2015:1) support this statement when they acknowledged that adolescent girls and young women in southern Africa are uniquely vulnerable to HIV and are subject to eight times more infection than their male peers. The population group of Sunnyside suburb consists of black Africans, whites, coloureds and Indians. Young women of this entire population group were given questionnaires.

3.2.1. Study site

"Study site" refers to the physical place where research is conducted. The study was undertaken at Sunnyside, which is one of the suburbs of Tshwane in Pretoria. This suburb is next to Arcadia, Hatfield and Muckleneuck suburbs. One of the advantages of living in Sunnyside is its accessibility to the city centre, thus enabling one to walk to the centre of the city and neighbouring suburbs. It has an estimated population of 39282 (Statistics South Africa 2010). Most of the people in this area are employed. (Donaldson, Jurgens & Bahr 2003:11) state that the highest gross employment density per hectare in Pretoria is found in the CBD and Sunnyside. According to Donaldson *et al*., (2003:11), this suburb has the highest percentage of residential units among the suburbs of the inner city.

Professor Alpaslan of the Department of Social Work at Unisa acknowledges that Sunnyside used to be a white neighbourhood in the days of apartheid but currently non-white inhabitants populate it (Alpaslan 2011:114). Sunnyside streets are mostly lined with blocks of flats that date back to the fifties and sixties; there are a few old houses. Most of the flats are built of red brick and are large balconied multi-storey blocks. Some of the young women populating the flats are students and they like this area because the northern side of the suburb is within walking distance of the University of Pretoria and the Unisa Sunnyside Campus. Most of the youth like this suburb because it has many restaurants, clubs, bars and salons owned by African migrants in Esselen Street, which is the busiest. The main shopping complex is Sunny Park, which has banks, restaurants, clothing shops and grocery shops. The other complex is Barclay Square in Walker Street, which also has restaurants and clubs.

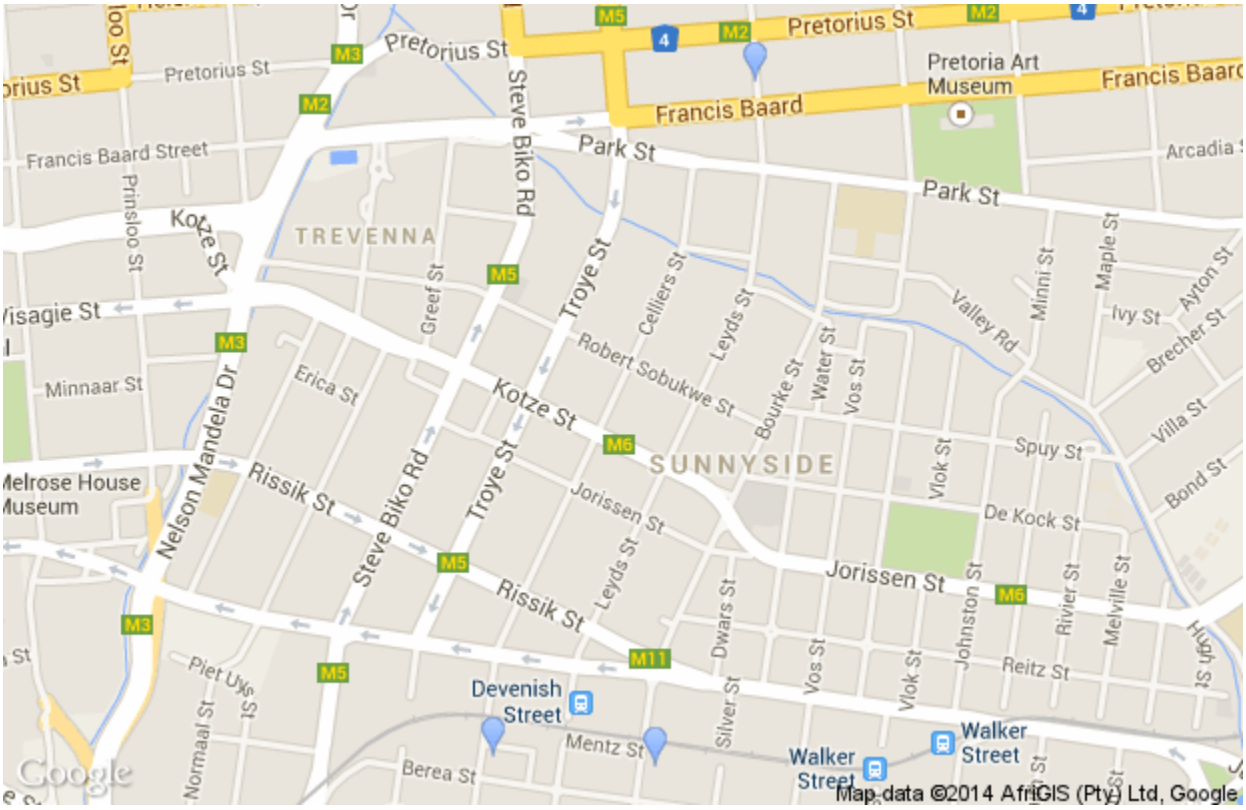

Figure 1: Map of Sunnyside (www.afrigis (PTY) Ltd,google)

Sunnyside has only one police station in Leyds Street although the Tshwane Metro Police Department (TMPD) acknowledges this area as one of the places with a high crime rate (Van Zuydam 2013). Sunnyside is a risky place. Of the 20 most dangerous areas in South Africa, Sunnyside ranks 18th while Pretoria central ranks 5th (Hosken 2008:2). More than 336,000 (14%) of the 2.4 million inhabitants of Tshwane are already HIV positive and the number continues to grow (Njaramba & Sebastian 2008:11). The nearest services which offer counselling for HIV/AIDS in Sunnyside are the Catholic Women's League (CWL), which provides counselling for people who reside in Sunnyside; the Society for Women & Aids in SA (SWAASA.) and the United States Peace Corps (USPC). There are also faith-based organisations and other non-governmental organisations (NGOs) as well as a few churches in Leyds Street where God is worshipped.

Sunnyside has a racially and ethnically diverse population. As the majority of respondents were not born in Pretoria. The majority of the people in this area are blacks with a few coloureds, Indians and whites. Most of the respondents in this study who live in Sunnyside suburb come from different provinces in South Africa and other African countries like Zimbabwe, Congo, Nigeria. Some of them left their partners at home and migrated to Sunnyside where they found new partners and employment. Most of these young women in Sunnyside are students but some of them are employed.

3.3 SAMPLING DESIGN AND PROCEDURE

Neuman (2011) defines sampling as a small collection of units taken from a larger collection. The type of design the researcher chose for the study had a major impact on the sample size. Descriptive study needs hundreds of subjects to give acceptable confidence intervals or to ensure statistical significance for small effects. In this step, representatives from a total population were chosen to constitute the sample to use in collecting data for the research study. The population of this study consisted of only

young women who resided in Sunnyside flats and other dwellings such as houses and backyard rooms in Pretoria.

The researcher used the probability-sampling method called simple random sampling to select 158 young women. Probability sampling is defined as having the distinguishing characteristics that each unit in the population has a known non-zero probability of being included in a sample (Babbie 2014:235). According to Babbie (2014:205), in probability sampling the researcher can specify in advance that each segment of the population be represented in the sample. The researcher chose to employ a probability sample because she had a list of all the dwellings in the area as a sampling frame. She also assigned a single number to each element in the list. Sunnyside suburb accommodates 380 residential units.

Babbie (2014:207) refers to random sampling as a sampling method in which each element has an equal chance of selection independent of any other event in the selection process.The researcher decided to use simple random sampling to select every woman starting at a random point in the suburb. Simple random sampling is a type of probability sampling in which the units composing a population are assigned numbers; a set of random numbers is then generated and the units having those numbers are included in the sample (Babbie 2014:206). At each selected visiting point, a woman aged 18 to 24 was asked to complete the questionnaire. If more than one woman in the age group was available for participation in the study at a selected visiting point, their ages were recorded and the researcher randomly gave them the questionnaires. When there were no women between the ages 18 and 24 at the chosen visiting point, or when the inhabitants refused to participate, the researcher moved to the next visiting point. She recorded all the flats and dwelling areas that she visited for the day, so that she could return to collect the questionnaires. By using this method, 158 female respondents were eventually sampled for participation in this study: 143 black Africans, 6 coloureds, 5 whites and 4 Indians.

Babbie (2014:212) emphasises that random sampling allows a researcher to statistically calculate the relationship between the sample and the population, that is, the size of the sampling error. Because samples are not perfectly representative of the population from which they are drawn, one cannot be sure that the conclusions drawn from the sample can be generalised to the entire population. The estimate of the relationship is less likely to be biased if a researcher has a high participation rate in a sample selected randomly from a population.

3.4. DATA COLLECTION PROCEDURES

3.4.1. Instrumentation

Research instrument is a tool used to collect data (Babbie 2014). The decisions as to how variables are to be operationalised and what sample is to be used in the study affect the decision as to how the variables are to be measured and the data collection strategy. As a result there is a need for detailed planning, groundwork and a contract with those who can affect the research's access to data.

The researcher used survey research. Babbie (2014:261) describes survey research as a research which involves acquiring information about one or more groups of people about their characteristics, opinions, attitudes, or previous experiences by asking questions and tabulating their answers. The purpose of the survey was to estimate the prevalence of sexual coercion, alcohol use, and high risk sexual behaviour experienced by young women in Sunnyside. Data was collected from 158 young women between the ages of 18 and 24 years who resided in Sunnyside.

Babbie (2010:255) contends that surveys include the use of questionnaires as an instrument specifically designed to elicit information useful for analysis. The researcher used the survey data in order to serve the purpose of the study which was to provide an understanding of the risk factors that rendered young women living in Sunnyside

vulnerable to HIV. Survey data was used in this study because it has advantages but it also has limitations. Some of the advantages of surveys which have been noted by Neuman (2011:51) are:

- They allow for the collection of quantitative data on various forms of behaviours and events.
- Survey data is useful for estimating the prevalence of specific patterns of behaviour in particular populations.
- The use of this method gave the researcher the freedom to use a wide range of description tools and she could summarise answers to questions in percentages, tables and graphs.
- It was easy and quick for respondents to answer the respective questions and for the enumerator to enter the information in the questionnaire.

Survey questionnaires also have limitations, some of them being:

- The data is limited by the extent to which a person recalls certain events and admits to engaging in certain behaviour.
- Young women may under-report sensitive issues such as sexual behaviour and violence.
- Another limitation of questionnaires is that while they measure acts of behaviour, they provide little information about the meaning and context of such acts (Babbie 2010).

A structured closed ended questionnaire was used as the primary data collection tool for this study. According to Neuman (2011:260), a structured closed ended questionnaire asks a question and gives the respondent fixed responses from which to choose. Because the researcher's questionnaire contained sensitive questions such as sexual behaviour and liquor consumption, the researcher used the closed question as Neuman (2011:260) emphasised that sensitive questions are accurately answered by closed questions.

Mistakes, poor responses, unforeseen problems with measuring instruments and bad links at this stage can affect the quality of the data that is available for analysis.The development of the research instruments was largely informed by the reading and preparation done during the research proposal-writing phase. The first draft of the questionnaire was submitted to the supervisor for her comments, after which amendments and revision of the same were done. Pre-testing was also carried out among a small group of women living in Sunnyside, but their responses were only used to test the questionnaire and were not included in the analysis.

The final questionnaire used contained sections which included demographic information and the Sexual Relationship Power Scale. The demographic questionnaire was used to gather data regarding the variables and personal variables such as age, socio-economic status and level of education. The questionnaire also contained questions regarding socio-cultural and environmental factors. The last section of the questionnaire contained the Sexual Relationship Power Scale and decision making. Variables such as age, educational level and socio-economic status were located in the codebook and were transferred to the statistical software for Microsoft excel xlstats 2015 program. Data was drawn from the questionnaire for description and interpretation.

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3.4.2. Permission to access the study population

Prior to conducting this research, the researcher obtained ethical approval from the Department of Sociology, University of South Africa in November 2013. The researcher also visited randomly selected flats and other dwellings in Sunnyside and randomly asked young women to participate in the study with the use of a self-administered questionnaire. The first person the researcher met in Sunnyside was a caretaker‘s wife with whom she made friends. She introduced the researcher to her husband who is the caretaker of a block of flats used in the research. The researcher explained her study to him and an appointment was made for her to come to the building to meet the

participants. This allowed the caretaker time to inform all the tenants. The researcher observed that the place was quiet during the week.

The caretaker phoned the researcher two days before the appointment date to come and distribute the questionnaires to the female tenants. It was a Saturday morning when she went with her brother to the building. The situation was different from that of the first day. There was a lot of movement at the flats; everybody was busy and there were many people. The researcher realised that because of the weekend, some people were going to the malls while others were going to work. Those who were going out of the flats did not want to fill in the questionnaires; they told the researcher that they did not have time. Despite this setback, those who remained were able to complete more than fifty questionnaires on the first day and it was very fruitful.

The caretaker also introduced the researcher to other caretakers in other buildings. For other dwellings like houses, it was very difficult for the researcher to find the respondents, because most of their gates were locked and she had to make an appointment first, but she managed to get few of them after coming for the second and third time. It took the researcher about a month from the 3rd of March 2014 to the 2nd of April 2014 to distribute the questionnaires. The informed consent form was included in the questionnaire. The researcher gave these young women the questionnaires and returned the following day to collect them. It was very difficult because most of the participants complained that they did not have time to complete the questionnaire and the researcher had to return the following day to collect them. Most of the participants in this study were blacks, followed by few coloureds, whites and Indians.

3.5. MEASUREMENT OF VARIABLES

The operationalising of variables is one of the most important links between the conceptualisation of the research question and the selection of an appropriate data collection method to measure the variables. Deciding on the appropriate level of measurement for a construct often creates a problem. According to Neuman

(2011:173), the appropriate level of measurement for a variable depends on two things: first how a construct is conceptualised and second the type of indicator or measurement that a researcher uses. Quantitative researchers conceptualise variables and refine concepts as part of the process of measuring variables that come before data collection or analysis (Neuman 2011:63). Participants in this study completed a self-administered questionnaire originally compiled on a review of literature that covered socio-demographic factors, socio-economic, socio-cultural, HIV risk behaviours and sexual power. Sexual power was measured through two factors: relationship control and recent experiences of forced sex. Babbie (2010:255) acknowledges that in social research, variables are often operationalised when researchers ask people questions as a way of obtaining data for analyses and interpretation.

3.5.1 Validity

This refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie 2014:153). It is the measure that accurately reflects the concepts it is intended to measure. The absence of validity occurs if there is a poor fit between the constructs a researcher uses to describe, theorise or analyse the social world (Babbie 2014:155). The questionnaire was developed from the relevant literature and pre-tested by a group of female volunteers not included in the study. Comments by the volunteer mock-respondents were incorporated into the final questionnaire.

Construct validity was used in this study as Babbie (2014:156) states that construct validity is the degree to which a measure relates to other variables as expected within a system of theoretical relationships. The construct validity was evaluated by testing the relationship between the Sexual Relationship Power Scale and the number of variables such as socio-economic status, socio-cultural factors and environmental factors hypothesised to be associated with relationship power. The Sexual Relationship Power Scale was developed by Pulerwitz, Gortmaker and De Jong in 2000 to measure power

in sexual relationships and to investigate the role of relationship power in sexual decision making and HIV risk. The Sexual Relationship Power Scale contains 23 items in two subscales which are decision making dominance and relationship control (Pulerwitz *et al.,* 2000:637). As part of the validation process, the Sexual Relationship Power Scale and theoretically relevant variables were tested in this study using the psychometrics scale construction of factor analysis and Pearson's chi-square test for trend.

Variables theoretically associated with sexual relationship power such as the history of forced sex, physical abuse, condom use, relationship satisfaction, marital status, length of relationship and age were added to the questionnaire in order to test construct validity. The sixteen questions used to construct the relationship control scale from the Sexual Relationship Power Scale consist of 23 items, and 2 subscales.The respondents were to answer yes or no. The questions for the Sexual Relationship Power Scale were paired to elicit the same information about the respondents and their partners, for example, forced sex was created using the following question: Do you withhold sex to get even with your partner? Sexual violence was created using the following question: Do you have sex when you do not want to? Physical abuse: Have you ever hit or been hit by your partner? Condom use: Do you feel free to discuss condom use with your sexual partner? Emotional abuse: Are you afraid to tell your partner when your feelings are hurt?

3.5.2 Reliability

This means that the numerical results produced by an indicator do not vary because of characteristics of the measurement process or measurement instrument itself (Neuman 2011:164). Reliability is the accuracy or consistency of the instrument in measuring what it is supposed to measure over a period of time (Babbie 2010:155). To ensure reliability in this study, the researcher pre-tested the data collection instrument with a

group of young women who reside in Sunnyside so that when it was used in the main study it was more appropriate and reliable.

Reliability in this study was used as the questionnaire contained a modified Sexual Relationship Power Scale which maintained good internal consistency reliability (coefficient alpha=0.84 for English). Reliability analysis was calculated for two dimensions of factors using the factor analysis.The Chi-square test was also used to determine whether there was a significant association between the four variables of Relationship Control, Decision-making Dominance, Emotional Abuse and Relationship Dissatisfaction. The statistical hypothesis denotes that the null hypothesis Ho= independent variables while Ha=dependent variables with an alpha p=0.5.

3.6 DATA ANALYSIS

Data analysis is a systematic organisation and synthesis of research data (Pilot & Beck 2012:725). The researcher used quantitative analysis as Babbie (2010:422) declares that quantitative analysis is the numerical representation and manipulation of observation for the purpose of describing and explaining the phenomena that those observations reflect. The researcher used descriptive statistics to analyse the data collected. The analysis of the findings of this study was guided by its objectives.

The analytical approach was informed by feminist social construction and gender and power theories. The researcher also created a codebook and gave each case an identification number to keep track. According to Babbie (2010:425), a codebook is a document that describes the locations of variables and lists the assignments of codes to the attributes composing those variables. Variables such as age, educational level and socio-economic status were located in the codebook and were transferred to the statistical software for the Microsoft excel XLSTATS 2015 program. Factor analysis was also used to clarify the Sexual Relationship Scale domain. The researcher performed

the principal component analysis to determine the number of factors to extract. This was done by investigating the eigenvalues, scree plots and correlation matrix.

Various factor rotation methods were tested to determine the best fit. The Principal Axis Factoring with obligue method yielded the best results. The researcher examined six factor solutions for various scales depending on the suggestions from the three indicators and decided on the factor solution that seemed to be theoretically and psychometrically the most sound in each case. The first Principal Axis Factoring yielded four factors. Items with communalities above 0.20 were included. The second order of factor analysis was perfomed and only two factors were left.

3.7 ETHICAL CONSIDERATIONS

Neuman (2000:90) refers to ethical issues as the concerns, dilemmas and conflicts that arise over the proper way to conduct research. Babbie (2010:64) defines ethical issues as associated with morality and both words concern matters of right or wrong. In this research the researcher adhered to the relevant ethical principles. The research was cleared by Unisa‘s ethics committee in November 2013 and following are some of the ethical principles that have been adhered to.

3.7.1. Informed consent form

Neuman (2000:96) describes an informed consent form as a written agreement given by subjects after they have learnt something about the research procedure. Babbie (2010:71) asserts that it is important to inform respondents about the nature of the research and obtain their verbal or written consent to participate. An informed consent form that describes the nature of the research project, the nature of a respondent’s participation, the risk and the benefits of participating in the study was presented to the participants. Young women were also assured that if they agreed to participate, they had the right to withdraw from the study at any time. The participants were also given

the opportunity to ask questions about any aspect of the research at any time or after their participation in the research. Informed consent forms were signed by the research participants before they answered the questionnaire. The research study also adhered to the ethical research policy of Unisa.

3.7.2. Anonymity and confidentiality

Anonymity is achieved in a research project when neither the researcher nor the reader of the findings can identify a given respondent (Babbie 2014:68). Anonymity protects the identity of specific individuals from being known. This study was sensitive to confidentiality and anonymity. To ensure confidentiality, the researcher collected data using codes rather than names of respondents. The research participants were also assured that the information of the research would not be available to anyone who was not directly involved in the study and data was locked up by the researcher in a safe place.

3.7.3 Protection of privacy

Babbie (2010:71) argues that in a survey research, self-administered questionnaires can be anonymous and interviews can be kept confidential. In this study, the questionnaire did not require any form of identification when completed. The researcher identified young women by assigning numbers to different questionnaires to use them both during data collection and in the final research. This ensured that data collected could not be traced back to particular individuals in order to maintain their right to privacy.

3.7.4 Pilot test

The researcher did a pilot test of the questionnaire with a small group of respondents with similar characteristics to those of the population; thus 10 young women who were students and workers living in flats in Sunnyside were given questionnaires for the pilot

test. The researcher asked the respondents in the pilot test whether the questions were clear and explored their interpretations to see whether the intended meaning was plain.

3.7.5 Protection from harm

The researcher used anonymous, self-administered questionnaires and worded sensitive questions carefully to avoid harm in emotional or psychological issues. Babbie (2014:65) recommends in terms of avoidance of psychological harm in the course of a social research study that the researcher must be aware of the dangers and guard against them.

3.8. CONCLUSION

This chapter highlighted the background to the research methodology and a descriptive research design was introduced. A brief discussion of population and sampling; data collection methods; data analysis and interpretation; and validity and adherence to ethical principles was given. The results of the study which are based on analyses of information obtained from the survey are presented in the next chapter.

CHAPTER 4: FINDINGS

4.1. INTRODUCTION

This chapter outlines the statistical findings of the research study. Tables and graphs are presented to illustrate the results obtained. In this chapter, the researcher also analyses the research questions and the objectives and provides a summary of the findings. Findings in this chapter are reported in terms of the responses to the questionnaire.

The questionnaire comprised the following three sections:

- Biographical characteristics of the respondents
- Question items on intended findings on high risk sexual behaviour
- Evaluation of sexual relationship power and decision making

4.2. BIOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

The questionnaire was compiled to accommodate certain biographical data of participants such as age, marital status, employment status, level of education, language and the province they came from. In this study, 158 young women between the ages of 18 and 24, living in Sunnyside, participated in the survey. The results of this data collection are displayed below:

Table 4.1 Frequency distribution of socio-demographic characteristics of young women in Sunnyside N=158

Variable	**Number (N) 158 Frequency**	**Percentage % Total=100%**
Race		
Black Africans	143	90.5
Coloureds	6	3,8
Whites	5	3,2
Indians	4	2,5
Age		
18-21	71	44.9
22-24	87	55.1
Daily activities		
Working	65	41.1
Tertiary/university	30	19
Attending school	42	26.6
Unemployed	21	13.3
Level of education		
Matric	39	24.7
Diploma	57	36,1
Degree	40	25.3
Master's degree	12	7.6

Phd	4	2.6
Other	6	3.7
Living arrangement		
Rented flat with family	70	44.30
flat with friend	45	28,5
flat with partner	37	23.4
Own flat or house	6	3.8
Years of stay in Sunnyside		
3months-1 year	29	18.4
2-10 years	117	74.0
11-16 years	9	5.7
Non-response	3	1.9
Reasons for moving to Sunnyside		
School/university	95	60
Looking for work	48	30
Having worked there	8	5
To live with other family members	6	4
Non-response	1	1
Province they came from		
Limpopo	77	49.0

Mpumalanga	6	3.8
Western Cape	27	17.0
Free State	7	4.4
Kwa-Zulu Natal	13	8.2
Gauteng	7	4.4
North West	15	9.5
Other provinces (Eastern Cape, Northern Cape)	6	3.7
Born in Pretoria		
Yes	7	4.0
No	151	96.0
Language spoken		
English	10	6.3
Afrikaans	9	5.7
Tsonga	9	5.7
Ndebele	19	12.02
Venda	13	8.2
Swazi	5	3.2
Xhosa	10	6.3
Sotho	54	34.18
Zulu	20	12.7
Tswana	9	5.7

Results

4.2.1 Respondents in terms of age

Respondents were asked to indicate their age in order to establish the dominant age group in Sunnyside. The results are presented in table 4.1 above.

The information from table 4.1 shows that the respondents ranged in age from 18 to 21 (44.9%), with the larger proportion falling within the age category of 22 to 24 (55.1%). The median age was 21. According to Erikson's developmental stages (1980) this is the stage of young adulthood (the 20s) and is portrayed as a period of competition versus collaboration, during which people find new friendships and sexual partnerships (Walker, Payne, Smith & Jarrett 2004:99).

4.2.2 Respondents' daily activities

The reason for this question was to establish what the respondents did as part of their daily activities; whether they worked, attended school or were unemployed. The respondents were given a list of activities to choose from. The results are presented in table 4.1 above.

Table 4.1 reveals that among the 158 young women surveyed, 41.1% worked, 26.6% attended school and 19% were at tertiary institutions. A small percentage (13.3%) of the respondents was unemployed, and this is a high number if they have to pay rent and buy food. They were supported either by their parents or by partners. Wingood and Diclemente (2000:546) in the theory of gender and power state that women who are economically dependent on their male partners have few alternatives but to engage in HIV risk behaviours imposed by those partners. These results show that a high number of respondents attended school, which means they were still dependent on their parents or partners.

4.2.3 Level of education

Respondents were asked to indicate their level of education in order to establish whether their level of education had any influence on their lifestyle or behaviour. Respondents were given a list of levels of education to choose and the results are presented above in table 4.1.

More than half (36.1%) of the young women surveyed in this study had obtained a diploma, while 25.3% had a degree and 24.7% matric. Only 7.6% had obtained a master's degree and 2.6% a PHD, while 3.7% had a college certificate. This study showed that the majority of women in Sunnyside were formally educated. The fact that the majority of the respondents had a secondary level of education might be indicative of the respondents' ability to be aware of the risk factors that influence women's vulnerability to HIV infections. The theory of gender and power states that being less educated restricts women's access to HIV prevention programmes (Wingood & Diclemente 2000:546).

4.2.4. Living arrangements

The researcher wanted to know whether the respondents had rented a flat on their own or were living with other people. A list of living arrangements was given to respondents to choose from. Results are shown in table 4.1:

Table 4.1 shows that 70 (44.30%) of the respondents rented their dwellings, flats and houses with family members while 28.5% lived with their friends and 23.4% with partners. Only 6 (3.8%) of the respondents had their own flats and houses. Most of the respondents rented flats so had to pay rent to the owners of the flats. The results showed that most of the respondents rented flats with their family members, which is a good thing for families to be together and take care of one another. Family influence has

been cited as a social exposure in the theory of gender and power and is often viewed as a protective factor in health (Wingood & Diclemente 2000:553).

4.2.5. Years of stay in Sunnyside

Respondents were asked to indicate their years of stay in Sunnyside in order to determine whether they changed environments**.** According to table 4.1 above, 18.4% of the young women had lived in Sunnyside for a period of 3 months to 1 year, whereas 74% had been living there for 2 to 10 years. Those who had lived in Sunnyside for 11 to 16 years accounted for only 5.7% and the non-response rate was 1.9%. Sunnyside is an established, stable suburb as shown by some respondents having lived there for more than 10 years and not changing environments. They had migrated to Sunnyside because of school and work.

4.2.6. Reasons for living in Sunnyside

Respondents were asked their reasons for living in Sunnyside in order for the researcher to understand why they had moved to this suburb. Table 4.1 depicts that 60% of the respondents moved to this place to attend school or university. Almost a third (30%) of the respondents had moved to Sunnyside because they were looking for work, while 5% already had work there. Almost 4% had moved there to live with other family members and 1% did not respond. These findings showed that most of the respondents moved to Sunnyside because they were students.

4.2.7. Province they came from

Respondents were asked the province they had come from. The researcher asked this question because circular migration has been associated with the spread of HIV in South Africa. The results of these questions are revealed as follows.

Table 4.1 shows which province the respondents came from. The majority of young women living in Sunnyside were from Limpopo (49.0%), followed by Western Cape (17.0%), Northwest, (9.5%) and Kwa-Zulu Natal (8.2%). The minority of young women came from Free State and Gauteng, both with 4.4% followed by Mpumalanga 3.8% and other provinces such as the Eastern Cape and Northern Cape accounting for 3.7%. The results of table 4.1 reveal that most of the respondents in Sunnyside moved to Pretoria; they were not born there.

4.2.8. Born in Pretoria

The respondents were asked if they were born in Pretoria; a binary choice of “Yes” or “No” was provided. The results of table 4.1 reveal that most of the respondents were not born in Pretoria. Of the 158 young women surveyed, 96.0% answered that they were born in other provinces. Only 4% reported that they were born in Pretoria. The results of this table show that most of the respondents in Sunnyside were not born in this province.

4.2.9 Language spoken

Respondents were asked to indicate the language they spoke in order for the researcher to understand the type of community living in Sunnyside. The results are presented below.

According to table 4.1, the majority of the respondents spoke Sotho (34.18%) and 12.7% isi Zulu while Ndebele accounted for 12.02%. The minority group were the Venda with an average of 8.2% followed by isiXhosa, English and Tsonga with an equal distribution of 6.3%. Setswana and Afrikaans also had an equal distribution of 5.7%, and the Swazi with 3.2%. Table 4.1 shows that young women who are living in Sunnyside speak different languages, meaning that they are multicultural. Most of

the respondents (n=139) in this study who speak Tsonga, Ndebele, Venda, Swazi, isiXhosa, Sotho, Zulu and Tswana were blacks while the minority, 19 (n=19) who speak English, Afrikaans and other languages were whites, coloureds and few Indians.

4.2.10 Marital status

Respondents were asked to indicate their marital status. The reason for this question was that marital status determines their vulnerability to many diseases such as HIV and STIs. Results are presented below.

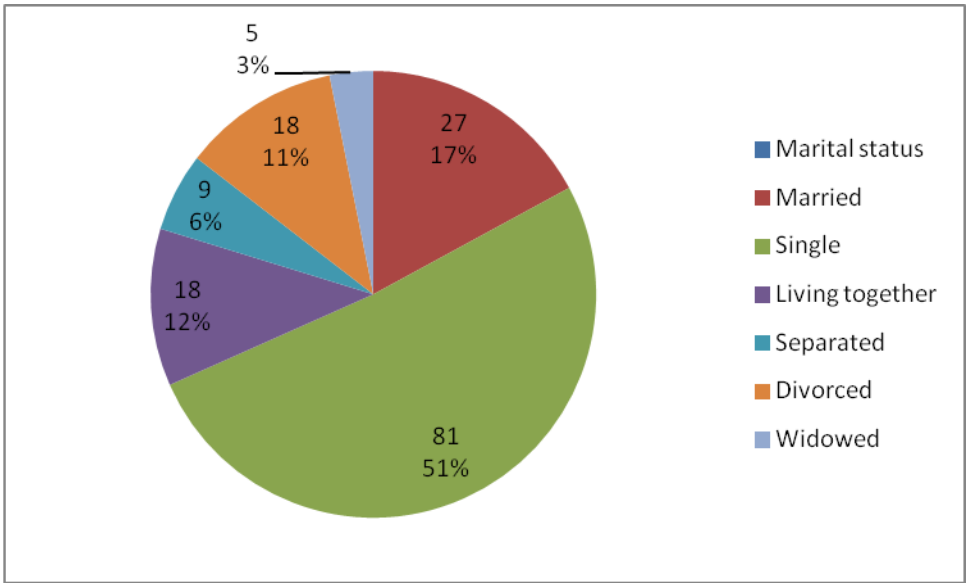

FIGURE 4.1 Marital status of the respondents (N=158)

Figure 4.1 indicates that 51% of the respondents were single while only 17% were married, and those who were living together (12%) or divorced (11%) had an equal distribution of 12%. Respondents who indicated that they were separated accounted for 6% and widows only 3%. Half of the young women in Sunnyside were single; they were in a better position of independence. This could, however, make them more vulnerable to disease such as HIV/AIDS because they controlled themselves. The study of transactional sex among young people in northern Tanzania shows that marital status

and HIV are significantly associated (Wamoyi *et al.,* 2010:10). The socio-economic status of women in Sunnyside is discussed in the next section.

4.3 SOCIO-ECONOMIC STATUS

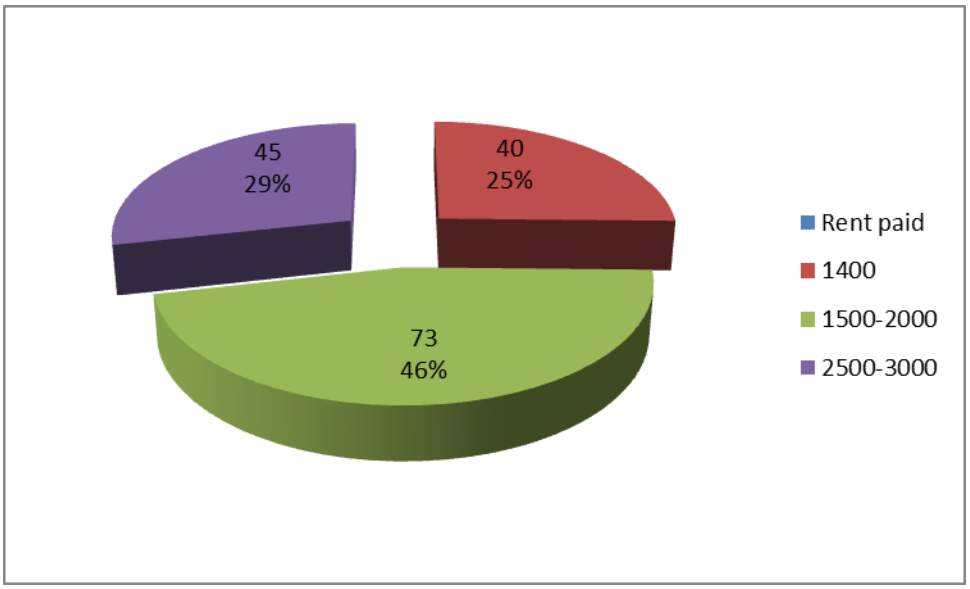

Figure 4.2 Rent paid (N=158)

The researcher was also interested in the amount of rent paid by the respondents and figure 4.2 indicates that the majority of respondents, 46%, paid rent for an amount of R1500-2000, while 29% paid R2000-2500 and the minority, 25%, paid from R1400.00. The results of the study show that most of the respondents paid a lower rent. This is an advantage to the respondents because most of them were students.

4.3.1 Person responsible for rent

Respondents were asked this question in order to discover the persons who took care of these young women. A list of people was given to choose from. Results are presented below.

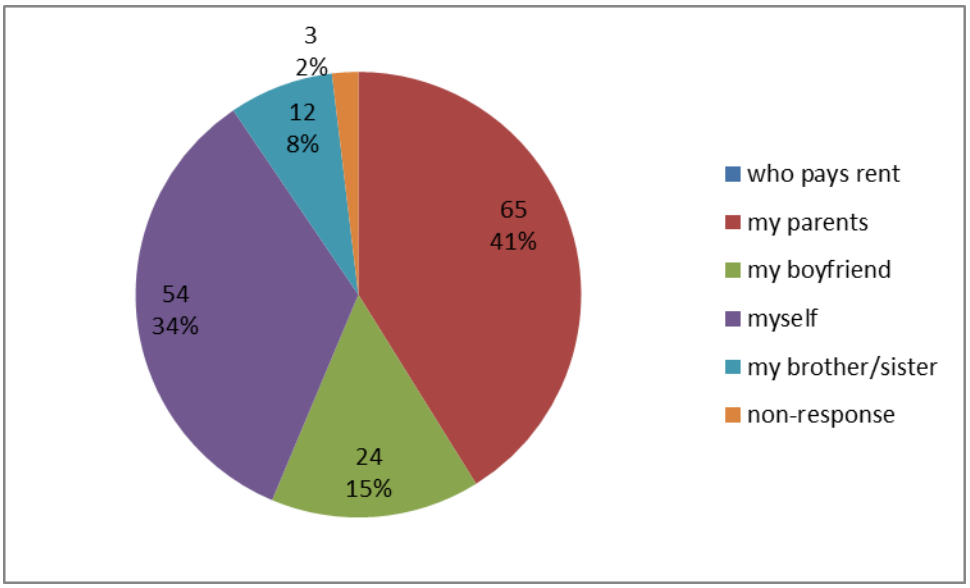

Figure 4.3 Person responsible for rent (N158)

Figure 4.3 shows who was responsible for paying rent. An average of 41% reported that their parents paid the rent for them, while 34% paid for themselves; 15% had boyfriends and 8% brothers and sisters who paid their rent; 2% did not respond. This study shows that mostly parents paid rent for the respondents, which implies that the respondents' parents were taking care of them.

4.3.2 Employment status

Respondents were asked to indicate their employment status. The reasoning behind this question was to check whether the respondents worked because unemployment is classified as an economic exposure to HIV in the theory of gender and power, sexual division of labour (Wingood & Diclemente 2000).

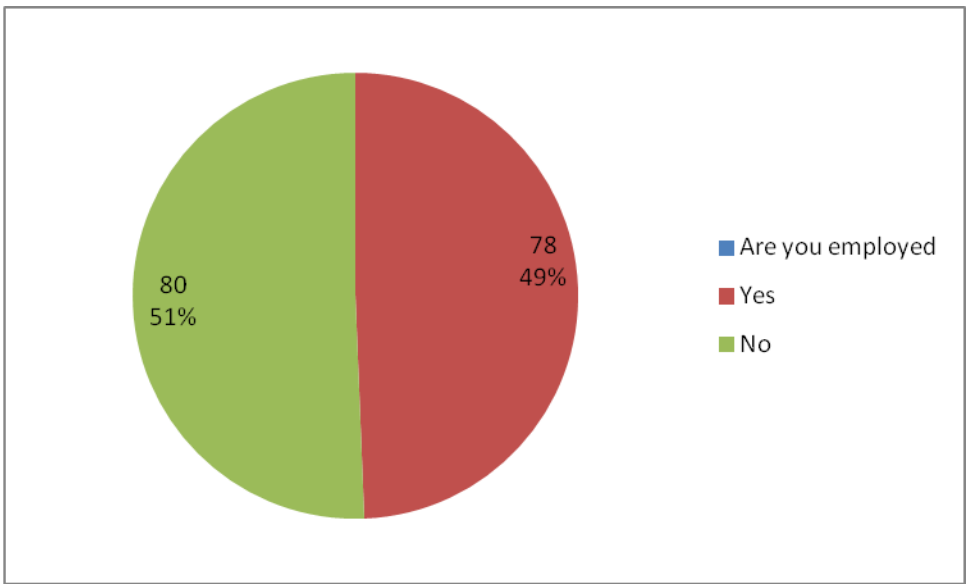

Figure 4.4 Employment status N =158

According to figure 4.4, the percentage of employed (49%) and non-employed respondents (51%) is virtually the same. The theory of gender and power posits that women who are unemployed depend on their partners economically and have few alternatives but to engage in risk behaviours imposed by their partners (Wingood & Diclemente 2000:546). This study showed that a slightly larger percentage of respondents was unemployed. The reason for this is that most of them were still attending school (table 4.1).

4.3.3 Personal monthly income

Respondents were asked their monthly personal income in order to determine whether they could survive on the income. The results are presented in figure 4.5.

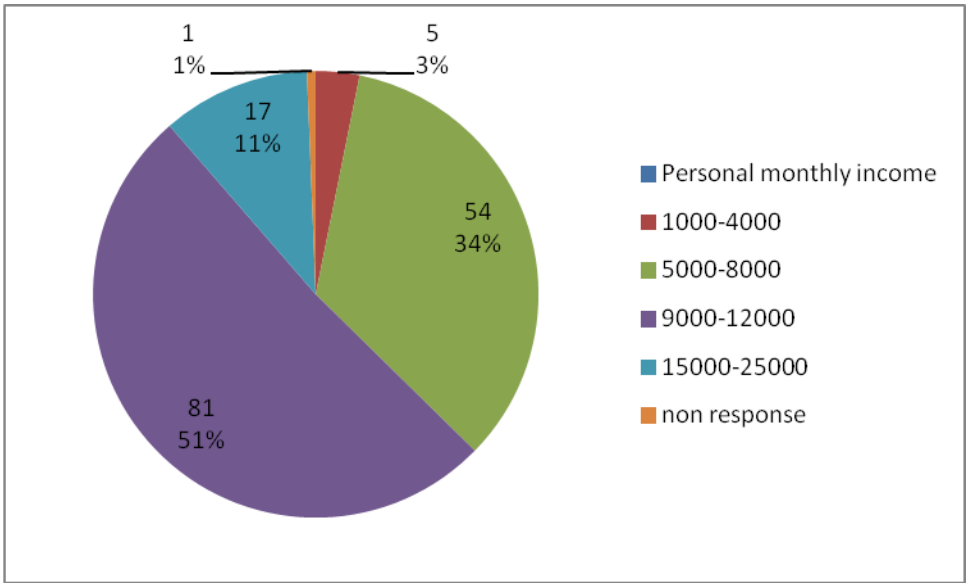

Figure 4.5 Personal monthly income (N=158)

Figure 4.5 indicates that young women who earned R1000-4000 account for only 3% while 34% earned R5000-8000. Most of these young women (51%) earned from R9000-12000. Respondents who earned R15000-25000 account for only 11% while non-response accounts for 1%. This shows that the majority of respondents earned an average income and the reason for this is that they were educated.

The next section is an analysis of the sexual behaviour of the young women in this age group living in Sunnyside.

4.4 SECTION B SEXUAL BEHAVIOUR FINDINGS

Table 4.2 Frequency distribution of sexual behaviour characteristics of young women in Sunnyside

Variable	**Number (N) 158 Frequency**	**Percentage % 100%**
Sexually active	**(N) 153**	
yes	132	86.3
No	21	13.7
Age of sexual debut	**(N) 153**	
9-11	4	3.0
12-13	5	3.8
14-16	26	19.7
17-19	62	47
20-24	35	26.5
Sexual orientation	**(N)158**	
Completely heterosexual	88	55.6
Completely lesbian	23	14.6
Not fully heterosexual	12	7.6
Bisexual	7	4.4
Non-response	28	17.8
Currently have a partner	**N(158**)	
Yes	132	83.6
No	26	16.4
Number of sexual partners	**N(132**)	
1 partner	105	79.5
2 partners	17	12.9
3-5 partners	10	7.6
Age of steady partner	**(N)132**	

18-20years	11	8.4
21-25 years	46	34.8
26-30 years	23	17.4
31-35 years	11	8.4
36-40 years	16	12
41-50 years	25	19
Age of other partners	**(N)27**	
21-30 years	8	29.63
31-40 years	11	40.74
41-50 years	8	29.63
Use of condoms consistently	**(N132)**	
Never	4	3
Almost never	15	11.36
Almost always	17	12.88
Always	50	37.88
Involved with steady sexual partner	24	18.18
Condom at last sexual intercourse	22	16.7
Desire sex without condom	**(N50)**	
Yes	27	54
No	23	46

4.4.1 Sexually active N=153

Respondents were asked whether they were sexually active and had to choose yes or no as an answer. Only 153 respondents answered this question. The reason for this question was that one of the most common ways of becoming infected with HIV infections is through sexual intercourse. Findings are presented below.

Approximately 96% (N=153) of young women who took part in the survey completed the section on sexual behaviour. Among these 153 young women, 86.3% reported being sexually active while 13.7% indicated that they were not sexually active This shows that most of the respondents were sexually active.

4.4.2 Age of sexual debut

Respondents were asked the age of their sexual debut. The reason was that the researcher wanted to know whether they had started to have sex at an early age because women's early sexual debut increases vulnerability to HIV infection. Studies from different cultural settings reveal that circumstances of adolescents' first sexual encounters have immediate and long-term consequences for their sexual health in later life (Shisana *et al.,* 2014; Dekeke 2014).

Only 132 young women responded to this question regarding sexual debut. A minority of respondents (3.0%) began to be sexually active between the ages of 9 and 11. They were followed by respondents between 12 and 13 years (3.8%); between 14 and 16 years (19.7%); those between 17 and 19 years (47%) and the majority between 20 and 24 (26.5%). According to these findings, most young women in Sunnyside were sexually active between the ages of 17 and 19. Shisana *et al.,* (2014:65) concur that having sex at a later age reduces susceptibility to infection per act of sex for females.

4.4.3 Sexual orientation

Respondents were asked this question in order to discover whether they were heterosexual, lesbian or bisexual. The reason for this was that the most common route for HIV infection nowadays is through heterosexual relationships. The results are revealed in table 4.2 above.

Table 4.2 indicates that 55.6% of young women who participated in this survey were completely heterosexual, while 14.6% were completely lesbian. The minority (7.6%) were not fully heterosexual while 4.4% were bisexual. An average of 17.8% of the young women did not respond. Heterosexual rather than lesbian behaviour predominates in this area of study. According to the Centre for Disease Control and Prevention (2012:1), high-risk heterosexual contact is the source of 80% of newly diagnosed infections of HIV/AIDS.

4.4.4 Currently have a partner N=158

Respondents were asked whether they had a partner. The reason for asking this question was that some of the respondents might be sexually active without having a partner. The results are revealed in table 4.2.

Table 4.2 shows that 83.6% currently had partners while 16.4% reported that they did not. The results show that most of the respondents had partners.

4.4.5 Number of sexual partners N =132

Respondents were asked the number of sexual partners they had. The reason was that the number of sexual partners influences the risk of HIV infection. Only 132 respondents answered this question. Results from table 4.2 are revealed as follows.

Of the 132 respondents, the majority (79.5%) had only 1 partner; 12.9% had 2 partners while 7.6% had 3 to 5 partners which is a high risk for HIV infection. Multiple sexual

partners have been identified as one of the major risks for HIV infection (Mutinta 2014:153). The fact that there are still young women in Sunnyside who have 2 partners or more shows that there is a high risk of HIV infection among them. The results of this study show that the majority of respondents have 1 partner.

4.4.6 Age of steady partner N=132

Respondents were asked to respond to this question in order for the researcher to understand in which age category their steady partner fell. Only 132 respondents answered this question. The results from table 4.2 are revealed below:

The largest proportion of respondents in table 4.2 (34.8%) had partners who were between 21 and 25 years of age and, surprisingly, respondents who had partners who were between 41 and 50 years (19%) followed them. An average of 17.4% of the respondents had partners of between 26 and 30 years of age and 12% of between 36 and 40 years of age. The minority (8.4%) were equally distributed between 18 and 20; and 31 and 35 years. Because young women who participated in this study were between the ages of 18 and 24 years, these findings reveal that they had partners who were more than 5 to 10 years older than they were. The theory of gender and power theorises that female adolescents are less likely to use condoms if they are more attracted to older partners (Wingood & Diclemente 2000:553). This creates an imbalance of power in a relationship that affects young women in Sunnyside.

4.4.7 Age of other partners N=27

Respondents who answered that they had more than two partners responded to this question. This was for the researcher to determine the age gap of other partners. Results are revealed as follows.

Only 27 participants, young women who had more than two partners, answered this question about the age range of other partners. Of the 27 respondents, 29.63% had

other partners aged between 21 and 30 years of age while 40.74% had other partners aged between 31 and 40 years, the highest percentage. Eight respondents (29.63%) had partners of between 41 and 50 years of age. These results support the statement above that the majority of respondents have partners who are 5 to 10 years older than they are. A large age discrepancy between a young woman and her partner is a risk factor for HIV (Shisana *et al.,* 2014:67).

4.4.8 Use of condoms consistently N=132

Respondents were asked if they used condoms because, currently, male and female condoms are the only ones available and the most effective technology to prevent HIV and other sexually transmitted disease. The question on the use of condoms as represented in table 4.2 was answered by respondents who agreed that they were sexually active (N=132). Of the 132 respondents, the majority (37.88%) responded that they always used condoms. Twenty-four (18.8%) respondents indicated that they used condoms when they were involved with their steady partners; 16.7% had used condoms at last intercourse and 12.88% used condoms. Fifteen (11.36%) of the respondents almost never used condoms and 3% of the respondents never did. The results show that most of the respondents used condoms. The fact that 3% of the respondents never used condoms indicates that they are at a high risk of contracting HIV infections.

4.4.9 Ever desire sex without condoms

The researcher wanted to know whether the respondents, especially those who responded that they used condoms always, ever desired sex without condoms. If they desired sex without a condom they might fall into a trap of not using it once, which made them more vulnerable to HIV infections. The results are presented below:

4.4.10. Desire sex without condoms N=50

Table 4.2 illustrates that only 50 respondents agreed that they always used condoms. The majority of young women respondents (54%) indicated that they did desire sex without condoms; while 46% answered that they did not desire sex without condom. Findings from table 4.2 show that most of the respondents desired sex without a condom on occasion. Now, in South Africa, correct and consistent use of condoms is the only integral component of the HIV prevention strategies that individuals can choose according to the Human Sciences Research Council South Africa 2012.

4.4.11 Having been engaged in one of the following N=158

Respondents were asked if they had ever engaged in injecting drugs, body piercing, vaginal sex, anal sex, traded money or drugs for sex, six or more alcoholic drinks. The results are revealed in figure 4.6 below.

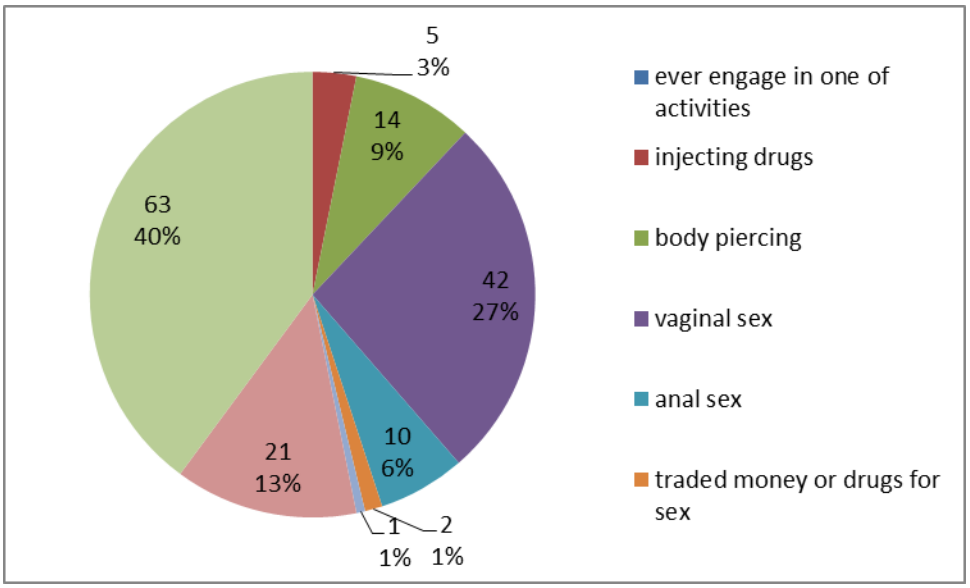

Figure 4.6 Been engaged in one of the following N=158

Figure 4.6 indicates that of the 158 respondents who completed the questionnaire, 27% agreed that they had had vaginal sex with more than two partners in the past year

without using a condom. Twenty-one (13%) respondents had had six or more alcoholic drinks in a single day in the past six months followed by sex. Fourteen (9%) of the respondents had done body piercing in the past year with a shared instrument. Ten (6%) respondents had had anal sex with more than two partners without using a condom. One (1%) had traded money or drugs for sex; another 1% traded drugs for sex. Sixty-three (40%) respondents did not engage in any of the above. The results of this study show that the majority of respondents did not engage in any of these activities.

4.4.12 Knowledge of anyone who is HIV positive

Respondents were asked to answer yes or no to whether they knew anyone who was HIV positive. Respondents were asked this question because knowledge of HIV is very important especially for young people who are sexually active. The results of the findings are as follows.

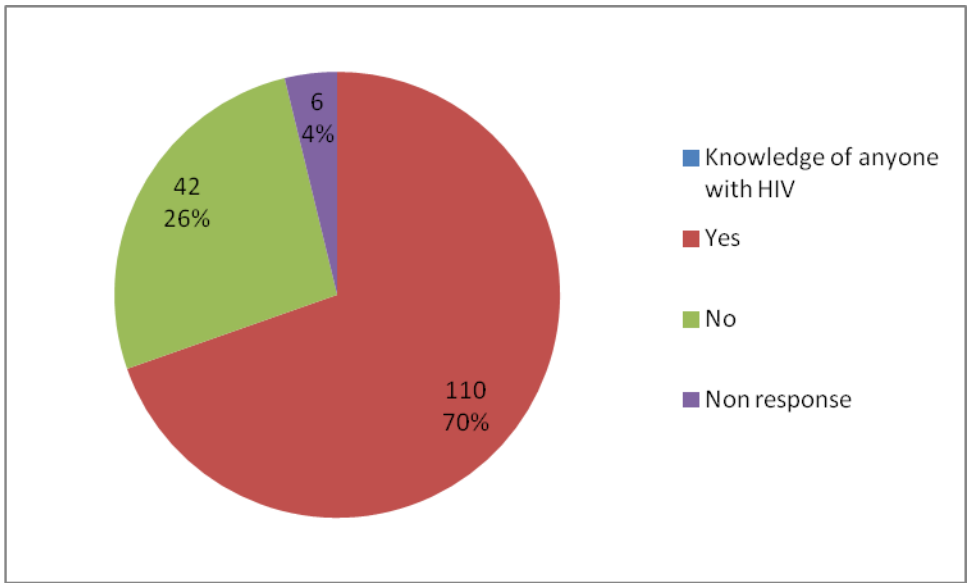

Figure 4.7 Knowledge of anyone who is HIV positive N=158

Figure 4.7 reveals that 70% of the respondents reported knowing someone who was HIV positive; 26% did not know anyone who was positive while 4% did not respond.

From the findings, it is clear that most of the young women in Sunnyside have knowledge of someone who is HIV positive. According to Shisana *et al.,* (2014:98), knowing someone with the disease plays an important role in changing perceptions of the seriousness of HIV.

4.4.13 Young women think HIV is

Respondents were asked this question in order to determine whether they knew what HIV was and any further knowledge of HIV. Myths about the cause and meaning of HIV abound. The results are as followed in figure 4.8.

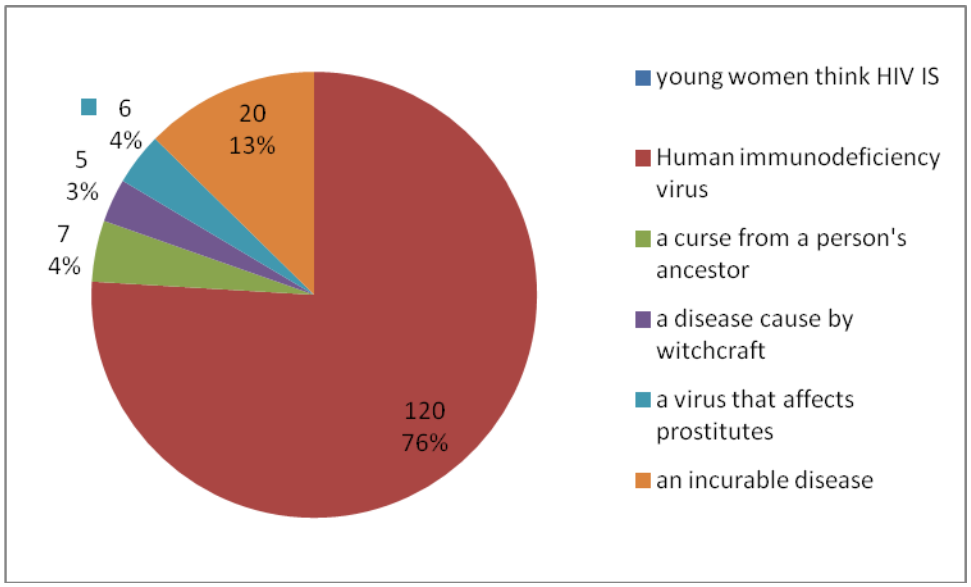

Figure 4.8 Perceptions of young women regarding HIV N=158

The majority of the respondents (76%) in figure 4.8 knew what HIV stands for as they identified HIV as the human immunodeficiency virus. Twenty (20) respondents (13%) knew that it was an incurable disease; 4% reported that it was a virus that affected prostitutes and 4% believed it to be a curse from a person's ancestor. Five (3%) of the respondents answered that it was a disease caused by witchcraft. From the findings, it is clear that the majority of young women know what HIV is. However, according to the

South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2012, having knowledge about HIV transmission does not necessarily result in behavioural change and efforts to prevent HIV infection (Shisana *et al*., 2014:93). This is just a prerequisite for engaging in HIV prevention practices.

4.4.14. Perception of close friends who are at risk of getting the AIDS virus

The respondents were asked whether they perceived their friends to be at risk of getting the AIDS virus. This question (yes or no answer) was asked because most young people do not test for HIV because they perceive themselves as not at risk of being infected. The findings are revealed in figure 4.9 as follows**.**

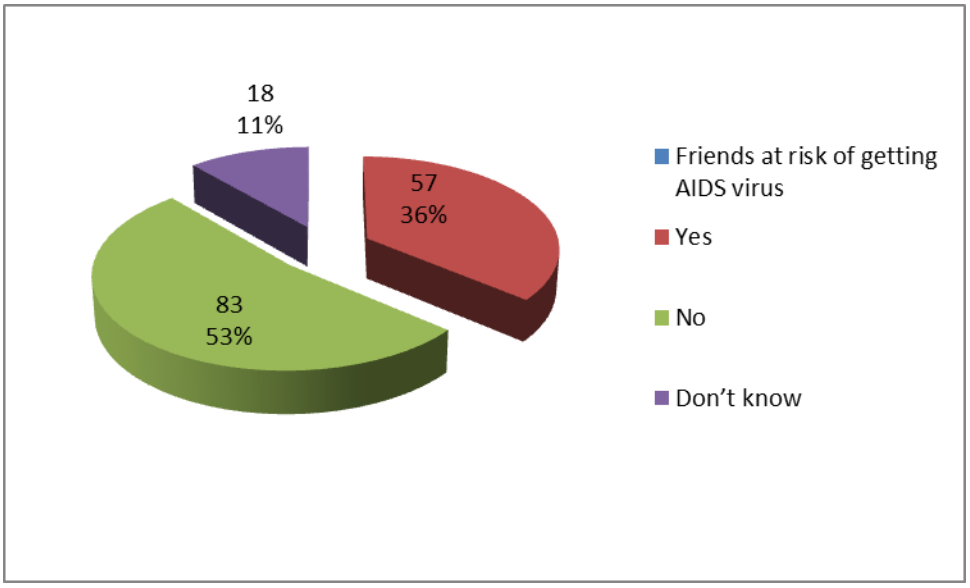

Figure 4.9 Close friends at risk of getting the AIDS virus N=158

Figure 4.9 shows that only 36% of the respondents agreed that their close friends were at risk of getting the AIDS virus, while the majority (53%) did not agree and only 11% did not know. According to Shisana *et al.*, (2014:86), there is an association between perceptions of HIV infection and sexual behaviour. The Health Belief Model (HBM) perceives that one's personal beliefs influence health behaviour (Rosenstock, Strecher,

Marshall & Becker 1988:177). Wingood and Diclemente (2000:554) in their theory of gender and power emphasise perceived risks of acquiring HIV as a personal risk factor. This indicates that the majority of young women in Sunnyside do not perceive their friends to be susceptible to the disease, and as a result they are more likely not to take preventive measures.

4.4.15 HIV TEST

Respondents were asked if they had tested for HIV to determine whether they knew their status. All the respondents answered this question. The findings are revealed in figure 4.10.

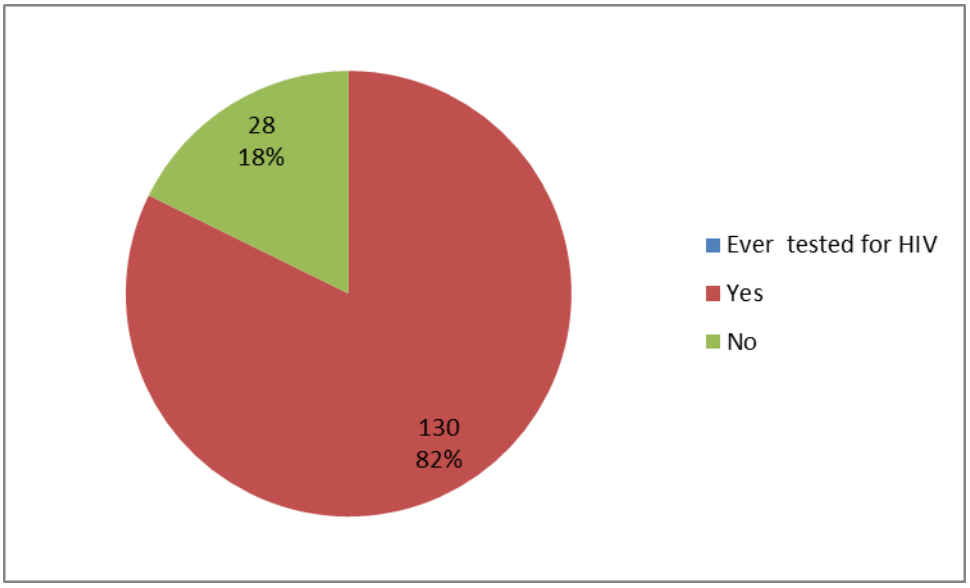

Figure 4.10 Ever tested for HIV (N=158)

Most of the respondents (130; 82%) in figure 4.10 indicated positively which shows that they had tested for HIV. Twenty-eight respondents (18%) had not tested at all. According to this finding, the high a number of respondents who had tested for HIV supports the results of figure 4.7 that respondents have a good knowledge of HIV.

4.4.16 If no, what could be the reasons

Respondents were asked their reasons for not testing and a list of reasons was provided to choose from. Results are given in figure 4.11.

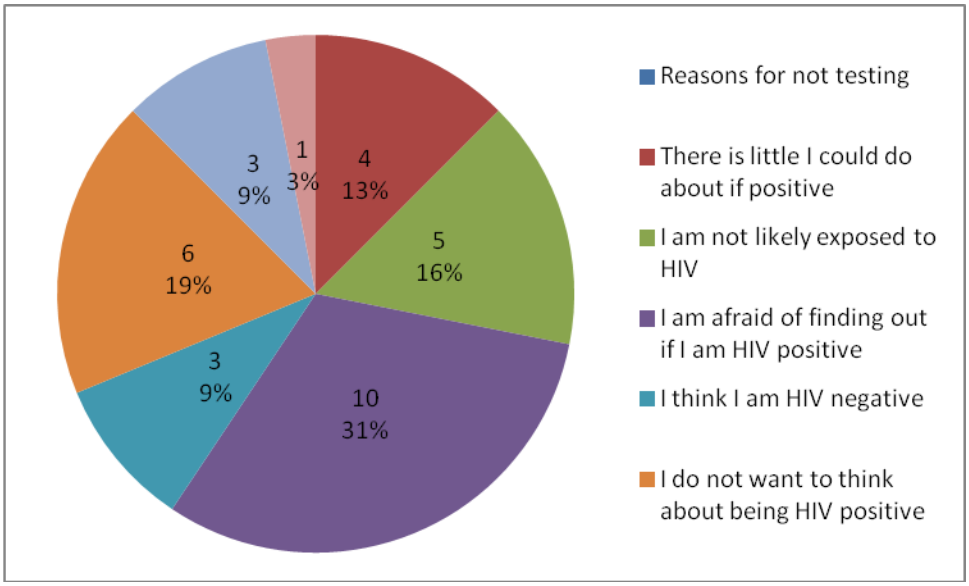

Figure 4.11 Reasons for not testing (more than one selection) N=32

The 28 respondents who answered this question in figure 4.11 are the respondents who indicated in figure 4.10 that they had not tested for HIV. The question allowed respondents to make more than one selection. In other words, some selected more than two reasons. Ten (31%) respondents indicated that they were afraid of finding out whether they were positive and six (19%) did not want to think about being HIV positive. Four (13%) respondents said there was little they could do about it if positive. Three (9%) respondents indicated that they did not have time. One (3%) in each case was unsure of whether to be tested, and did not have any reason for avoiding testing. The findings indicate that fear of testing and ignorance of being positive are the major blocks among young women to know their status and be tested for HIV/AIDS.

4.4.17 Exposure to HIV prevention messages in the past six months

Respondents were asked whether they had been exposed to prevention messages in the past six months. This was in addition to the question in figure 4.7 of the knowledge of prevention they had about HIV/AIDS. The results of the findings are as follows.

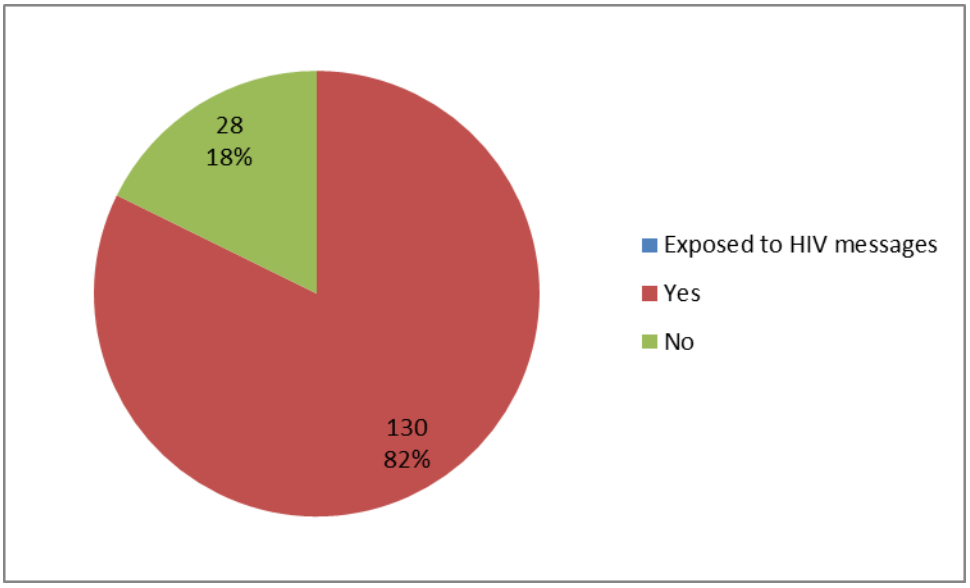

Figure 4.12 Exposed to HIV messages N=158

Figure 4.12 indicates that 130 (82%) respondents had been exposed to HIV prevention messages in the past six months. Twenty-eight respondents (18%) had not been exposed to HIV prevention messages. Evidence from these findings indicates that most young women are literate about HIV prevention messages.

4.4.18. if yes where

Respondents were asked where they had learnt about HIV prevention messages. All respondents N=158 answered this question and they were allowed to choose more than two answers. The results are revealed in figure 4.13 below.

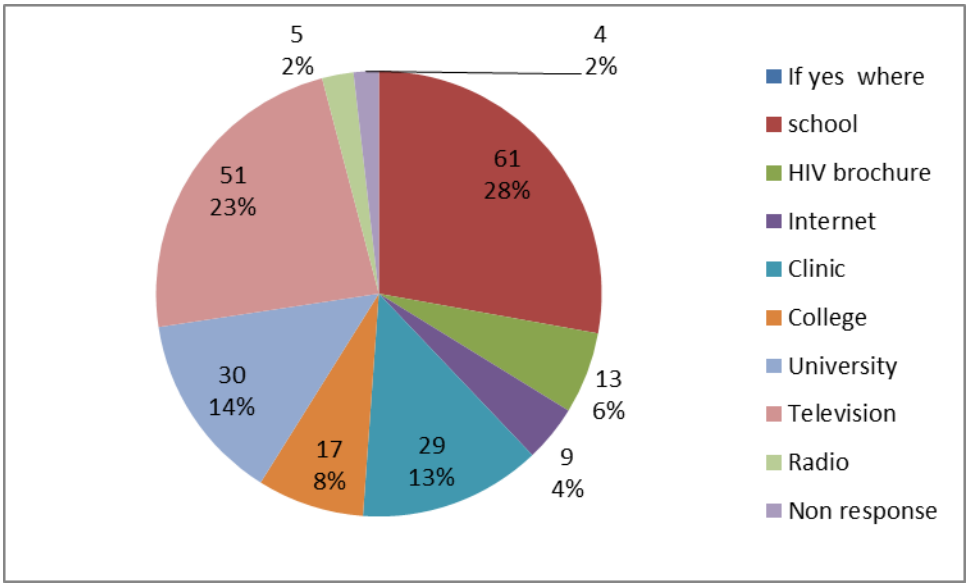

Figure 4.13 Place of exposure to HIV messages N=158

Figure 4.13 indicates that 28% of the respondents learnt about HIV prevention messages at school; 23% from television; 14% at university; 13% from information at the clinic; 8% at college and 6% from HIV brochure messages. The minority, 4%, learnt from the internet and 2% did not respond. The results of this study reveal that young women in Sunnyside have knowledge of HIV prevention messages.

4.4.19 Cultural beliefs that influence attitudes about sexual intercourse

The researcher wanted to find out whether there were cultural beliefs that influenced young women's attitudes to sexual intercourse. The reason for this question was that several studies have shown that women who adhere to traditional norms are more likely to engage in behaviour that increases their risk of HIV (Gilbert & Selikow 2011; UNAIDS 2013).

4.4.20 List of cultural beliefs in the order of importance

Respondents were given a list of cultural beliefs to choose from. The results are provided below in figure 4.14.

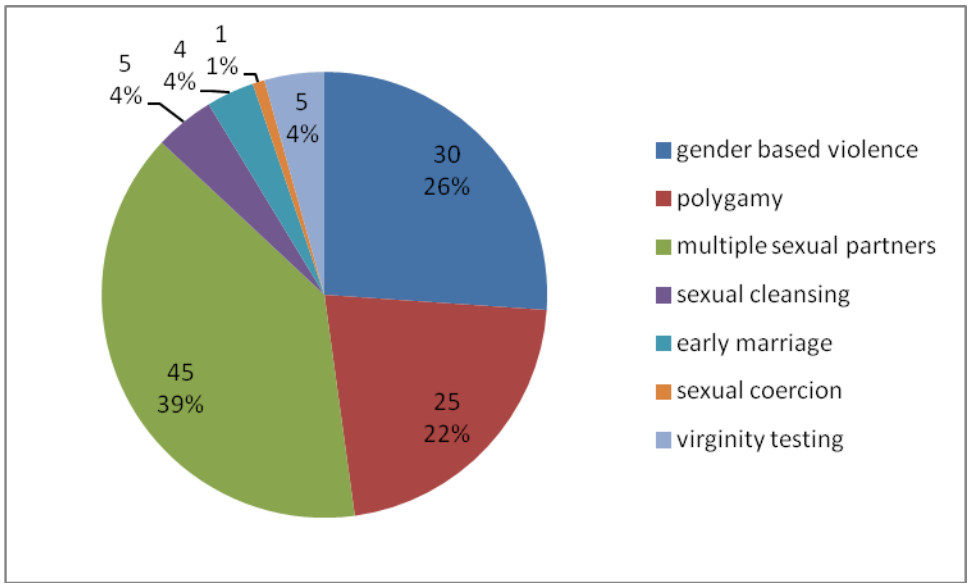

Figure 4.14. List of cultural beliefs N=115

A high percentage of respondents (39%) regarded multiple sexual partnerships as the main cultural belief that influenced their attitude to sexual intercourse, closely followed by gender-based violence (26%) and polygamy (22%). Virginity testing, sexual cleansing and early marriage were of equal distribution at 4% while sexual coercion only 1%. Findings show that multiple sexual partnership was a cultural norm that increased respondents' risk of HIV.

4.4. 21 Social beliefs that influence attitudes to sexual intercourse

Respondents were also asked whether there were social beliefs that influenced their attitudes to sexual intercourse. Results are revealed in figure 4.15 below.

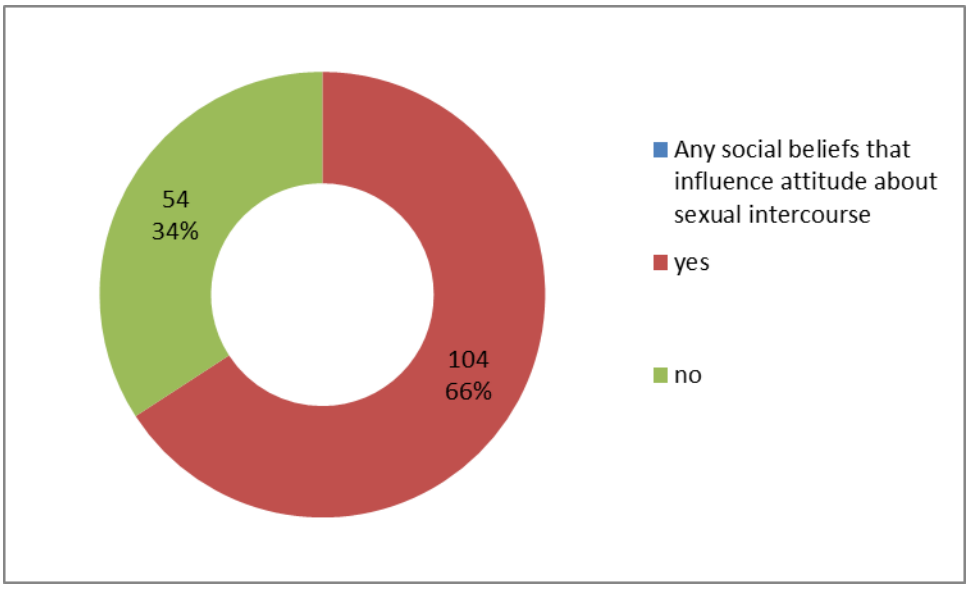

Figure 4.15 Social beliefs N=158

The highest number of respondents (66%) reported that there were social beliefs that influenced their attitudes to sexual intercourse, while 34% did not agree.

4.4.22 List of social factors that influence attitudes to sexual intercourse

The researcher also wanted to find out whether there were social factors that influenced the attitudes of young women in Sunnyside to sexual intercourse. The results of the findings are revealed in figure 4.16 below.

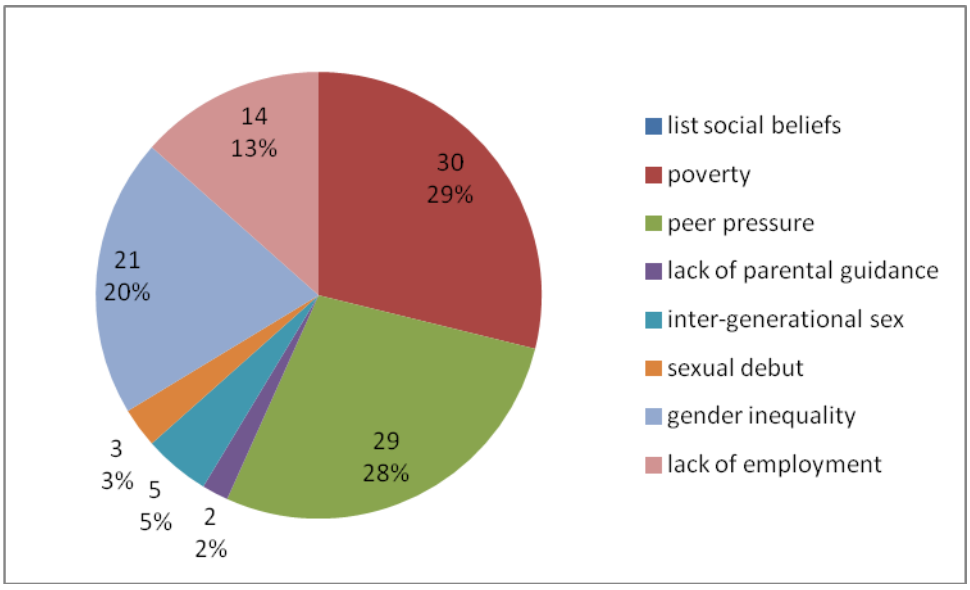

Figure 4.16 List of social factors N=104

According to figure 4.16, poverty was regarded by 29% of the respondents as the main social factor that influenced their attitudes to sexual intercourse. More than a quarter (28%) selected peer pressure. This was followed by 20% for gender inequality and 13% for lack of employment; 5% for intergenerational sex; 3% sexual debut and 2% for lack of parental guidance.

4.4.23 Description of alcohol consumption patterns

The researcher wanted to know about the alcohol consumption of the respondents. The reason was that alcohol consumption is regarded as a behavioural risk factor (Dekeke & Sandy 2014:4). Results are revealed in figure 4.18.

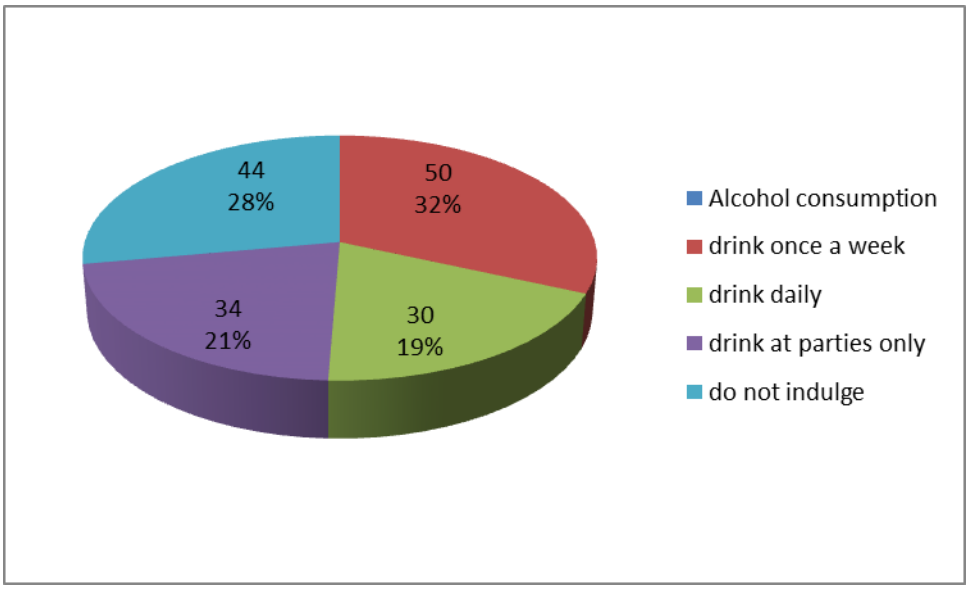

Figure 4.17 alcohol consumption =158

Figure 4.17 indicates that the majority of respondents (32%) drank once a week while 28% did not indulge. Almost a quarter (21%) of the respondents drank at parties only while 19% drank daily. According to the ICAP Blue Book (2012:24.2), alcohol use is a sexual disinhibitor that may place individuals at risk of acquiring HIV through unsafe sex. Findings reveal that the majority of respondents drank alcohol once a week.

4.4.24 Place of alcohol consumption

The researcher wanted to know the places where the respondents imbibed alcohol. This was for her to understand the environment in which the respondents liked to drink. The results are as follows.

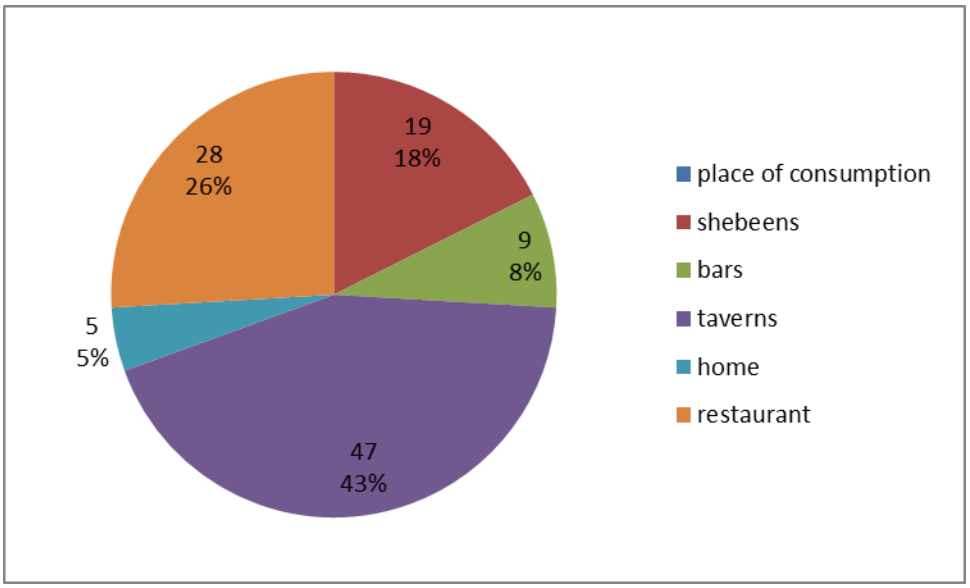

Figure 4.18 Place of consumption N=108

The 108 respondents who indicated in figure 4.18 their place of consumption answered the question. Of the 108 respondents, 43%, the majority, revealed that they drank at taverns; 26% at restaurants; 18% at shebeens; 8% at bars and 5% at home. The findings of this study show that a high number of respondents enjoy drinking in taverns.

4.4.25 Advantages of drinking alcohol before sex

Respondents were also asked if there were advantages to drinking alcohol before sex and their views are revealed below in figure 4.19.

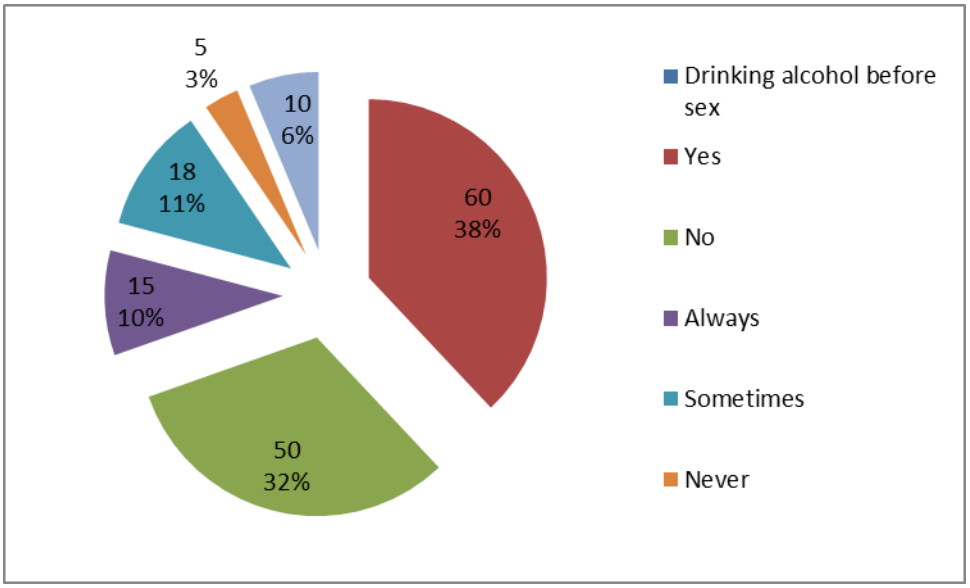

Figure 4.19 Advantages of drinking alcohol before sex N=158

Figure 4.19 indicates that the majority of young women, 38% of the 158 participants, indicated positively, meaning that they thought there were advantages to drinking alcohol before sex. The 44 respondents (figure 4.17) who reported that they did not indulge, indicated that there were no advantages to drinking alcohol before sex. Fifteen (10%) of the respondents thought that there were always advantages; 11% believed that sometimes there were advantages and 3% reported that there were never advantages. A small number (6%) did not respond. The findings of this data show that the majority of the respondents believed that there are advantages to drinking alcohol before sex.

4.4.26 Reasons for drinking alcohol before sex

The researcher wanted to know whether alcohol played an important role in the young women's lives and what their views were. Only 60 respondents reported that there were advantages to drinking alcohol before sex and the findings are revealed below.

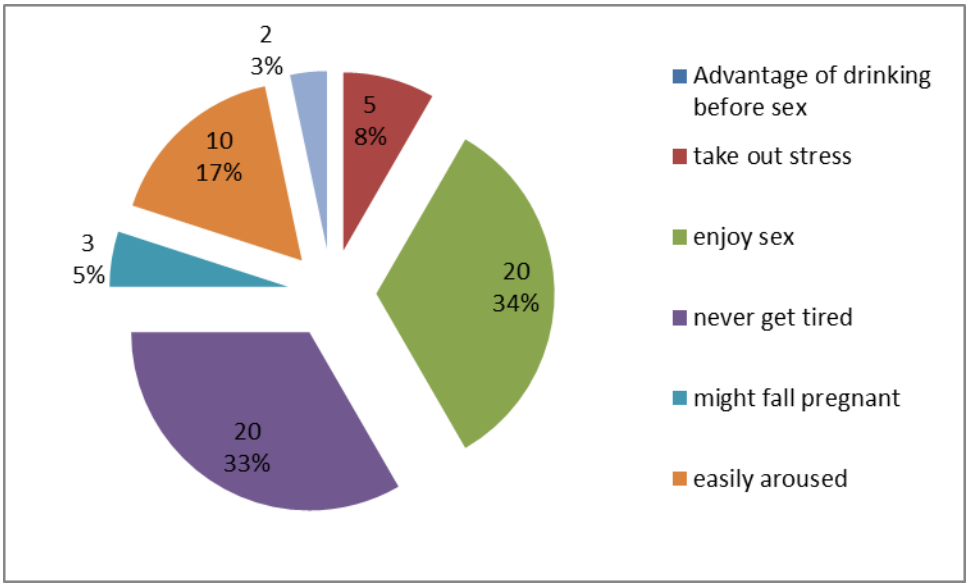

Figure 4.20 Reasons for drinking alcohol before sex N=60

Slightly more than a third of the respondents (34%) indicated that they enjoyed sex after drinking alcohol; 33% reported that they never felt tired when having sex after alcohol; 17% mentioned that they were easily aroused after alcohol and 8% thought that alcohol reduced their stress. A small number (5%) thought that they might fall pregnant and 3% indicated that drinking alcohol before sex caused them to lose control of their emotions. Research suggests that there is an existing relationship between alcohol abuse and an increased risk of STDs as well as HIV/AIDS (Phetoe 2011). Findings of the study reveal that most of the respondents enjoy sex if they are drunk.

4.5. SEXUAL RELATIONSHIP POWER AND DECISION MAKING

In this section eligible participants were all young women who were sexually active and had a partner (N=132). The researcher administered the South African adaptation of Sexual Relationship Power and Decision making developed by Pulerwitz *et al.,* (2000). To validate the Sexual Relationship Power Scale, data was collected from study subjects on physical abuse, emotional abuse, sexual violence, forced sex, and condom use. Decision making and relationship power were also added. Sixteen questions were

used to construct the relationship control scale and these were from the Sexual Relationship Power Scale, which consists of 23 items and 2 subscales

The respondents were to answer yes or no. The questions for the Sexual Relationship Power Scale were paired to elicit the same information about the respondents and their partners, for example:
Forced sex was created using the following questions: Do you withhold sex to get even with your partner?
Sexual violence: Do you have sex when you do not want to?
Physical abuse: Have you ever hit or been hit by your partner?
Condom use: Do you feel free to discuss condom use with your sexual partner.
Emotional abuse: Are you afraid to tell your partner when your feelings are hurt?
Relationship dissatisfaction: Do you feel that you are stuck in this relationship? Are you unhappy with your friendship?
Decision making: Do you rely on your partner to make most of the decisions in the relationship?

4.5.1 Percentage of respondents who reported experiencing a relationship of physical abuse, emotional abuse and relationship dissatisfaction using the Sexual Relationship Power Scale and its Subscale (Age 18-21)

Respondents were asked if they were abused emotionally, physically and experienced relationship dissatisfaction. The reason for this question was to measure power within sexual relationships. The results are revealed in figures 4.22 and 4.23 below.

Sexual relationship power and decision making

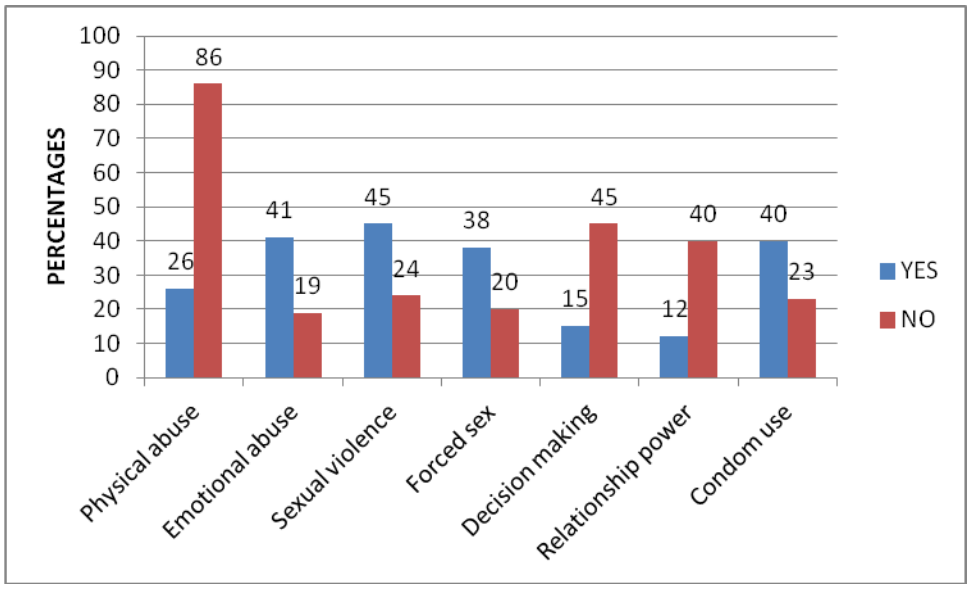

Figure 4.21 Sexual relationship power and decision making age 18-21 N=132

Figure 4.22 reveals that the 132 young women who indicated that they were sexually active were categorised into two groups: those from 18 to 21 years and those from 22 to 24 years of age. In the younger group of 18 to 21 years, 86%, the highest percentage, did not experience physical abuse, while 26% felt that they were physically abused; 41% of the young women experienced emotional abuse while 19% reported that they did not; 45% of the respondents experienced sexual violence while 24% did not. Young women who reported forced sex account for 38% and 20% did not. A minority of respondents (15%) were unable to decide for themselves while 45% reported making their own decisions. With regard to relationship power, 12% of the respondents agreed that they were satisfied with their relationships but a larger number of the respondents (40%) were not satisfied. The question on condom use was repeated as the researcher wanted to know who had the most power regarding condom and the results show that only 40% stated that they had the power to negotiate condom use while 23% did not.

4.5.2 Percentage of respondents who reported sexual relationship power of physical abuse, emotional abuse and relationship dissatisfaction by the Sexual Relationship Power Scale Subscale (age 22-24)

Sexual relationship power and decision making

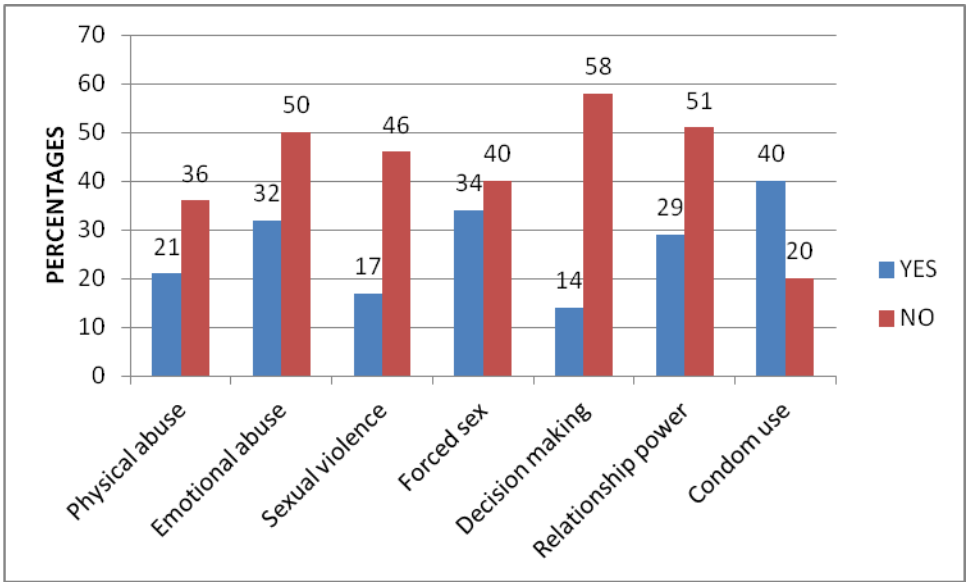

Figure 4.22 Age 22-24 N=132

According to the above figure 4.23, only young women between the ages of 22 and 24 years were classified as an older age in order for the researcher to compare the two age groups with regard to sexual relationship power and decision making. Almost a quarter (21%) of the young women stated that they were physically abused by their partners and 36% were not; 32% of those who responded reported abuse while 50% did not. A few participants (17%) experienced sexual violence while 46% did not; 34% experienced forced sex and 40% did not. The results reveal that only a few young women (14%) could make decisions on their own with regard to their relationships. Most of the decisions were made by their partners (58%). Only 29% of the respondents reported more power in a relationship while 51% reported less. Condom use was also included in the relationship power scale to measure the relationship control factor: 40% of the young women reported that they had the power to use a condom while 20%

(half of the respondents) did not have the power to control their partners regarding condom use.

Table 4.3 Indication of the overall relationship power between the two ages (18-21 and 22-24) N=132

	Physical abuse	Emotional abuse	Sexual violence	Forced sex	Decision making	Condom use	Relationship satisfaction	Total	Mean %
Age 18-21									
Yes	26	41	45	38	15	40	12	217	31.0
No	86	19	24	20	45	23	40	257	36.7
Age 22-24									
Yes	21	32	17	34	14	45	29	192	27.4
No	36	50	46	40	58	20	51	301	43

Table 4.3 reveals the overall results of the Sexual Relationship Power Scale. The respondents aged 22 to 24 did not experience power in their relationships. The results indicate that the women between 18 and 21 experienced much physical abuse, forced sex, emotional abuse, and sexual violence and could not make decisions on their own, more so than those of 22 to 24 years of age could. They were also afraid to use or negotiate condom usage. Both results were cross tabulated and the total was calculated in order to find the mean. This table shows that the mean of respondents who reported positively in all the variables at 18 to 21 years is 31.0% while negative responses are 36.7%. Young women between 22 and 24 years of age who reported positively account for 27.4% while negative responses account for 43%. The use of condoms in both groups reveals that half of the respondents did not have the power to insist on condom usage. This is still a high percentage.

Table 4.4 Factor analysis for Sexual Relationship Power Scale N=132

Correlation matrix (Pearson (n)):

Variables	physical abuse	emotional abuse	sexual abuse	forced sex	decision making	relationship power	condom use
physical abuse	**1**	0.869	0.937	0.815	0.952	0.993	0.533
emotional abuse	0.869	**1**	0.987	0.995	0.677	0.804	0.882
sexual abuse	0.937	0.987	**1**	0.966	0.786	0.889	0.795
forced sex	0.815	0.995	0.966	**1**	0.600	0.741	0.924
decision making	0.952	0.677	0.786	0.600	**1**	0.982	0.249
relationship power	0.993	0.804	0.889	0.741	0.982	**1**	0.428
condom use	0.533	0.882	0.795	0.924	0.249	0.428	**1**

Eigenvalues:

	F1	F2
Eigenvalue	5.849	1.151
Variability (%)	83.553	16.447
Cumulative %	83.553	100.000

Factor pattern:

	F1	F2	Initial communality	Final communality	Specific variance
physical abuse	**0.959**	-0.282	1.000	**1.000**	**0.000**
emotional abuse	**0.973**	0.230	1.000	**1.000**	**0.000**
sexual abuse	**0.998**	0.070	1.000	**1.000**	**0.000**
forced sex	**0.946**	0.325	1.000	**1.000**	**0.000**
decision making	**0.828**	-0.561	1.000	**1.000**	**0.000**
relationship power	**0.919**	-0.395	1.000	**1.000**	**0.000**
condom use	**0.750**	0.662	1.000	**1.000**	**0.000**

Values in bold correspond for each variable to the factor for which the squared cosine is the largest

According to table 4.4 the seven variables were significantly associated with relationship power. Relationship of physical abuse p<001; emotional abuse p<001; sexual abuse p<001; forced sex p<00; decision making p<001 and condom use p<001. The modified scale results also show that it maintains a good internal consistency reliability (alpha=.83). The Sexual Relationship Power Scale was also explored separately to test the validity and reliability using the chi-square distribution. The results are revealed in table 4.5 below.

Overall Sexual Relationship Power Scale Chi-square distribution of the two ages 18-21 and 22-24.Test statistics and observed values HO:P=0.5

Table 4.5

	Yes	No	Total
Relationship control	59	6	65
Decision making	150	364	514
Power in relationship	118	156	274
Emotional control	98	146	244
Total	425	672	1097

Expected values (fe)

	Yes	No	Total
Relationship control	25.18	39.82	65
Decision making	199.13	314.87	514
Power in relationship	106.15	167.85	274
Emotional control	94.53	149.47	244

X2=96.3036 degree of freedom df=3, p-value <05, at 1% level of significance=0.01, Critical value =11.345

The null hypothesis Ho is rejected at 1% level of significance. Because test statistics are more than the critical value=11.345, the alternative hypothesis Ha is accepted. The Sexual Relationship Power Scale remained significantly related to variables (P<05): of relationship control, decision making, power in a relationship and emotional control.

4.6 DISCUSSION: SUMMARY AND INTERPRETATION

The researcher adopted the descriptive analysis method to analyse data from the questionnaires. It was possible to analyse because of the coding that had been done before. The findings were categorised under the following demographic characteristics: environmental, socio-economic status and sexual behaviour. The latter includes cultural, social and sexual relationship power. The findings of the study support the theoretical perspective of gender and power in relationships and are discussed below.

4.6.1 Biographic factors

The findings of the biographic characteristics of the respondents revealed that the majority of young women aged between 18 and 24 who lived in Sunnyside reported being single and being in heterosexual relationships. Most of these young women were educated. This age group falls under the category of the age group 20 to 34 years – a high-risk group of HIV exposure as identified by Shisana *et al*., (2012:53). The study also revealed that 23.4% of young women in Sunnyside lived with their partners but were not married, which is also regarded as high-risk exposure to HIV/AIDS.

4.6.2 Socio-economic status of women in Sunnyside

Dibua (2009:12) concurs that socio-economic factors indirectly influence HIV/AIDS transmission since they influence the individual's decision to indulge in HIV/AIDS risk behaviours. Almost 78 (49%) of the respondents in the research were employed and the highest monthly personal income was R15000-25000 (11%) and the lowest (3%) R1000-4000.00. The majority of these young women (52%) were single and most of them paid rent of between R2500 and R3000. Some of the young women were unemployed and according to Wingood & Diclemente (2000:546) in their theory of gender and power, the structure of sexual division of labour emphasises that women who are unemployed may have to rely on their male partners economically. Poverty

both at the individual and societal level has been associated with HIV prevalence (Mutinta 2014:153**)**. The findings of this study revealed that some of young women in Sunnyside received lower incomes and indicated poverty as one of the main factors influencing the risk of HIV/AIDS. This was supported by 29% of the respondents who iterated that poverty influenced their attitudes to sexual intercourse. The theory of gender and power emphasises that women in lower income brackets and penury are less likely to use condom and indeed may not be able to afford HIV prevention materials thus increasing their exposure to HIV (Wingood & Diclemente 2000:546).

4.6.3 Sexual behaviour

Most of the young women researched in Sunnyside (86.3%) indicated that they were sexually active and the majority of them (13.7%) became sexually active between the ages of 17 and 19 years of age. Heterosexual (55.6%) rather than lesbian (14.6%) behaviour predominated in the area of study; a few instances of bisexual behaviour also did exist. Heterosexual relationship is regarded as the fastest mode of HIV transmission in South Africa nowadays (Shisana *et al*., 2014:1). The results also revealed a low practice of intergenerational sex, which means a relationship between individuals from high-risk groups. An average of 9% of the respondents (aged 18-24) had partners who were in the age range of 40 to 50 – more than 5 to 10 years older than they were. Shisana *et al.,* (2009) identified this practice of age mixing or intergenerational sex as a contributing factor to the spread of HIV/AIDS. The age group 18-24 is considered as the age of high youthful excitement and this group represents the group of highest HIV prevalence as well as highest sexual activity (UNAIDS 2013:6).

The use of alcohol is also a problem when the results of this study are considered. More than a quarter (32%) of the respondents reported that they drank alcohol once a week. Surprisingly there were also young women who drank on a daily basis in Sunnyside according to the findings of this study. The majority of the respondents (43%) preferred drinking in taverns and restaurants and this was due to the many restaurants and taverns situated in Sunnyside. Young women also mentioned the following advantages

of drinking alcohol before sex, the most important being that they enjoyed sex more (34%); followed by sex never felt tired (33%); they were easily aroused (17%); and having drinks before sex lessened stress (8%). Alcohol and drug use was identified as a risk factor for HIV/AIDS (ICAP Blue Book 2012). The above views are in line with many South African studies in Gauteng and Western Cape Province, which demonstrate that alcohol consumption is strongly linked to risky sexual behaviours including unprotected sex and multiple sexual behaviours (Phetoe 2011).

More than half of the young women researched in Sunnyside (53%) also thought that their friends were not at risk of getting the AIDS virus because of their behaviour. This is despite the fact that some of the respondents in this study (18%) did not test for HIV at all, giving the reason that they were afraid of finding out whether they were positive or not.

Condom use was indicated by more than 37.88% of respondents as a behavioural change option, but an average of 3% of the respondents never used condoms and this indicated a high risk of contracting HIV infections. More than half (54%) used condoms but desired sex without condom. The results of this study also disclosed that 27% of the respondents stated that they had had vaginal sex with more than two partners in the past years without using a condom and 6% had had anal sex with more than two partners without using a condom. As result, young women in Sunnyside have poor condom usage skills, which are regarded by DePadilla, Windle, Wingood, Cooper, & Diclemente (2012:9) in their theory of gender and power as a behavioural risk factor.

4.6.4 Socio-cultural factors

Multiple sexual partners were identified as the most important socio-cultural factor in this study, which predisposes people to HIV/AIDS. Having multiple sexual partners exacerbates the likelihood of exposure to HIV through expanding sexual networks. The

minority percentage of respondents (7.6%) reported having 3 to 5 partners, which is a high risk for HIV transmission among the people.

Cultural beliefs and customs that influence attitudes about sexual intercourse were identified by respondents and include gender-based violence, polygamy, sexual cleansing and sexual coercion. Polygamy (having more than one wife) is still practised in some parts of southern Africa, and it is difficult to stop it because in many areas it is regarded as a traditional practice (Bond 2011:15). Polygamous relationships are one of the fastest ways of spreading HIV/AIDS. Sexual cleansing is a ritual in which widowed women are forced into sexual relations that are often unwanted (Bond 2011:29). It is a belief in most African cultures that women need to be cleansed of the dead men's spirits (Bond 2011:29). Sexual cleansing also includes vaginal practices such as dry sex which include douching, application of substances to the external genitalia and various procedures for surgical or anatomical modification of women's genitalia (Smit, Chersich, Beksinska, Kunene, Manzini, Hilber & Scorgie 2011:245). This practice is very common in South Africa especially in KwaZulu-Natal Province (Smit *et al*., 2011:255). Only 4% of the respondents in this study noted sexual cleansing as a belief that influenced their attitude to sexual intercourse. This practice exposes women to HIV infections because there is no guarantee that it is safe.

Sexual violence is the use of force or manipulation to get someone to engage in unwanted sexual activity without his or her consent (Vetten 2014:1). Findings from this study indicate that young women in the age group 18-21 experienced sexual violence (45%). Surprisingly, in the older age group (22-24) only 17% reported sexual violence. Violence against women is also a major problem in South Africa (Gilbert & Selikow 2011:329). Gender-based violence, which was chosen by 26% of the respondents in this study, can be regarded as violence that includes physical abuse, emotional abuse, sexual abuse and rape. Gender-based violence is one of the leading causes of HIV/AIDS in this country (Gilbert & Selikow 2011:330). All these factors have been

identified in this study as contributing factors to the spread of HIV/AIDS among young women in Sunnyside.

Social beliefs that influence young women's attitudes to sexual intercourse in Sunnyside were also identified in this study. Poverty was considered a major factor influencing indulgence in heterosexual activities. Poverty also established the socio-cultural and sexual behavioural HIV risk factor among young women in Sunnyside.

Peer pressure, intergenerational sex, gender inequality and lack of employment were also mentioned as very important factors that influenced young women's attitudes to sexual intercourse. Peer pressure was identified as one of the major factors influencing youth to participate in high-risk behaviour, for example, pressure from friends to have sexual intercourse or to drink alcohol (Mutinta 2014:152). Inter-generational sex, which is the practice of age mixing such as young women having sex with older males, has been acknowledged as a major transmission of HIV infection in South Africa (Shisana *et al.*, 2009:2). The concept of gender equality in South Africa is still male dominated; women are socialised to over-respect men and act submissively towards them (Gilbert & Selikow 2011:328). The findings of this study show that there are unequal power relations between respondents and their partners in the age group of 18-21 years, particularly when negotiating sexual encounters.

4.6.5 Knowledge of HIV/AIDS

There is a high knowledge of HIV/AIDS among the respondents as the results revealed that 70% of the respondents knew someone who was HIV positive. The majority of these young women (76%) knew that HIV stands for human immunodeficiency virus, but there were some who still thought that HIV was a virus that affected prostitutes. A large number (82%) of respondents who tested for HIV indicated that young women in Sunnyside had knowledge of HIV. Respondents who had not tested (31%) gave the reason that they were afraid of finding out that they were positive while 16% thought that they were negative and 19% did not want to think about being HIV positive. This

study showed that 3% of the respondents who had no knowledge of HIV did not care. The results also revealed that most of the respondents had been exposed to HIV prevention messages at school, on television, at university and on radio. Accurate knowledge of HIV transmissions can result in behavioural change and efforts to prevent HIV infection among young women in Sunnyside.

4.6.6 Sexual Relationship Power Scale

Variables that are theoretically associated with sexual relationship power such as history of forced sex, physical abuse, condom use, relationship satisfaction, decision making were added to the questionnaire in order to test construct validity. Because Pulerwirtz, Gortmaker & DeJong (2000:641) and others previously demonstrated that these variables are significantly associated with relationship power, the same questions were used in this study. According to the results of the Chi-square test, the Sexual Relationship Power Scale remained significantly related to five variables (P<05). The modified scale results of factor analysis also show that it maintains a good internal consistency reliability (alpha=.83).

The results of this study indicated that respondents who fell under the age category of 18-21 years experienced physical abuse, emotional abuse, sexual abuse and forced sex with the mean average of 31.0% compared with respondents who were older (22-24 years) at the mean average of 27.4%. According to the gender and power theory, women who experienced physical exposure such as physical abuse, emotional abuse and forced sex, were likely to be in a high risk of HIV infection and were less likely to negotiate condom use in their relationships (Wingood & Diclemente 2000). Reliability analysis was calculated for four dimensions of factors that yielded alpha values between 0.750 and 0.998. Internal consistency reliability of the four factors was ascertained using Chi-square of 96.3036 with 11345 degree of freedom; p=0.05 level was obtained.The Chi-square test was used to determine whether there was a significant association among the four variables of relationship control, decision making

dominance, emotional abuse, and relationship dissatisfaction. The results reveal that there is a significant relationship among the four variables with p-value <05.

4.7 CONCLUSION

In this chapter, the findings of the research study were presented, discussed and interpreted with theoretical models of gender and power, which were supported by the Sexual Relationship Power Scale. Findings from this study revealed that young women in Sunnyside are knowledgeable about HIV/AIDS, even though some of them are still fearful of knowing their status. Behavioural risk factors such as the use of alcohol among young women in Sunnyside were explored. It was evident from the findings of the study that socio-economic and socio-cultural factors placed women at an increased risk of becoming HIV-infected. The Sexual Relationship Power Scale also proved in this study that many young women in Sunnyside were experiencing emotional abuse, physical abuse and forced sex. In the next chapter, the researcher discusses conclusions from the study and recommendations arising from the findings.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion and summary of the findings according to the objectives, draws conclusions and makes recommendations. The overall aim of the study was to describe the socio-economic, socio-cultural, environmental risk factors that influenced young women's vulnerability to HIV infection.

5.2 SUMMARY OF FINDINGS ACCORDING TO OBJECTIVES

5.2.1 Objective 1: The socio-economic and environmental factors that influence young women's vulnerability to HIV infection

The first objective of the study was to describe the socio-economic and environmental factors at Sunnyside that influence young women between the ages of 18 and 24 years who are vulnerable to HIV infection. From the study, it emerged that poverty was the main socio-economic factor that affected young women in this suburb, but according to the results, most of these young women were employed with only 13% unemployed. The high standard of living might be the cause of the problem and might have forced the respondents to choose poverty as the main difficulty because the finance that was required per month in addition to basic needs varied. According to this study, the highest amount of rent paid was between R2500 and R3000 per month. An unemployed person could not afford this alone. This factor is a disturbing one. Normally we regard people living in suburbs as the ones who can manage financially, but because the researcher did not investigate in detail the meaning of the poverty the participants talked about, it is important for future researchers to take this further.

The findings of the study also revealed that the highest salary earned by participants was between R15000 and R25000 and there was no indication of women who earned more than that. This means that men were the ones who earned higher salaries. According to the theory of gender and power, sexual division of labour, the resulting economic imbalance may force women to be financially dependent on men, thereby creating vulnerability in all spheres (Nyamhanga & Frumence 2014:3). A lower income increases women's exposure to HIV.

According to the theory of gender and power, sexual division of labour, women are usually delegated the responsibility of women's work. This assignment constrains women because the nature and organisation of women's work limits their economic potential and confines career patterns (Wingood & Diclemente 2000:542). Therefore, women suffering more adverse economic exposures and socio-economic risk factors would be more burdened by the sexual division of labour compared with women not having these exposures, and would subsequently experience poorer health outcomes. Nyamhanga and Frumence (2014) state that women earning lower salaries are less likely to use condoms and women living in poverty may not be able to afford HIV prevention materials, thus increasing their exposure to HIV.

The fact that there were young women who were unemployed means that someone was supporting them. This study mentioned that some of these young women depended on their partners. Nyamhanga and Frumence (2014:3) assert that economic dependence on partners forces women to sacrifice the adoption of health protective behaviours including overlooking partner infidelities and violent behaviour.

The other factor that arose in this study was the behavioural risk factor. There was also the practice of intergenerational sex (relationship between high-risk groups). Findings in this study revealed that 19% of the young women in Sunnyside had partners who were more than 5 to 10 years older than they were. In their study, Dellar, Dlamini and Abdool Karim (2015) state that age-disparate relationships and age differences between young people and their sexual partners have been hypothesised to increase the risk of HIV for young people. The structure of social norms and affective attachments manifests in

stereotypes such as men being more sexually attracted to younger women and younger women being more attracted to older men for material gains (Wingood & Diclemente 2000:553). Older partners are more likely to have been exposed to HIV and this is a risk to young women because they may also be infected with HIV.

The use of drugs and alcohol was also identified as a problem in this study. Results from this study also revealed that 3% of the young women were injecting drugs; 1% traded money for drugs; 1% traded drugs for sex and most of them drank alcohol. Mutinta (2014:154) agrees that the use of alcohol and drugs has been associated with HIV. Thus, women who are problem drinkers are four and half times as likely to suffer from an STD. Alcohol/drug use is a sexual disinhibitor that may place individuals at risk of acquiring HIV through unsafe sex (Dekeke & Sandy 2014:4).

5.2.2 Objective 2: The socio-cultural factors that influence young women's vulnerability to HIV infection

The second objective was to describe and explain the socio-cultural factors that influence young women's vulnerability to HIV infection. Multiple sexual partnerships was the main cultural belief that influenced young women's attitudes to sexual intercourse in Sunnyside. Information derived from this study showed that 7.6% of the young women in Sunnyside had three to five partners and reported being in relationships with multiple sexual partners. According to the theory of gender and power, the greater the number of sexual partners young women have, the greater their potential exposure to HIV will be (Wingood & Diclemente 2000). Therefore, limiting the number of sexual partners is the second major factor in reducing the vulnerabilities of young women to HIV/AIDS.

Condom use was identified as a problem in this study. Despite the fact that 37.88% responded that they always used condoms, the number of respondents who almost never used condoms (11.36%) was very high. In addition to that, 54% of the young women desired sex without condoms. Many of these women, because of the circumstances of their relationships, might also have wanted to conceive. This is a

problem as to date there is no method for women to protect themselves from HIV if they desire to have a child.

Gender-based violence was the most important socio-cultural factor that influenced young women's attitudes to sexual intercourse. According to the findings of this study, many young women between the ages of 18 and 21 reported that they were involved in sexual violence (45%) and 38% were forced to have sex, while 41% were emotionally abused. Increasing gender-based violence has come to be viewed as a major factor influencing not only increased rates of HIV, but also STIs, teenage pregnancies, rape and child abuse (Leclerc-Madlala 2008:29). Spahic and Husic (2011:4) highlight the higher degree of gender-based violence as an important part of the environment in which expectations of and meanings attached to sex are formed.

5.2.3. Objective 3: Factors that affect young women in Sunnyside

Poverty and unequal distribution of income cause stress. People with inadequate incomes live and work in stressful environments and conditions. This socio-economic factor contributes to the practice of risky sexual behaviours for young women in Sunnyside.

Peer pressure that results in the drinking of alcohol and the use of drugs puts young women in Sunnyside in high-risk situations because drunkenness may lead to rape. Many researchers associate rape with HIV/AIDS (Vetten 2014; Bond 2011). Socio-cultural practices that are harmful to young women such as polygamy and sexual cleansing affect young women in Sunnyside as they continue practising them even if they are far away from their homes.

Young women between the ages of 18 and 24 in Sunnyside indicated that they experienced physical, sexual, and emotional abuse as well as forced sex. According to the theory of gender and power, sexual division of power, women suffering more adverse physical exposures and behavioural risk factors experience poorer health outcomes and tend to be powerless (Wingood, Diclemente 2000:543). It emerged, therefore, that young women in Sunnyside were affected by all the structures in the

theory of gender and power, that is, the sexual division of labour, sexual division of power, and the structure of cathexis.

5.2.4. Objective 4: Possible measures for changing young women's behaviour in Sunnyside

Identification and consideration of possible measures for changing young women's behaviour will reduce the spread of HIV/AIDS among young women especially in South Africa. Findings from this study show that a high percentage of young women use condoms but there are still those who never do (3%). Although it is important to stress the use condoms for HIV prevention, several reasons were revealed for poor condom usage. Many women in heterosexual relationships do not use condoms because they want to become pregnant. Women in a steady relationship also do not use condoms and this is a high risk of HIV because one does not know what the other partner is doing outside the relationship.

Power imbalance between young women and their partners also causes these young women not to insist on condom use. Women also have difficulty in negotiating safer sex with their partners because of lower social status and fear of violence. Violence has been shown in this study to be an obstacle to women's safer sexual practices. Gender and cultural norms also play an important role in strengthening prevention programmes among young women. Polygamy (22%) and sexual cleansing (4%) are mentioned in this study as being practised and both can increase the risk of HIV/AIDS. This was supported by Tigawalana (2010:2) when he assert that in a polygamous societies, a man can have many sexual partners but a woman has to be faithful to one, this can increase the chances of HIV transmission and acquisition in women. The results of the study of prevalence and self-reported health in KwaZulu-Natal, South Africa (2011) indicate that 90.2% of women perform vaginal practices. This practice has been associated with a lower likelihood of women consistently using condoms (Smit *et al.,* 2011:245). Both of them are obstacles for policy makers because they are practised by certain African cultural groups (Bond 2011:19).

Young women should avoid these cultural practices as it has been acknowledged that they have side effects such as inflammation and the concentration of some types of microbicides (Smit *et al.,* 2011:254). Consequently, these factors may increase the risk of HIV/AIDS. The importance of fertility in African communities also hinders the practice of safe sex. Young women who are under pressure to prove their fertility to their partners may fall pregnant because they do not use condoms, this was acknowledged by (Osei, Mayhew, Biekro, Collumbien 2014:140) in their study when they assert that as relationships stabilize, couples abandon condoms and adopt traditional methods, out of fear that modern methods could affect fertility. They need to be taught to seek medical help for their health before proving their fertility. Some young women in Sunnyside must also reduce their number of sexual partners, the intake of alcohol as well as the use of drugs.

Sound evidence on the effectiveness of HIV prevention measures is especially important considering the tendency of many governments and international aid agencies to demand this.

5.3 STRENGTHS AND WEAKNESSES OF THE STUDY

5.3.1 Strengths of the study

The study was able to meet the objective as set out at the beginning, which was to describe the socio-economic, socio-cultural, environmental risk factors that influence young women's vulnerability to HIV infection and identify possible measures for changing young women's behaviour in Sunnyside. The researcher also used the Sexual Relationship Power Scale (SRPS) to validate the SRPS data collected from participants on physical abuse, forced sex, condom use and relationship satisfaction. Findings revealed by the SRPS measurement indicated that young women between the ages of 18 and 21 experienced lack of relationship power, which precluded their ability to avoid physical and sexual violence. According to Pulerwitz *et al.,* (2002), the association between SRPS and consistent condom use indicates that relationship power should be addressed when designing and implementing effective HIV/STD prevention

programmes. The researcher believed that her present study through its literature review successfully filled the gap of focusing on the risk factors that caused young women in Sunnyside to be vulnerable to HIV infection.

5.3.2 Limitations of the study

This study like other studies has technical issues such as the following:

5.3.2.1 Sample size

The participants in this study were recruited as a small probability sample consisting of 158 young women. The researcher originally planned to achieve a sample size of 200 young women between the ages of 18 and 24 but owing to time constraints it was difficult to find young women between the ages 18 and 24 years. Most of them were above that age and some of the questions were not answered. The researcher felt that this sample was too small for the purpose of generalising the results to a larger population. The selected sample could only represent a limited number of the total population of the women in Sunnyside.

5.3.2.2 Gender

All the participants in this study were young women who were vulnerable to HIV infection risks. Being a woman researching women's lives may have resulted in biased and feminist conclusions, as sensitive questions were asked in the questionnaire. Men were not part of the study and the interpretation of these findings should be limited to women, including the researcher.

5.3.2.3 Geographical area (study site)

As the study site was restricted to Sunnyside, a specific suburb in Pretoria, the results of the study cannot be fully representative of the entire population of Pretoria.

5.3.2.4 Access to the area

It was very difficult from the beginning to access the area without knowing anyone as Sunnyside is one of the suburbs of Pretoria with a high crime rate and is labelled as a

dangerous and risky place (Van Zuydam 2013). Being a woman in a risky place is not safe but the researcher with the help of the caretaker of one of the blocks of flats was able to access the flats and houses to distribute the questionnaires.

5.4 RECOMMENDATIONS

The researcher believes that her present study successfully fills the gap focusing on the risk factors that influence young women in Sunnyside vulnerable to HIV infection. She identified the following risk factors as the most important factors that must be dealt with in furthering future research in Sunnyside: poverty, peer pressure, alcohol or drug use, condom use, multiple sexual partners, gender inequality and gender-based violence. As a result, the following factors were recommended by this study.

- Poverty has been classified as a social problem; therefore HIV/AIDS programming needs to be done in a way to address the social issues of sexual behaviour. The researcher was unable to do an extensive research on the socio-economic factors, but she stressed that poverty was the most important factor that contributed to the young women's high risk of HIV infection. She recommended that further studies be carried out in order to gain a better understanding of the meaning of poverty and its impact on young women in this area. Economic programmes that enhance women's participation in the national economic front should be instituted to deal with women's vulnerability because of poverty in order for them to adhere to safe sex messages. Further studies are also needed in relation to gender power in the social structure and the consequences of the feminisation of poverty, meaning that women are still lacking the power for decision making in the household. They are also denied the ability to enjoy their basic rights like freedom, respect and dignity.

- Young women need to be empowered regarding self-respect and understanding of their self-worth. Most women lack economic power and feel that they cannot risk losing their partners as their source of financial support.

- Women should be taught the use of female condoms as the majority of them today have not yet used them, and it is important for female condoms to be always accessible like male condoms. It is important to stress using condoms for HIV prevention because most women in South Africa who are in heterosexual relationships do not use condoms; some may want to become pregnant. Research is also needed to develop a contraceptive technology that will allow women to bear children without the threat of acquiring HIV.

- Substance abuse prevention also known as drug abuse prevention must also be considered in order to prevent the onset of substance use, meaning using one or many psychoactive substances (such as alcohol or drugs) without giving rise to health or behavioural problems that might harm the users themselves. Environmental prevention which focuses on changing community conditions or policies so that the availability and the demand of substances are reduced must also be considered. Protective factors are important to consider prevention of substance abuse among adolescents. Protective factors refer to anything that prevents or reduces vulnerability or the development of a disorder such as substance abuse disorder (Tull 2009).

- Changing behaviour is a long-term goal. Consequently, the Transtheoretical Model of Behaviour Change must be considered to encourage everyday behaviour change. The Transtheoretical Model describes the stages through which an individual progresses to intentionally modify addictive or other problematic behaviours (Consolvo, McDonald & Landay 2009:405).

- Prevention strategies that take into account women's lack of power in determining conditions under which women have sexual intercourse should be explored to reduce HIV/AIDS infection among women and girls. Legislation that enhances women's decision-making powers in the family needs to be put in place to protect women from abuse and inequality.

- The South African government needs to re-evaluate programmes that address sexual behaviours, drug use, and highly stigmatised and vulnerable populations.

- Individual, small group and community interventions by people who are at a high risk of HIV infection can reduce risk behaviour and can play an important role in many comprehensive HIV prevention strategies if they are approached.

5.5 CONCLUSIONS

The aim of this study was to describe the socio-economic, socio-cultural and environmental risk factors that influence young women's vulnerability to HIV infection. The study showed that poverty, peer pressure, polygamy, multiple sexual partners, gender-based violence and condom use were the main factors that influenced the vulnerability to HIV of young women living in Sunnyside. In order to understand the link between all these factors and HIV/AIDS the researcher suggests that further studies be conducted in these areas. This study also showed that there is a high knowledge of HIV/AIDS among young women in Sunnyside but the above obstacles still need to be reviewed. This study evidenced the fact that vulnerability to HIV/AIDS was predicted regarding the social behaviour of women and socio-cultural gender norms roles associated with women.

The Sexual Relationship Power scale in this study showed that young women between 18 and 24 years experienced physical, emotional and sexual abuse as well as forced sex in their relationships. The study also showed that there was a link between sexual relationship power and the use of condoms because those who experienced abuse were less likely to use condoms. The results of this study revealed that there was a need to recognise women's agency in resisting violence and forced sex by men.

The community in Sunnyside is a multicultural society and the social structures are deeply rooted in the cultures of the people and must not be taken for granted. The study showed that urbanisation and migrant labour exposed the Sunnyside community to a variety of new cultural influences. As a result, it was important to construct an effective empirical case that patriarchy was damaging to women's health. The study revealed that male violence was used to control women throughout their lives and this increased

women's vulnerability to HIV/AIDS infection. Therefore, it was useless to call for abstinence while women were being coerced into sexual activity. The current policies that have been put forward in South Africa for protecting and empowering women remain ineffective to address women's right to refuse unprotected sex.

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APPENDIX A INFORMED CONSENT FORM

EXPLORING SOCIO-ECONOMIC, CULTURAL AND ENVIRONMENTAL FACTORS INFLUENCING YOUNG WOMEN'S VULNERABILITY TO HIV: A STUDY IN SUNNYSIDE (PRETORIA)

Dear participants

My name is Regina Tlhako. I am a student at the University of South Africa in the Department of Sociology. I am currently registered for a Master's Degree in Social Behavioural Studies in HIV/AIDS. This survey is in partial fulfilment of the requirements for the degree. The aim of my study is to investigate and describe factors that influence young women's vulnerability to HIV infection in the Sunnyside area.

Many of the questions are sensitive but be assured the information you give me is totally confidential.

This survey is totally anonymous and I will make no attempt to identify the person/s who take/s part in this survey. I also undertake not to divulge the results of this survey to anyone other than my study leader, Mrs M Jobodwana.

Please make an X in the box or write the answer when asked to do so.

Declaration by participant:

I hereby agree to participate in this study. I understand that participation is voluntary and that I can withdraw from the study at any time without prejudice.

I have read the procedures for this study described above and I understand what the study is all about and how it is being conducted.

Signature..... Date.....

APPENDIX B: QUESTIONNAIRE

1. Demographic information

					For coding
1	How old are you?	|___|___|18-21		71	1
		22-24		87	
2	What are your daily activities?	Working		65	2
		Attending school		42	
		Attending university or tertiary educational institution		30	
		Unemployed		21	
3	What is your level of education?	Matric		39	3
		Diploma		57	
		Degree		40	
		Masters		12	
		PhD		4	
		Other		6	
4	Please describe your living arrangement	Rented flat with family		70	4
		Rented flat with friends		45	
		Rented flat with partner		37	
		Own a flat		6	
5	How long have you lived in Sunnyside?	Years |_11__|_16__|	Months |___|___|	9	5
		3 months -1 year		29	
		No response		3	

6	What is the main reason for your moving to this place?	School/university	95	6
		Looking for work	48	
		Have work there	8	
		To live with other family members.	6	
		No response	1	
7	Were you born in Pretoria?	Yes	7	7
		No	151	
8	If no, which province do you come from?	Limpopo	77	8
		Mpumalanga	6	
		Western Cape	27	
		Free State	7	
		Kwa-zulu Natal	13	
		Gauteng	7	
		North West	15	
		Other provinces, Eastern Cape, Northern Cape	6	
9	What is the main language that you speak?	Zulu	20	9
		Sotho	54	
		Xhosa	10	
		Tswana	9	
		Swazi	5	
		Venda	13	
		Ndebele	19	
		Tsonga	6	

		English	10	
		Afrikaans	9	
10	What is your marital status?	Married	27	10
		Single	81	
		Living together	18	
		Separated	9	
		Divorced	18	
		Widowed	2	
11	How much rent do you pay?	> R1400	40	11
		R1500-R2000 per month	73	
		R2000-R2500 per month	45	
12	Who pays the rent?	My parents	65	12
		My boyfriend	24	
		Myself	54	
		My brother / sister	12	
		No response	3	
13	Are you employed?	Yes	78	13
		No	80	
14	**If Yes** What is your personal monthly income?	R1000-4000	5	14
		R1000-R4000	8	
		R5000-R8000	54	
		R9000-R12000	81	
		R15000-25000	9	

2. Tell me about yourself

2.1	Are you sexually active?	Yes		132	15
		No (NB: If no, do not continue to complete the questionnaire		21	
		No response		5	
2.2	**If Yes** How old were you when you had sex the first time?	|___|___|	9-11	4	16
			12-13	5	
			14-16	26	
			17-19	62	
			20-24	35	
2.3	How would you describe your sexual orientation?	Completely heterosexual		88	17
		Completely homosexual		23	
		Not fully heterosexual		12	
		Bisexual		7	
		No response		28	
2.4	Do you currently have a partner?	Yes		132	18
		No		26	
2.5	**If yes,** how many sexual partners do you have?	1 partner		105	19
		2 partners		17	
		3-5 partners		10	
2.6	How old is your steady partner?	|___|___|	18-20 years	11	20
			21-25 years	46	
			26-30 years	23	

			31-35 years	11	
			36-40 years	16	
			41-50 years		
2.7	What is the age range of the other partners if available?	|___|___| and |___|__|		21
		21-30		8	
		31-40		11	
		41-50		8	
2.8	Do you use condoms consistently?	Never		4	22
		Almost never		15	
		Almost always		17	
		Always		50	
		Involved with steady sexual partner		24	
		Used condom at last sexual intercourse		22	
2.9	If you **always** use condoms during sexual intercourse, do you ever desire sex without condom?	Yes		27	23
		No		23	
2.10	Have you ever been engaged in one of the following activities? (**You can make more than one selection)**	Injection drug use (lifetime or past year) with shared needle		5	24
		Body piercing (past year) with shared instrument		14	
		Vaginal sex with ≥2 partners (past year) without ever using condoms		42	
		Anal sex with ≥2 partners (past year) without ever using condoms		10	

		Traded money or drugs for sex (past year)	2	
		Traded drugs for sex (past year)	1	
		Six or more alcoholic drinks in a single day in the past six months and followed with sex.	21	
		Did not engage in any of the above activities	63	
2.11 2.12	Do you know anyone who is HIV positive?	Yes	110	25
		No	42	
		No- response	6	
	In your opinion, what do young women think HIV is?	Human Immunodeficiency virus	120	26
		A curse from a person's ancestor	7	
		A disease caused by witchcraft	5	
		A virus that affects prostitutes	6	
		An incurable disease	20	
2.13	Do you think most of your close friends are at risk of getting the AIDS virus?	Yes	57	27
		No	83	
		Don't know	18	
	Have you ever tested for HIV?	Yes	130	28

2.14		No	28	
2.15	If no, what could be the reasons (you can make more than one selection)	There is little I could do about it if positive	4	29
		I am not likely exposed to HIV	2	
		I am afraid of finding out if I am HIV positive	10	
		I think I am HIV negative	5	
		I do not want to think about being HIV positive	6	
		I am unsure of where to get tested	1	
		I do not have time	3	
		I do not have any reason for avoiding testing	1	
2.16	Have you been exposed to HIV prevention messages in the past six months?	Yes	130	30
		No	28	
2.17	If Yes, where? **(You may choose more than one answer**)	At school	61	31
		University	30	
		College	17	
		On television	51	
		HIV prevention brochure	13	
		From the Internet	9	
		From the clinic	29	
		From the radio	5	
		No response	4	

2.18	Are there any cultural beliefs that influence your attitudes to sexual intercourse? **If No skip to Q 2.20**	Yes	115	32
		No	43	
2.19	**If Yes** Please list the beliefs in the order of importance	Gender-based violence	30	33
		Polygamy	25	
		Multiple sexual partners	45	
		Sexual cleansing	5	
		Early marriage	4	
		Sexual coercion	1	
		Virginity testing	5	
2.20	Are there any social factors that influence your attitude to sexual intercourse? **If no ,please skip to Q 2.22**	Yes	104	34
		No	54	
2.21	**If yes** Please list the social factors	Poverty	30	35
		Peer pressure	29	
		Lack of parental guidance	2	
		Inter-generational sex	5	
		Sexual debut	3	
		Gender inequality	21	
		Lack of employment	14	
2.22	How would you describe your alcohol consumption patterns?	Do not indulge	28	36
		Drink at parties only	34	

		Drink daily	30	
		Drink once a week	50	
2.23	If you do drink alcohol, where do you usually drink? (Place of consumption)	Shebeens	19	37
		Bars	9	
		Taverns	47	
		Home	5	
		Restaurant	28	
2.24	Do you think there are advantages to drinking alcohol before sex?	Yes	60	38
		No	50	
		Always	15	
		Sometimes	18	
		Never	5	
2.25	**If yes,** what are the advantages of drinking before sex? (please list the advantages)	Takes out stress	5	39
		Enjoy sex	20	
		Never get tired	20	
		Might fall pregnant	3	
		Easily aroused	10	
		Cannot control your emotions	2	

3. SEXUAL RELATIONSHIP POWER AND DECISION MAKING AGE 18-21 YEARS

	Yes	No
3.1. Do you feel that your relationship would fall apart without your efforts?	33	27
3.2. Have you ever hit or been hit by your partner?	26	36
3.3. Are you afraid to tell your partner when your feelings are hurt?	11	48
3.4. Do you feel free to discuss condom use with your sexual partner?	40	20
3.5. Is it difficult to express your true feelings to your partner?	15	43
3.6. Do you feel rejected when your partner spends time with friends?	30	30
3.7. Do you feel shame when your partner makes a mistake?	37	25
3.8. Do you have sex when you don't want to?	37	54
3.9. Do you withhold sex to get even with your partner?	39	20
3.10. Do you think your partner's opinion is more important than your own?	5	55
3.11. Do you rely on your partner to make most of the decisions in the relationship?	8	40
3.12. Are you afraid to let your partner really know what you are feeling?	12	52
3.13. Do you keep silent in order to keep the peace?	16	42
3.14. Do you freeze up when in conflict with your partner?	17	45
3.15. Are you unhappy with your friendships?	13	48
3.16. Do you feel that you are "stuck" in this relationship?	12	50
3.17. Do you have to control your emotions most of the time?	39	20
3.18. Do you lose control of your emotions during times of conflict?	29	33
3.19. Do you place your partner’s needs ahead of yours?	6	41

SEXUAL RELATIONSHIP POWER AND DECISION MAKING AGE 22-24

3.1. Do you feel that your relationship would fall apart without your efforts?	37	47
3.2. Have you ever hit or been hit by your partner?	21	64
3.3. Are you afraid to tell your partner when your feelings are hurt?	14	69
3.4. Do you feel freely to discuss condom use with your sexual partner?	55	31
3.5. Is it difficult to express your true feelings to your partner?	14	72
3.6. Do you feel rejected when your partner spends time with friends?	32	53
3.7. Do you feel shame when your partner makes a mistake?	31	54
3.8. Do you have sex when you don't want to?	17	66
3.9. Do you withhold sex to get even with your partner?	34	60
3.10. Do you think your partner's opinion is more important than your own?	14	69
3.11. Do you rely on your partner to make most of the decisions in the relationship?	23	63
3.12. Are you afraid to let your partner really know what you are feeling?	13	71
3.13. Do you keep silent in order to keep the peace?	45	41
3.14. Do you freeze up when in conflict with your partner?	28	58
3.15. Are you unhappy with your friendships?	11	74
3.16. Do you feel that you are "stuck" in this relationship?	29	57

3.17. Do you have to control your emotions most of the time?	45	40
3.18. Do you lose control of your emotions during times of conflict?	41	47
3.19. Do you place your partner's needs ahead of yours?	20	66

END OF SURVEY

Thank you for taking part in this study