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**A Practical Application of Psychological Theory: Use of the Theories
of Reasoned Action and Planned Behaviour to Gain a Better
Understanding of HIV Related Behaviour among Youth in the
Communities of Kayamandi and Mbekweni**

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Abstract

HIV has made and is making a significant impact on South African society. Current statistics on the epidemic show that it is spreading very rapidly and the projections for the future indicate a further spread of the epidemic. Already in the year 2000, 36,2% of women presenting at antenatal clinics in KwaZulu-Natal were diagnosed with HIV (Department of Health, 2001).

Interventions at the level of prevention are clearly important and needed while a comprehensive cure is still unavailable and the current medical treatments that stabilise the disease are too expensive for most South Africans. For prevention interventions to be successfully applied, a clear understanding of how a person makes decisions is needed.

This thesis set out to investigate how the youth of two African communities made decisions in relation to HIV. Three sets of behaviour were isolated for specific attention, namely serial monogamy, use of condoms and obtaining medical treatment for STDs. Serial monogamy was selected over permanent monogamy as the qualitative research component done first indicated that virtually all the respondents felt that permanent monogamy was not acceptable practise in their community. The aim of the research was to assess the potential contribution that research guided by psychological theory can make to understanding how the respondents from these two communities make decisions concerning HIV. The Theories of Reasoned Action (TRA) and Planned Behaviour (TPB) were used primarily (Fishbein and Ajzen, 1975, Ajzen, 1988). Two principle research methodologies were used. Initially, 43 depth interviews and two focus group interviews were conducted to collect qualitative data. Following this a survey of 406 respondents, used the methodologies defined by the Theories of Reasoned Action and Planned Behaviour (Fishbein and Ajzen, 1975, Ajzen, 1988), to collect information on the primary influences of the three behaviours.

The results from the qualitative data indicated that people were aware of AIDS and knew the three protective behaviours being investigated. However there was a general rejection of the safer sexual practices, with the emphasis being put on pleasure and social acceptance. A strong message appeared especially from the male respondents that using safer sexual practices would undermine their position and power in the community. The data from the survey strongly contrasted with the results of the qualitative research and the information from the literature review, indicating that vast majority of people intended to use the safer sexual practices. This

difference in the results obtained posed difficult questions for the analysis. Models, based on the Theories of Reasoned Action and Planned Behaviour, were developed from the data. These showed that all the behaviours were influenced to a large degree by attitude, while perceived behavioural controls played a large role for the behaviours of condom use and treatment of STDs.

In conclusion, despite the apparent problems with the survey data, the theories were felt to have added to the understanding of the behaviours in question and to have played a useful role in directing the research. The results also provided clear direction for intervention and further research.

Chapter 1

Introduction

AIDS as an issue presented itself on the international horizon for the first time in the early 1980s, when cases of the disease were identified in the USA. Although many people had already died of AIDS-related illnesses prior to this, it was only in 1982 that the term "Acquired Immune Deficiency Syndrome" or "AIDS" was coined and this stark new feature of our modern reality began to enter the world's consciousness (Shilts, 1987; Morin, 1988). The attention initially focused on the USA, and to a lesser extent Europe, then gradually moved, and Africa began to be acknowledged as being the continent under greatest threat. Already in 1982, 1 668 cases had been identified in 17 countries. This grew to 100 410 cases in 138 countries in 1988, and was clearly going to grow massively from there (Panos, 1988). In 1992, 611 589 cases had been reported to the WHO, which estimated that the total count was considerably higher, at around 2 500 000 (WHO, 1993). AIDS cases also represent only a fraction of those infected with the virus and so the total number was likely to be more than ten times higher. By May 1992, conservative figures put the cumulative total of adult HIV-positive people at 10 - 12 million, of which 7 million were in Africa (WHO, 1993). In December 2000, UNAIDS estimated the figures for the epidemic to be 36.1 million globally, with 25.3 million living in Africa (UNAIDS, 2000).

South Africa was clearly going to be affected in a major way, although in the mid-1980s when this began to be acknowledged, the prevalence levels were still very low (Padayachee and Schall, 1990). All the indications of high levels of spread were there, including high levels of sexual activity (Leclerc-Madlala, 1997), a high incidence of STDs (Ballard, 1993a), plus the unique social conditions of apartheid, migrant labour, the oppression of women and a developed transport infrastructure, which would facilitate the spread of HIV throughout the country (van Niekerk, 1991; Head, 1992; Schneider, Steinberg and IJsselmuiden, 1993; Lurie, 1997). These forecasts were proven true in the 1996 figures from the Dept. of Health's 7th National HIV Survey of women attending antenatal clinics, which showed very rapid growth in prevalence (Galloway, 1997; HIV, AIDS and STD Directorate, 1997).

From the very early days, even before the official coining of the term AIDS, psychology was involved in attempting to understand the behaviours that related to AIDS, and developing methods to change such behaviours (Becker and Joseph, 1988; Simkins and Eberhage, 1984; Batchelor, 1984). This was essential, as with no effective treatment or vaccine yet available, people believed that only behaviour change could limit the epidemic (Osborn, 1986; Baum and Nesselhof, 1988; Becker and Joseph, 1988; Quinn, 1990). The nature of the epidemic

took the issue beyond the realms of biomedicine. One resulting problem is a tension between the "hard" science of medicine and the "soft" social sciences, with conflicts of interest appearing and both competing for limited financial resources for research and intervention (Packard and Epstein, 1991; Strelbel, 1993). This relationship has presented a unique opportunity for the medical and social science fraternities to work together in a complementary manner, with such collaboration happening at the levels of care, research and prevention work. Unfortunately it has often left the medical grouping in the traditional dominant position (Patton, 1990). The role of psychological theory is increasingly being recognised and with that, attempts are being made to apply a range of theories to intervention and research processes (Bell, 1990; Bloor, McKeganey, Finlay et al, 1992; Romer and Hornick, 1992, Thompson and Oskamp, 1996; Hardeman, Pierro and Mannetti, 1997; Laub, Somera, Gawan et al, 1999). This discussion and examination of ideas needs to continue, both in attempts to halt the transmission of HIV and in the development of the discipline of psychology. It is towards these twin aims that this thesis is directed.

One of the major problems in halting the epidemic is that although many people knew the key facts enabling them to protect themselves from HIV, these were often accompanied by many misperceptions, especially about HIV transmission (Strelbel, 1993). In addition, even where knowledge about AIDS was good, this often did not bring about the necessary behaviour change (Becker and Joseph, 1988; Valdiserri, Arena, Proctor et al, 1989; Adamchak, Mbizvo and Tawanda, 1990; Quinn, 1990). Morin (1988) concluded as a result that knowledge is a necessary, but insufficient condition to facilitate behaviour change. The need for a more developed approach further opened the door for psychology to play a meaningful role. The next consideration was whether people perceived themselves to be at risk.

This thesis addresses the potential for psychological theory to make an effective contribution both in understanding behaviour relating to the spread of HIV and in combating the spread of HIV in the South African context. Much has been written and spoken about, both within HIV activists' circles and amongst academics, around the possible contributions that can be made by theory (Weinstein, 1989; Thompson and Oskamp, 1996; Choi, Yep and Kumekawa, 1998). What is going to be attempted is a fuller understanding of the potential contribution that psychological theory can make in providing direction around the HIV epidemic. This will entail looking at what is already known about the South African context, then reviewing the general theory literature that is available. Following this, a particular theory will be selected and submitted to evaluation within two local communities.

Application of Psychological Theory

In his thesis, Tredoux (1996) presents, as one of the crises in psychology, the lack of application of theory to life situations. He argues that for psychology to grow or even survive, there needs to be a greater sense that it can make a useful contribution to human understanding and be applied with profit to situations occurring outside a laboratory. Although there have been clear applications within the areas of clinical and industrial psychology, and more recently community psychology, the contribution of social and cognitive psychology has not been as visible. Neisser (1976, 1978) was especially critical in relation to cognitive and memory research and defined new directions for the future. His argument is that theory, and in turn research, must have public profile and interest, be clearly applicable and get beyond the laboratory.

Potter (1982) intensifies the discussion by arguing that the suggested link between pure theory and applied "technology" is not as clear as is supposed, because in many scientific fields, advances in application have not necessarily come from the field of theory, but from advances in the area of technology. He further creates a separation between applicable theory and applied theory. In the case of applicable theory, which he argues does not go far enough, problems are taken from the outside world and used as a base for theoretical work. This is done without any real relationship being looked at, i.e. the problem will be examined, but without reapplying those lessons usefully back into the world. Danziger (1990) also attacked the two-step model linking pure and applied theory, drawing evidence that in most cases up until World War II, the process links were not made.

This does not mean that no contributions have been made within social and cognitive psychology. For example, the role of psychology has already been important in various fields: those of AIDS (Kelly, Murphy, Sikkema et al, 1993; Mkhize, 1994; Crewe, 1995; Hardeman, Pierro and Mannetti, 1997; Dijher, Kooman and Kok, 1997; Finkelstein, and Brannick, 1997; Rudolph and Steins, 1998; Herek and Capitanio, 1998; Conley, Taylor, Kemey, et al, 1999; Cole and Visscher, 1999), the understanding and combating of racism (Foster, 1991a; de la Rey, 1991; Duckitt, 1991) and the understanding of what happens when crowds become violent (Foster, 1991b). Tredoux (1996) applies aspects of cognitive psychology to the use of police identification parades. Smith, Lindsay and Pryke (2000) did similar work looking at factors influencing eyewitness accounts of crime. Support theory has been used to evaluate how respondents weight local versus more distant evidence (Brenner and Kochler, 1999). The effects of collective efficacy versus self-efficacy were examined to assess effects on work performance cross-culturally in America and Hong Kong (Schourbroek, Lam and Xie, 2000). Even these comprise an insufficient list, with further examples being found in journals, such

as the Journal of Applied Psychology, the Journal of Applied Social Psychology and the Journal of Community and Applied Social Psychology. However it can be argued that psychology is still not playing a sufficiently applied role.

Outline of the HIV epidemic

A better understanding of the HIV epidemic is required for the contextualisation of this debate. The Human Immunodeficiency Virus is a retrovirus, often taking years before it starts to have a major effect on the host person's health. On entering the host's body HIV binds itself to the CD4 molecule of T lymphocyte cells of the human defence system. When conditions are right the virus begins a new life cycle inside the body (Beverly and Sattentau, 1993; Green, 1995; Staprans and Feinberg, 1995). This understanding of AIDS has been questioned by some scientists including Duesberg (1991), who claims that HIV does not meet key criteria of Koch's postulates or classical conditions of viral pathology, but his is a small minority view. To complicate the picture, in 1985 another retrovirus, HIV2, was identified amongst patients from West Africa, which has a similar life history also developing into AIDS (Mortimer, 1993).

The drug treatment and vaccine development of HIV focuses on interrupting this lifecycle of the virus. Zidovudine or AZT is the major and best known of the medical treatments, but others such as Didanosine, Zalcitabine and Stavudine have also been used. The best results in terms of efficacy and the reduction of side effects have been obtained in combination therapies (Fischl, 1995). Alternative therapies focusing on aspects such as the taking of special herbs and vitamins or changing to a healthier life style, have also become popular (Abrams, 1995). In Africa the use of traditional herbal remedies have also been explored (Rutayuga, 1992; Scheinman, Nesje, Ulrich et al, 1992).

Tests to identify people carrying the virus have been available since 1984. The ELISA and Western blot tests remain the most commonly used tests, with the main problem being the seronegative window period between the time of initial infection and the development of a detectable immune response (Saag, 1995; Mortimer, 1993). Once tests were available, there was pressure to introduce mandatory testing as a measure of protection, but it was rejected on ethical, humanistic, practical and basic cost grounds (Patton, 1985; Bayer, 1989; Manuel, 1999). The dominant attitude is still that mandatory testing is unacceptable, and was also rejected by authors when discussed in relation to pregnant women (Nakchbandi, Longenecker, Rucksecher, et al, 1998) and to mentally ill patients (Coumos and Bakalar, 1997). One argument for regular testing at a personal level was that it would allow the person to begin taking drugs such as AZT at an earlier stage and to make the changes to their life

style which would delay the onset of AIDS and improve their quality of life for a longer period (Bayer, 1992; Graham, Zeger, Park et al, 1992).

The progression from HIV infection to full blown AIDS can vary considerably in terms of time. After ten years 50%-70% of cases would be expected to have progressed to the stage of development of major symptoms. These symptoms include the constitutional symptoms such as weight loss or diarrhoea, neurological symptoms, secondary infections and secondary cancers (Mindel, 1993). This progression can be delayed considerably by the use of anti-retroviral drugs. In Africa the major symptoms are weight loss in association with fevers or diarrhoea, tuberculosis, Kaposi's sarcoma, neurological impairment and candidiasis of the oesophagus (de Cock, 1993). The connection with TB has serious implications for the South African context, as it can cause the TB epidemic to worsen as well (Gilks, 1992; Maartens, 1992). HIV has been isolated from semen, cervical secretions, lymphocytes, cell free plasma, cerebrospinal fluid, tears, saliva, urine and breast milk (Mortimer, 1993). Only semen and blood are particularly infectious, although transmission happening from a mother-to-child via breast milk has become recognised as a form of transmission (Adler, 1993; Tess, Rodrigues, Newell, et al, 1998). Some preventive measures against transmission via breast-feeding have been identified (O'Gara and Martin, 1996; Dunn, Tess, Rodrigues et al, 1998; Gibb and Tess, 1999). The most common forms of transmission are therefore via sexual intercourse, injections of blood and from mother-to-child (de Cock, 1993; McKenzie, 1991). In Africa the focus is on what is termed the Pattern 2 methods of transmission, which are via heterosexual sex, contaminated blood products and mother-to-child transmission (Savarit, de Cock, Schutz, et al, 1992). Other than in the early phase of the epidemic in SA, where a number of gay men were infected, this has been the dominant pattern of infection (Padayachee and Schall, 1990).

For the purposes of this thesis the focus will be on sexual transmission, so that will be highlighted in this review. Sexual transmission and mother-to-child transmission are also the dominant means of transmission in the South African context. Intravenous drug use is still very limited in South Africa and needle stick injuries among health workers produce only isolated cases of infection (Ritota, Quirke and Byer, 1996). The danger of unsafe injections in medical settings and the use of unsterilised needles is unclear, but this is recognised as a serious problem in poorer countries (Simonsen, Kane, Lloyd et al, 1999; Kane, Lloyd, Zaffon, et al, 1999). The blood transfusion service screens donors and all donations are tested for HIV, although limited cases of infection have still occurred (Cohn, Hartman, Schwyzer et al, 1990). The principle means then, of self protection, are in turn, permanent monogamy on the part of both partners, using condoms and obtaining treatment for STDs (Aral and Holmes, 1991; Wasserheit, 1992; Johnson and Adler, 1993; Schneider, Steinberg and Ijsselmuiden,

1993). All of these protection methods are aimed at reducing the chances of HIV being passed from one person to another. Having a single partner for life or reducing the number of partners reduces the number of opportunities for the transmission of infection (Lisken, Church, Piotrow et al, 1989). Using condoms introduces a barrier in the sexual encounter, thereby preventing the exchange of bodily fluids during sex (Lisken, Church, Piotrow et al, 1989). There has been some debate about the effectiveness of condoms for HIV prevention, due to the fact that on occasion, they fail with some individuals. However, generally they are accepted as providing good protection (Feldblum and Fortney, 1988; Gordon, 1989; Perlman, Kelaghan, Wolf et al, 1990; Benton, Jalley, Smith et al, 1997; Pinkerton and Abramson, 1997). Treatment of STDs as a prevention method is based on the fact that having an STD will facilitate the transmission of HIV. STDs assist transmission by introducing breaks into the membrane of the sexual organs or by ensuring that there are more receptor sites for the virus when it enters the human body (Cates and Bowen, 1989; Clumeck, Caraël and van der Perre 1989; Wilson and Lavelle, 1990). A 40% reduction in HIV incidence was noted in a rural population in Tanzania, resulting from improved STD treatment (Grosskurth, Mosha, Todd et al, 1995). This has supported other published research on STDs and HIV infection (Laga, Manoka and Kivuvu, 1993; Wasserheit, 1992; Over and Piot, 1993). Different structures of relationships have been considered to allow for sex without condoms. If both partners are HIV-negative then unprotected sex is safe. Negotiated safety is then an option which allows partners to negotiate options such as unprotected sex within a relationship and sexual contact outside that relationship, as long as these contacts are safe (Kippax , Noble, Prestege et al, 1997; Elford, Bolding, Maguire et al, 1999). Negotiated safety was not originally considered as an option for this investigation.

Given that the stigma attached to HIV is driving those who are infected to hide their status, it is important to consider a fourth behaviour in terms of prevention, namely acceptance of the person with AIDS (PWA) (Brandt, 1991; Strelbel, 1993). If this acceptance could take place it might also allow for a person who is diagnosed early to receive additional treatment and to obtain benefits, however reduced this treatment may be, given the current circumstances of the person (Strelbel, 1993). It will also allow AIDS to have a visible presence, increasing the chances that people will perceive themselves to be at risk and as a result, change their behaviour (Gevisser, 1995).

Internationally within the gay male community, significant changes in behaviour have taken place, although some high-risk behaviour does occur (Becker and Joseph, 1988; Bayer, 1989; Freudenberg, 1990; Quinn, 1990; McCusker, Stoddard, McDonald et al, 1992; Elford, Bolding, Maguire et al, 1999; Kegeles, Hays, Pollack, et al, 1999). Since 1996 there has been

an increase in risk taking behaviour again, possibly as a result of the promise offered by the new anti-retroviral therapies (Eskstrand, Stall, Paul, et al, 1999). There is also evidence that commercial sex workers have adapted their behaviour to reduce risk, although this varies with different sites (Ngugi, Simonsen, Bosine et al, 1988; Ford and Koetsawang, 1999; Prybylski and Alto, 1999; Egger, Pauw, Lopatatzidis et al, 2000; Ohshige, Mario, Misushing et al, 2000; Campbell, 2000). Outside these groups, compliance with safer sexual practices has generally been low internationally. In many areas multipartner sexuality is still common. Condom usage itself is very low and a number of problems were expressed with using them (Riekert, Jay, Gottlieb et al, 1989; Williams and Semanchuk, 2001), although this has improved over time (Glaziou, Bobet, Loy et al, 2001; Rotheram, Lee, Zhou et al, 2001). The problem is more severe among developing countries. In 1989 a world-wide review of couples in developing countries found that less than 1% were then using condoms (Goldberg, Lee, Oberle et al, 1989). A study of 722 Zimbabwean males found that only 5% were using condoms at the time of the survey (Mbizvo and Adamchak, 1989). The situation has improved over time and more recent research shows increased use of safer sexual practices. In the urban areas of Uganda, an increase in condom usage of 30-40% and a decline of 9% in casual sex, has seen a reduction in HIV infection of 40% among pregnant women attending antenatal clinics (Asiimwe, Opio, Musinguzi et al, 1997). An option of using microbiocidal products instead of condoms was found to be more favoured in Uganda (Pool, Whitworth, Green et al, 2001). In a rural community in Senegal, research reported a reduction in declared casual sex partners of 39% to 21% (Lagarde, Pison and Enel, 1997). A study of couples in Rwanda where one or both partners were HIV-positive led to increased condom usage (Roth, Stewart, Clay et al, 2001).

Around the world AIDS has tended to impact most directly on the minority groups, such as gay men, or those with less power, such as the poorer sectors of society or black people. As the epidemic developed the major groups affected have been commercial sex workers, black people and the poor (Sabatier, 1988; Panos Institute, 1990a; Doyle, 1993; Brophy, 1993; van der Vliet, 1996). With the international shift in the epidemic towards heterosexual transmission, women and children began to be more affected, especially in Africa (Berkly, Naamara, Okware, et al, 1990; Ankrah, 1991; Kanki and Coutinho, 1992; Buzy and Gayle, 1996; Wilton, 1997). The traditional roles that women have has made them more vulnerable, as shown by studies in Tanzania (Outwater, 1996), Uganda (Kamali, Carpenter, Whitworth et al, 2000), Russia (Kalichman, Kelly, Shabobias, et al, 2000) and from international reviews (Paterson, 1997). Mwale and Burnard (1992) argued that some of the cultural ceremonies could be turned around so as to offer women more access to power and control in the context of AIDS. In South Africa, women already constitute more than 50% of those infected (HIV,

AIDS and STD Directorate, 1997). Women have been found to be more vulnerable to infection (Bunting, 1996; Konde-Lule, Wawere, Sewankombo et al, 1997). Two estimates give the increased rate of women being infected by a man in a heterosexual encounter, as opposed to the reverse, as being three to five times higher (Anastos and Palleja, 1991) or at 1.9 times higher (European study group on heterosexual transmission of HIV, 1992). Some of the factors that may cause women to be more at risk is that many STDs are less identifiable, therefore are less likely to be detected and treated, and that the sperm may lie inside the woman for a period of time (Panos, 1990b). A later review extended these points adding that sperm carries a greater viral load than vaginal fluid, and that the mucous membrane of the vagina is more vulnerable to tearing (Shah and Bradbeer, 2000). It is also likely that certain oral contraceptives may increase the likelihood of HIV infection in women (Hankins, 1990; Panos, 1990b; Shah and Bradbeer, 2000). Wilton (1997) draws out a number of social factors that also impact on women and increase their chances of infection. These include their generally lower socio-economic status, their lack of power to determine roles in sexual practice, their weaker position in relationships with men, particularly in regard to limiting male promiscuity, and finally, the threat of sexual violence (Wilton, 1997). In some contexts effort was made to support women with HIV, such as the establishment of specialised services for women in certain areas in Bangalore. These support structures have made a large difference in the access to services and information for these women (Baksi, Harper and Raj, 1998). Another study found that looking after children with HIV infection reduced suicide levels in women with HIV. They appeared to be fortified by the caring role (Melvin and Sherr, 1997).

The origins of HIV remain uncertain. A number of theories have been put forward including the possibility that it is an adaptation of a similar virus to that found in the sooty mangabey monkey, seen as the origin of HIV2 (Montagnier, 1997); that it was developed by the CIA or another branch of the USA military research establishment (Geisler, 1994), or that it resulted from a poor quality polio vaccine (Hooper, 1999). The point of this is that nobody really knows or understands the origins of the virus, which allows HIV to become the target of projections and fears. A number of lay theories have developed as a result, one of the most pernicious being that it is a punishment from God, as was reported by Aggleton, Homans, Mojsa et al (1989).

Outline of the thesis

As stated above, this thesis looks at the potential contribution that psychological theory can make to an understanding of HIV-related behaviour and to persuading people to adopt safer behaviours. In this chapter the potential role of theory was briefly examined and an outline of

the HIV epidemic provided. The nature of the HIV epidemic, especially its method of transmission, indicates that effort should be directed towards understanding and changing the major risk behaviours. Even if in the long term medical treatments are found, many people will suffer and die in the interim unless a means can be found to answer the questions around why people put themselves at risk, and of changing this behaviour. Activists working in the field also need to know and understand how to intervene.

Chapter Two reviews the literature on AIDS in South Africa up to the current period. The focus here is on the behavioural studies. Research into the medical aspects is beyond the scope of the thesis and is largely excluded, or referred to only in passing. In Chapter Three a range of health behaviour theories that could make contributions around AIDS is reviewed and examined in relation to the nature of the contribution made. Each of these is dealt with briefly and a few, such as the Health Belief Model, Social Representations and Lay Theory, get slightly more attention. These theories are used to complement the Theories of Reasoned Action and Planned Behaviour later on in the thesis. Chapter Four covers a description of the two selected theories, Reasoned Action and Planned Behaviour, as well as their specific contribution to our current understanding of HIV-related behaviour. The focus is on the contributions rather than the history and development of the theory. The history is well documented in a range of texts from the original authors as well as others.

Chapter Five draws these reviews together, along with the underlying focus of the study given in the introduction, in order to set out the specific aims and objectives of the thesis. This is followed by motivations for several of the decisions taken for the research, particularly the age group selected and the two communities in which the research was done. Finally, introductions will be given of the two communities in terms of their histories and social structures. Chapter Six gives an outline of the methodology. This comprises a number of components, including the process of obtaining access, the approach used for the depth interviews, and the methodology of the Theory of Reasoned Action and Planned Behaviour as applied in this research.

Chapter Seven provides an analysis of the qualitative interviews done. This analysis was done primarily in relation to the key behaviour areas that are considered in the survey research, namely general information on HIV, serial monogamy, condom usage and treatment of STDs. As such they provide a key check against other data collected, although it is acknowledged that different methods do sometimes produce different types of results. Most respondents knew of the safer sexual practices of having fewer partners and using condoms, but there remains a significant gap between knowledge and practice. In Chapter Eight the first stage

results for the methodology of the Theories of Reasoned Action and Planned Behaviour are outlined. These results are the basis for the development of the survey questionnaire. Chapter Nine presents the full descriptive results of the survey. Responses to all the questions are outlined, plus the validity checks that were completed. The results showed a surprising level of commitment to serial monogamy, condom usage and treatment of STDs, as compared to the results found in the qualitative research and the literature. Questions are immediately raised as to the accuracy of these responses and what could have influenced the results. In Chapter Ten the results are presented as incorporated into the models for the Theories of Reasoned Action and Planned Behaviour. Different levels of association were found for each of the behaviours. These results are discussed briefly. Chapter Eleven discusses the results obtained in the light of the original questions raised in this chapter and presents the final conclusions. The limitations of the research and potential directions for future work are also outlined.

Chapter 2

HIV in South Africa

In this chapter the current position of the HIV epidemic in South Africa, and a summary of the research findings on the behaviours to be addressed in this thesis, will be outlined. It will begin by examining the status and progress of the epidemic, followed by knowledge levels around HIV, before finally looking at key HIV related behaviours, namely monogamy, use of condoms, rapid treatment of STDs and attitudes to people with HIV. Areas reviewed include epidemiology, knowledge, attitude and practice (KAP) studies, health systems research and qualitative studies of sexual behaviour and belief systems.

Due to the differing qualities of the research done and the reports written, there are problems with a review of this nature. There is also generally very little consistency in terms of the theoretical base, the nature of the information that is actually sought, the methodology used and the purpose of the research. Due to the wide variation in the nature of the research, it is difficult to present an overall critique of the work done. In the text below attempts were made to rely predominantly on papers that had been through a peer-review process, although other studies were included where those findings did fill gaps in the literature. It was noted that one particular trend was towards an increase in the sophistication of the research in the late 1980s and 1990s, as opposed to methodologies just being taken from international literature and simply applied. More attempts are being made to examine local conditions and build the research around these factors, as well as considering theoretical models more closely. Packer and Epstein (1991) make some telling critiques of the early phases of research in Sub Saharan Africa. They argue that insufficient account was taken of the environmental and contextual factors in the transmission of HIV, with the researchers using First World assumptions when developing research proposals and not giving sufficient attention to the context found in Africa. This narrow focus deflected attention from other core factors in HIV transmission, such as the high levels of background infection and malnutrition, and the use of unsterilised needles in medical treatment in areas where resources do not allow for the use of a new needle for every occasion.

History and current status of the HIV epidemic in South Africa

Initial cases of AIDS were detected among homosexual men in 1982. Then between 1982 and 1985 there were about 100 infections from blood transfusion, prior to the development of HIV antibody tests (Abdool Karim, Mathews, Guttmacher, et al, 1997). Epidemiological research from then onward showed the presence of two almost separate epidemics, one predominantly among gay men and the other through heterosexual spread. This separation is reinforced by

the different strain of the virus that was found in the different groupings (Van Harmelen, Wood, Lambrick et al, 1997). With the increase in heterosexual transmission there was also an increase in mother-to-child transmission (Friedland and McIntyre, 1992). There is a generally low transmission through needle sharing among drug users as this form of drug use remains uncommon in SA (Abdool Karim, Mathews, Guttmacher et al, 1997).

Size and spread of the HIV epidemic

The overall size and spread of the epidemic is calculated using the annual national antenatal HIV seroprevalence survey. Over a period of seven years the numbers of ante-natal clinic attendees found to be HIV-positive, during routine testing, increased more than 25 times from a prevalence of 0.76% in 1990 to 22.80% in 1998 (Department of Health, RSA, 1999) and 24.5% in 2000 (Department of Health, 2001). It is difficult to estimate actual population infection rates from this data, but using a series of assumptions it was estimated that in 2000 there were 4.7 million people with HIV (Department of Health, RSA, 2001). When divided according to age groups the highest prevalence for infections among ante natal clinic attendees were found in the age groups 20-24 (29.1%), 25-29 (30.6%) and 30-34 (23.3%). The under 20 age group was also high, 16.1% (Department of Health, RSA, 2001). In terms of a regional distribution, the Western Cape, where this research was done, had the lowest rates, with 5.2% being infected. The highest rates were found in KwaZulu-Natal (36.2%), Mpumalanga (29.7%), Gauteng (29.4%) and the Free State (27.9%) (Department of Health, RSA, 2001). The areas of high prevalence were those first affected in SA, so have the largest spread. The Western Cape is the last to have been affected, but is following a similar course. Over the period 1990-92, HIV infection among women was 3.2 times more prevalent compared to men (Abdool Karim, Abdool Karim, Singh et al, 1992), but as the epidemic progresses this ratio is becoming more evenly spread (Abdool Karim, Mathews, Guttmacher et al, 1997). It is now estimated that there are 2.5 million women infected and 2.2 million men (Department of Health, 2001). Mother-to-child transmission is already a major arena for new transmissions of infection, with rates of 34.7% being found in Durban (Moodley, Bobat, Coutsoudis at al, 1995). Using caesarean section deliveries (Kuhn, Bobat, Coutsadis at al, 1996), or changing from breast feeding to the use of formulas (Bobat, Moodley, Coutsoudis et al, 1997), or the use of anti-retroviral drugs (Soderlund, Zwi, Kinghorn et al, 1999; Wilkenson, Floyd and Gliks, 2000) could reduce these rates.

Other sentinel groups have also shown high increases in HIV prevalence over the recent period. HIV prevalence increased among STD clinic attenders from 8% in 1991 to 40% in 1996 (Abdool Karim, Mathews, Guttmacher et al, 1997). In an STD clinic in Durban, 32% of men and 61% of women with a discharge related to an STD, were HIV-positive. A similar

sample in Cape Town taken in 1995 found 6% of men and 10% of women with discharges to be infected (National Reference Centre for Sexually Transmitted Diseases, 1997). Among blood donors, prevalence rates were a lot lower, partly due to the screening process used prior to donation at all points where blood is collected. The data, shown as so many infections per 100 000, was presented according to racial and gender categories, and ranged from: White men (127) and White women (82), which were the lowest, to African men (7796) and African women (12719) which were the highest (Abdool Karim, Mathews, Gutmacher et al, 1997). In a study of sex workers at a truck stop in the Natal Midlands, an HIV prevalence of 50.3% was found (Ramjee, Morar, Ximba et al, 1997).

TB is one of the most common opportunistic infections in South Africa (Cantwell and Birkin, 1996; Nuwaka, 1998). It therefore becomes a good measure of the numbers of people progressing from being asymptomatic to the early stages of disease. In Hlabisa, a small rural area in Northern KwaZulu-Natal, co-infection with HIV rose from 8.7% in 1991 to 28.3% in 1995, and was at about 70% in 1997 (Wilkinson and Davies, 1997). In 1999 the national TB figures for men were between 38 and 53 per 100000 (Western Cape 44.9 and 48.1) and for women between 15 and 23 per 100000 (Western Cape 17.2 and 20.4). Two high incidence areas for HIV, KwaZulu Natal and the North West Province, recorded increases of TB of 100% and 75% for men, and of 130% and 74% for women over the period 1994-95 (Kleinschmidt, 1999).

It is difficult to make exact predictions of the future in relation to the HIV epidemic, but these exercises are important for mapping the epidemic, planning interventions, the use of resources and the evaluation of interventions. The Doyle Model, which is widely used, is based on a number of assumptions, the most important of which is that populations can be described in terms of their risk profiles (Doyle, 1991). This model, which was set up in 1991, predicted that in 1996 there would be 1 736 371 HIV-positive cases, which is less than the estimate of 2.4 million. Using the Doyle model to predict into the future, it was estimated that there would be about 2.8 million cases by the year 2000 and 4.5 million cases in 2005, so these estimates may have to be adjusted upwards. By 2005 there would also be high increases in mortality as those who contracted HIV earlier would progress onto AIDS. The model also predicted that there would be 210 638 orphans from AIDS by the year 2000. This would grow to 933 504 by 2005 (Doyle, 1991). The overall size of the epidemic is obviously dependent on a number of factors including the number and quality of intervention attempts. The need for care of people with AIDS (PWAs) will increase as the epidemic progresses and more people develop AIDS. Already it is clear that retroviral drugs are unlikely to be provided by the state, due to the high cost. For this reason the Department of Health has already queried the

provision of anti-retroviral medication to pregnant women, which limits mother-to-child transmission (Soal and Granelle, 1999; van der Linde, 1999). The economic implications of the epidemic remain devastating, with large amounts of money having to be spent on the care of people with AIDS (Bloomberg, Steinberg, Masobe et al, 1991).

Epidemic among gay men

As was noted above, there appears to be a separation between the epidemic in the gay community and that which is influencing the heterosexual population. This difference is connected with particular social groups and sexual practice, but also, as identified above, the strain of virus involved (Van Harmelen, Wood, Lambrick et al, 1997). The epidemic in the gay community began in the early 1980s and grew rapidly before tapering off. The latter was the result of intensive intervention and support work which also facilitated education about AIDS taking place. This combination seemed to influence a change in attitudes to condom usage and other safe behaviours (Isaacs and Pegge, 1991; Isaacs and McKendrik, 1992). Research done in the late 1980s showed that already at that stage most gay men knew the key information about AIDS and had begun to make changes to their lifestyles (Shurink and Shurink, 1988, Shurink and Shurink, 1990). One of the key implications of the HIV epidemic was the further stigmatisation of the gay community and increased discrimination and homophobia. It has also made it more difficult for some gay men to "come out", with others having the particular problem of being "outed" by testing positive (Isaacs and McKendrik, 1992; Isaacs and Pegge, 1991). The gay community continued to do activist work around HIV and has played an important role in combating HIV in South Africa (Isaacs and Pegge, 1991). Many gay men do perceive themselves as being further excluded by the HIV epidemic and of the phenomenon of being seen as "the other" (Joffe, 1999). A recent survey of 185 gay men showed that a third of the sample who were having anal sex, both insertive and passive, were doing so without a condom, without knowing their sexual partner's HIV status. The number of sexual partners ranged from 1 to 150, but most had fewer than 10 in the previous year. Twenty percent found it hard to say no to sex that they did not want and 18% agreed that the sex they have is not always as safe as they would like. Eighty four percent were generally confident in what they knew about AIDS (Boxford, 2001).

Knowledge of HIV

In most studies from the early 1990s respondents' knowledge about HIV was sufficient for them to know what they had to do to protect themselves. Over 80% of most samples showed awareness of the key facts around sexual transmission and protection (Ijsellmuiden, Padayachee, Mashaba et al, 1990; Perkel, Strelbel and Joubert, 1991; Naidoo, Williams, Knight et al, 1991, McKinnon, 1993). There was some confusion around casual transmission

(Perkel, Strelbel and Joubert, 1991, Robertson, 1992). Some early studies showed that education took time to penetrate into all groups. For example, a study done with women attending a family planning clinic showed that only 52% cited sexual intercourse as a method of transmission, and that there were considerable confusions around causal spread and protection measures (Govender, Bhana, Pillay et al, 1992). An anthropological study of youth in two communities around Durban in 1990 showed that most people had heard of AIDS and had an understanding of how it is transmitted. This was an advance over the situation which existed a few years prior to that, when it was seen as a scare introduced by white propaganda (Preston-Whyte and Zondi, 1991). However AIDS had become so much a part of people's cognitive universe that some even joked about it, "if it is for me ... so be it" (Preston-Whyte and Zondi, 1991). This knowledge has increased and broadened over time (Campbell, 1997; Swart-Kruger and Richter, 1997). One of the concerns is that although knowledge was high, many studies reported that respondents did not believe that they were susceptible to HIV infection (Ijsselmuiden, Padayachee, Mashaba et al, 1990; O'Farrell and Will, 1989; Friendland, Jankelowitz, de Beer et al, 1991; Wood and Foster, 1995). When asked about HIV, many respondents did not believe that they would contract it and therefore did not need to practise monogamy or any other safer sexual practices. They were able to deny its existence or project the risk onto other communities (Strelbel, 1993; Perkel, 1992). Many people thought HIV would only happen to those in "high risk" groups such as promiscuous people, prostitutes, gays, etc. (Wood and Foster, 1995). The uncertainty around the origin of HIV and the racism inherent in many of the early education campaigns also contributed to denial (Strelbel, 1993). It allowed HIV to be blamed on others, to be seen as a foreign disease, or as racially imposed on the black people of South Africa. There was also considerable confusion about the information related to HIV and AIDS, with different belief systems affecting perception of key facts, e.g. HIV is curable by African healers if caught early on (Campbell, 1997). It was clear that education has to go beyond the immediate information and needs to look at all aspects of a person's life and how they perceive their own identity (Campbell, 1997).

A number of education campaigns using a range of different methods were used to get people's attention, a selection of which includes drama (Dalrymple, 1992), posters (Evian, Ijsselmuiden, Padayachee et al, 1990) and puppets (Skinner, Metcalf, Saeger, et al, 1991). STD clinics and other related services also did individual education and HIV intervention programmes (Schnieder, 1995). The general sense was that sustained campaigns involving attitudes were required, while the more creative educational work should form part of this, rather than a core (Kuhn, Steinberg and Mathews, 1992; Dalrymple, 1992). Both papers referenced in the previous sentence documented programmes, established in schools, that

extended over a period of time. Educational messages also have to be carefully evaluated and tested before being used, as was found in an evaluation of an educational poster to be used by the Johannesburg City Health Department (Evian, IJsselmuiden, Padayachee et al, 1990). Stein, Steinberg and Shongwe (1993), after an investigation in Johannesburg, recommended full community involvement at all levels so as to influence the social norms that guided sexual behaviour. One of the difficulties was that for youth, most sexual knowledge was picked up from peers, so those networks have to be tapped into if education is going to work (Mathews, Kuhn, Metcalf et al, 1990). It was significant that for large sections of the population there was very little parental education about sex. Most parents felt too embarrassed and did not have the necessary skills to be able to discuss sexual matters with their children. This considerably reduces their capacity to act as a positive normative influence (Mayekiso and Twaise, 1993). Preston-Whyte (1992a, 1992b) argues that research should be tied more closely to interventions, to the extent that the respondents become part of the process of the research intervention. Suggestions from countries in Africa to the north of SA, recommended interventions into STD management, condom distribution and improvements to health service management, in addition to education (Wilson and Lavelle, 1993).

Monogamy

Mutually faithful monogamy was uncommon in most of research samples. In a sample of urban mothers of teenagers, most of their teenage children had multiple partners and 56% of mothers had children from more than one partner (Abdool Karim, Abdool Karim and Nkomokazi, 1991). One of the problems with advocating monogamy, or with getting the community leadership to advocate monogamy, is that peer influence and pressure, especially from community leadership, is towards having multiple partners (Kustner, 1990). In a study among university students in the Western Cape, 72% had been sexually active, of whom 12 % had had three partners in the last nine months. Eighteen percent of the sample had been treated for at least one STD over that period (Strebel and Perkel, 1991). At a University in Durban, 43% of the sexually active students reported having had more than one sexual partner in the previous year (Naidoo, Williams, Knight, et al, 1991). The remainder of the data related to this behaviour will be examined under the headings of separate social groupings.

Women

The ability of women to enforce safer sexual practices is greatly undermined by their relative lack of power. In a study completed by Abdool Karim and Morar (1993), referenced in Abdool Karim, Mathews, Gutmacher et al (1997), half the sample of women thought that they had no right to insist on condom use. Only a third of the women felt that they could discuss

condoms with their partners, and generally felt unable to ask them about other partners or to insist on monogamy. There was an additional fear of incurring violence if they broached any of these issues. Miles (1991), in a study done in the Western Cape, noted that women found it difficult to negotiate safer sex for fear of a negative response, and even possibly violence. They felt that men had to acknowledge AIDS as a real risk in order to be able to be more responsible in relationships and to implement safer sexual practices. As stated in the review in Chapter One, the big issue affecting women is their access to power, which would enable them to increase their negotiating space within sexual relationships (MRC National AIDS Programme, 1992). With the changes taking place in South Africa it is expected that women will become more powerful, but currently it is only a select group of women who are better educated or economically better off, that are able to assert themselves. Generally the lesser power of women disadvantages them in relation to health issues, including the potential for contracting HIV (Ntoane, 1991; Walker and Gilbert, 2001). One area in which the primacy of male pleasure over the possible negative impact on the women is shown, is in the practice among women of having "dry sex". A woman inserts herbs or other preparations into her vagina prior to sex so that she will remain dry and tight, thereby increasing the man's sexual pleasure. This can make the sexual act uncomfortable and at times painful, and leads to abrasions and other problems for the woman, which can increase the risk of HIV transmission (Baleta, 1998). Some women have reported feeling more powerful as a result of having many partners. They select boyfriends who are able to pay for them, and buy them beautiful clothes and presents. Some women will select different men to pay for different items, so will keep multiple partners for their own profit, without this taking the form of a commercial sex arrangement (Hunter, 2001).

Polygamy is another key factor to take into account. In its traditional form this generally involved older men having multiple wives (White, 1993). While this is still practised, primarily in some of the more rural areas, the idea has been adapted in the urban modern scenario, allowing the male to take multiple girlfriends (Strebel, 1993; Shefer, 1999). When confronted most men will respond directly that they have an historical right to many partners, this being key to their self-esteem (Shefer, 1999). This idea is even, on occasions supported by women (Strebel, 1993). Part of this is a lack of control by women over their own bodies and their economic dependence on men, which accentuates the power imbalances (Katijiunajo, 1993). The system of lobola or brideprice further entrenches the notion of the woman as a possession of her husband, for which he has paid. Culture is once again being used by powerful groups as a tool to control women or other oppressed groups (Strebel, 1993). A study of black women in Durban found that they are rarely in a position to make purely rational, individual decisions about safe sex, since these decisions are directly linked to

social constructions of sexuality and the power relations that operate in cultures. Since gender is culturally constituted, cultural practices are closely linked to the organisation of gender roles and therefore influence safe sex practices (Hoosen and Collins, 2001). While both men and women will be influenced by the cultural constructions of their sexuality, the men are more often assigned the role of being in control of the women. These problems are leading to an increasing recognition that there is a need to tie HIV interventions into gender issues and to provide services to empower women, especially women who are abused (Jewkes, 2001).

Youth

HIV prevalence is highest among the youth between the ages of 15 and 30. This prevalence is indicative of the higher tendency towards risk taking behaviour in this subgroup, but it is also difficult to get reliable data here (Abdool Karim, Mathews, Gutmacher et al, 1997). A national study found that most girls (54.1%) became sexually active between the ages of 14 and 16, 7.5% before 14, with the average age of first intercourse being 16.3 years. Eighty two percent of boys reported beginning sexual activity before the age of 16, with 40.8% claiming to have started having sex by the age of 14 (NPPHCN, 1996). A similar study in Cape Town found the average age of first intercourse for girls to be between 15.3 and 16 years, and for boys to be between 14.6 and 16.6 years. 68.4% of Xhosa speaking boys and 60.8% of Xhosa speaking girls in Cape Peninsula schools were reported to be sexually active (Flisher, 1992). In the national study, 40% of the girls and 60% of boys who were sexually active reported having had more than one partner in the previous six months (NPPHCN, 1996).

In a study done prior to AIDS having become a major factor in South Africa, almost 80% of a sample of girls had commenced sexual intercourse by the age of 16, with this rising to almost 90% by the age of 18 (du Toit, 1987). In a study in the Transkei, almost a decade later, the average age for beginning sexual intercourse was 13.4 for boys and 14.9 for girls (Buya, Amoko and Ncayiyana, 1996). A study near Durban showed that most adolescents were sexually active by the age of 12 or 13. Sexual intercourse was the norm in relationships and a person's refusal to have sex was considered to be an indication that they were having sex with another person (Preston-Whyte and Zondi, 1991). Differences were found between the boys and the girls, in that boys could have many girlfriends, valued sex in its own right and were proud when their girlfriends fell pregnant. Even for girls the threat of pregnancy was not found to be a deterrent, because of the high value placed on fertility and the fact that the girl's parents would often take over the care of the child (Preston-Whyte and Zondi, 1989). Girls were expected to have only one boyfriend, and would be castigated by the entire community if found to be "promiscuous", but could not deny their men intercourse for fear of losing them. Historically used safer sexual practices, such as ukusuma or intercrucial sex, and the

supervision of girls by older sisters, have broken down. At the same time, many parents find it difficult to educate their children about sexuality, and will just tell them not to have sex. In the end the youth get their education about sex from their peers, and associated with this is a pressure to have sex (Preston-Whyte and Zondi, 1989). More recent studies have confirmed the existence of male domination of sexuality and that this relationship is being reproduced in the new generations of youth. This is identified as being a crucial point of intervention if behaviour change is to take place (Becker, 2001; Thorpe, 2001).

Impact of labour migrancy

Millions of South and southern African men (and women to a lesser extent) are migrant labourers. The migrant labour system in South Africa was used during apartheid to prevent black workers from settling permanently and establishing families in the cities, which were reserved predominantly for the white community. This resulted in the establishment of oscillatory migration patterns, where workers in urban areas maintained links with family in rural homesteads and moved between urban workplaces and rural homes on a weekly, monthly or annual basis, depending on the distance (Platsky and Walker, 1985). This oscillatory migration is a major factor in the spread of HIV and other sexually transmitted diseases. Despite the opening up of democracy, the long-term effects of apartheid are still being felt and oscillatory migration is still part of the reality of many South Africans' lives (Abdool Karim, Mathews, Gutmacher et al, 1997). In fact, despite the opening of democracy, migration patterns have remained, resulting in an increase in visits of men back to their rural homes and women to urban areas, thereby increasing the opportunities for infection (Lurie, Harrison, Wilkenson et al, 1997). In turn, there has been a collapse of the agricultural sector within the homelands as a result of the increasingly capitalist take over of production. This collapse, together with the gender imbalance of the population in rural areas, has led to women moving to the urban areas to find work or to get married. Many of the women, who did not get married or find work, have found themselves working in the commercial sex industry (Hunt, 1989). With rapid urbanisation, economic pressures and improved transport systems, the concept of migration is becoming more involved and increasing numbers of people are taking part in it. Women are also becoming more involved in migrant labour, although they tend to travel shorter distances and to maintain closer links with their families (Abdool Karim, Mathews, Gutmacher et al, 1997).

The majority of migrant labourers end up working on the mines. As with other migrant workers separated from their families for extended periods, patterns of sexual networking take place around the mining communities. The dangerous and socially impoverished conditions also impact on their lifestyle (Campbell, 1997). Studies have documented patterns which

include commercial sex, casual relationships, urban wives, or alternate urban households (Jochelson, Mothibeli and Lyons, 1996; Mandala, 1992). Separate studies have found that rural women with a migrant male partner are considerably more likely to contract HIV (Abdool Karim, Abdool Karim, Singh et al, 1992; Colvin, Abdool Karim, Connolly et al, 1997). Another study found that the rates of casual sexual activity were lower than expected: only 14.2% of the men claimed to have a girlfriend on the mine and 2.1% to having had sexual contact with a "bar-girl" over the past month (Ijsellmuiden, Padayachee, Mashaba et al, 1990). However these contacts are very dangerous because of their fleeting nature and the lack of discussion that happens around the sexual encounter. It is extremely difficult to intervene in these relationships involving casual sex as, due to the harsh conditions in the workplace it remains one of the few areas of personal control that is left to the migrant worker (Jochelson, Mothibeli and Leger, 1991). Sex between men on the mines was found to be generally safe as it tended to be monogamous, and because intercrucial rather than anal sex was practised (Moodie, 1988). Campbell (1997) found that sex plays a central role in the migrants' self image, with the concept of masculinity being of central importance. The migrant workers believe that sex has to be taken part in regularly or a man becomes unhealthy and mentally unbalanced (Campbell, 2001). Research comparing risky sexual behaviours amongst mine workers between 1995 and 1997 found that the percentage of those who had four or more partners in the previous year fell from 25% to 13%, and those whose last sexual partner was their spouse increased from 56% to 70%. Condom use with partners other than their spouse remained constant at 67% (Meekers, 2000).

Commercial sex

Exchange of sex for material assistance happens widely. This does not always follow the classical commercial sex industry base of prostitution in exchange for money, although this is also common, but includes, among migrant labourers, the phenomenon of having town-wives or girlfriends who receive favours, security and food in exchange for sex (Abdool Karim, Mathews, Gutmacher et al, 1997). A series of interviews, done with commercial sex workers in a hotel in Johannesburg, revealed that they were using condoms on most occasions, but still contracted STDs. When this happened, most would go to a traditional healer rather than a medical clinic, for fear of judgement as well as to preserve confidentiality (Malala, 2001). The migrant labour system also creates the context that leads to the development of prostitution, setting up networks of women who do this to survive (Krieger and Margo, 1991). Commercial sex workers at truck stops are also at high risk of infection. Those who requested the use of condoms earned less money and attracted fewer clients. To be able to protect themselves, sex workers need negotiation and communication skills which will enable them to persuade clients to use condoms, development strategies enabling the use of group strength

to facilitate unified action and lastly, accessibility to protective methods they can use and control, such as intravaginal microbicides (Abdool Karim, Abdool Karim, Saldon et al, 1995). A study done in 2000 found prevalence levels of HIV to be 56% among the both the commercial sex workers and truck drivers across five truck stops in KwaZulu-Natal (Ramjee and Gouws, 2001). Anal sex is often demanded and supplied by the commercial sex worker, which increases the risk of HIV infection. An odds ratio of 2.3 was found for anal sex in a study in KwaZulu-Natal (Abdool Karim, 1998). Attempts are now being made to legalise commercial sex work which would facilitate protection for the sex workers (Gardner and Sloan, 2001).

Street children also often engage in commercial sex for their own survival (Richter and Swart-Kruger, 1995). They constitute a specific risk group, and in international studies, have been found to have a 10-25 times higher risk of contracting infection than other groups of adolescents (Abdool Karim, Mathews, Guttmacher et al, 1997). In a study of boys on the street it emerged that they engage in vaginal, oral and anal sex, mostly unprotected. Rape by the older boys and men is common. Many also have girlfriends with whom they have a sexual relationship, and these women also take part in commercial sex. With the girls, customers often seek unprotected anal sex (Swart-Kruger and Richter, 1997).

Condom usage

Condoms are available in South Africa at retail prices in supermarkets and pharmacies, via a price subsidised social marketing programme, and from the government at no cost. The latter has increased its supply from 6 million in 1994 to 120 million in 1996 (Abdool Karim, Mathews, Guttmacher et al, 1997). In 1999, 160 million condoms were distributed by the Department of Health (AIDS Info, 2001). A study done in 1992 highlighted difficulties experienced by teenagers in obtaining condoms from family planning clinics. The clinics were difficult to locate, security staff at clinics impeded girls from seeking condoms, young women were discouraged from using them, information on condom use was rarely provided, and in some cases, the condoms had run out (Abdool Karim, Preston-Whyte and Abdool Karim, 1992). When the staff of the clinics were interviewed it appeared that they did not advocate condoms, as they are a poor form of contraceptive. The staff were usually under too much time pressure to provide education around condoms and felt that condoms were not generally requested because males did not like to use them (Abdool Karim, Abdool Karim and Preston-Whyte, 1992). Female condoms began to be promoted by the Department of Health in 1995, but at this point there is no research giving indications of how well they have been accepted (Abdool Karim, Mathews, Guttmacher et al, 1997).

Use of condoms is very low. All the statistics refer to sexually active youth. In the NPPHCN study of youth (1996), slightly more than a quarter of the sample, 28.5%, had used a condom before, and only 21.4% had used a condom in their most recent coital act. In the Western Cape sample, the lowest use of condoms (16.0%) was found to be among Xhosa speaking youth. This was compared with 68.6% among English speakers and 81.9% among Afrikaans speakers (Flisher, 1993). Use among adults in Cape Town was also extremely low with 76% of male and 81% of female attendees at an STD clinic claiming never to have used a condom (Abdool Karim, Mathews, Gutmacher et al, 1997). Among a sample of students from the University of Cape Town only 32.2% claimed to use a condom everytime they had sex (McKinnon, 1993). A study in the Transkei found condom usage in adolescent school students to be low among girls, of whom only 19.4% had used a condom, but with males this rose to 62.1%, with 20% claiming to enjoy using them (Buya, Amoko and Ncayiyana, 1996). Amongst patients attending an STD clinic in Cape Town it was found that 34.9% had used a condom in the last six months, but that only 24.5% used condoms regularly. Use of condoms was found to be related to knowledge about the transmission of STDs and awareness of the role of condoms (Reddy, Meyer, van den Boorne et al, 1999).

In a study from KwaZulu-Natal, the major reasons given for not using condoms included their limitation of sexual pleasure, that they were an indication of a lack of trust in the partner's faithfulness, the perception that they challenged the male ego, were embarrassing to use and were in conflict with religious beliefs (Abdool Karim, Abdool Karim, Preston-Whyte et al, 1992; Strelbel and Perkel, 1991). Both men and women said condoms broke the intimacy of the sexual event. For men this meant a reduction in sexual pleasure and for women it meant breaking the atmosphere. A common male perception was that if you were a real man you did not wear condoms. Men's desires and sexual pleasure were given a privileged status (Wood and Foster, 1995). One of the more common findings is that condoms are used only in casual encounters and not with regular partners because issues of love and trust are more important here. As a result, monogamous women are becoming infected by their sole partner's risky behaviour (Abdool Karim, Abdool Karim and Nkomokazi, 1991; Strelbel, 1993). Even when a condom is used it is often to prevent pregnancy rather than disease. This may limit the use of condoms in every sexual act (Mathews, Everet, Lombard, et al, 1996). Similarly, among students in Durban, only a third of those that used condoms did so to prevent AIDS (Naidoo, Williams, Knight et al, 1991). It was of interest to note that, prior to the HIV epidemic becoming a key health issue, condoms were seldom used as a form of contraceptive. In a study of teenage girls in the North West Province, the dominant contraceptives used were the Pill, IUDs or injectable contraceptives (Kau, 1988). In a study with school students, an additional problem was found pertaining to condom usage where 19.2% of those who

identified condoms as a form of protection did not know how to use them. In this case, only 11.4% had ever used a condom (Mathews, Kuhn, Metcalf et al, 1990). In response to this the authors suggest that the problem is a lack of a culture of condom usage and that the regular use of condoms needs to become part of the communities' culture (Preston-Whyte and Zondi, 1991). Finally, many myths around condom use have been reported, including that the condom will come off during sex and get stuck inside the woman (Strebel, 1993) or that they will injure the vagina (Nicholas, 1999). These myths also discourage use.

Women found it very difficult to negotiate condom use, fearing some form of retribution from their partners (Strebel, 1993; Schefer, 1999). In another study, female respondents stated that they could not use condoms as they were girls, so the decision was not theirs to take (Mathews, Kuhn, Metcalf et al, 1990). Studies found that girls were also expected to be submissive in relationships, and thus many felt that they could not possibly ask their boyfriends to use a condom, claiming that they would never allow it. They said that the men preferred "flesh on flesh". It was felt that if you asked your partner to use a condom you were acknowledging that you were having sex with another person and were therefore promiscuous. In contrast, the boys claimed that it was the girls who raised the objection to their using condoms (Preston-Whyte and Zondi, 1989, 1991: Baleta, 1999). This means that no one is taking responsibility. The female condom has more recently been found to be more culturally acceptable for both men and women. However, the authors of the study warn that gender discrimination and neglect of women's sexuality are still the main obstacles to the development and adoption of safer sexual practices that women can control (Susser and Stein, 2000).

STDs

The link between STDs and HIV has increased the urgency for STDs to be taken up as an issue of importance. Abdool Karim, Mathews, Guttmacher et al, (1997) found that the presence of an STD increased the chances of HIV transmission. The risk increases 8-10 times in the presence of a genital ulcer and 4-5 times if there is a urethral or vaginal discharge(Abdool Karim, Mathews, Guttmacher et al, 1997). In turn, HIV alters the course and presentation of STDs and has lead to treatment failure (Abdool Karim, Mathews, Guttmacher et al, 1997). About 69% of STD clinic attendees are between the ages of 20 and 30 (Schnieder, 1995). There are an estimated 4 million cases of STDs occurring in South Africa every year. Most treatment for STDs occurs in the specialist clinics, which are found in many communities. There have been problems with the treatment of STDs due to the lack of access to health services, judgmental attitudes of health care workers and the stigma associated with seeking or acknowledging treatment. This has lead to many STDs not being

treated or being insufficiently treated, thereby adding to the spread of diseases. Some patients also carry multiple STDs, which complicates diagnosis. One study estimated that 16% of men and 61% of women left the clinic with an STD insufficiently treated (Mathews, van Rensburg, Schierhout et al, 1998). There are also severe problems in the diagnosis of STDs, especially in cases of multiple infections. Genital ulcerative disease, syphilis, gonorrhoea, trichomoniasis and chlamydia appear to be the most common diagnoses. Unfortunately, there is no national data on the prevalence of STDs, so the data is uneven (Mathews, van Rensburg, Schierhout et al, 1998). A study done in Durban found that 36% of both men and women with genital ulcerative disease, continued to have unprotected sexual intercourse, even where the symptoms were obvious (O'Farrell, Hoosen, Coetzee et al, 1992). From the late 1980s studies of STD clinic attendees, showed that knowledge in relation to HIV was sufficient for them to know how to protect themselves, but that most people were not prepared to change their sexual behaviour to become monogamous, or start using condoms. Although they had an STD they did not consider themselves to be vulnerable to HIV (Mphakalasi, Rembuluwani and Vilane, 1990; O'Farrell and Will, 1989).

An STD survey in 1996 among clinic attendees in Hlabisa produced an estimate for the population in that region of 15.4% for men and 16.4% for women of STD incidence, in the age group of 20-24 years (Wilkinson, Connolly, Harrison et al, 1997). Two studies of university students found incidences of STD in one in twelve in Durban (Naidoo, Williams, Knight et al, 1991) and in 18% of the sexually active students at a university in the Western Cape (Strebel and Perkel, 1991). Among sex workers in the Natal midlands, 63% had a vaginal discharge, 45% a cervical discharge and 13% genital ulcers (Ramjee, Morar, Ximba et al, 1997). School students in the Transkei showed high rates of STDs , 48% for the males and 25% for females, with rates for genital ulcerative disease being 19% and 6.5% respectively (Buya, Amoko and Ncayiyana, 1996). In the Western Cape, syphilis in pregnant women showed a decline of between 15 and 25% during the 1985-92 period. However, in the fishing ports there was no similar decline (Coetzee, Coetzee and Heugh-Gertse, 1994). More advanced and directed methods of treatment are being established, but their efficacy still has to be assessed. However, the available prevalence data concerning STDs remains poor, the only ongoing material being obtained from STD clinics. This data excludes information on the many people who are asymptomatic. For example, chlamydia was noted in attendees of antenatal and family planning clinics at figures of 16% and 20-49% respectively (Pham-Kanter, Steinberg and Ballard, 1996). There is also the problem of clinics being under-resourced, especially in relation to follow up work (Schnieder, 1995).

Contact tracing, aimed at preventing further spread and re-infection is another important element of STD management. Contact cards are the most common system used in South Africa and this has had mixed success. In Gauteng the proportion of clients who present for treatment as a result of contact cards ranged from 2 to 14% (Schneider, 1995). In the Western Cape it was found that 2% of men and 16% of women sought treatment after their partners had informed them that they had an STD (Mathews, van Rensburg, Schierhout et al, 1997). One barrier to partner notification is that women are anxious about telling their partners that they have an STD for fear of being blamed or being seen as unclean or unfaithful. Some even fear that they will be beaten. Men also do not tell partners about STDs due to feelings of embarrassment (Harrison, Lurie and Wilkenson, 1997). In the Western Cape, some respondents complained that they did not have the skills to start discussions with their partners on intimate problems, such as having an STD (Abdoool Karim, Mathews, Gutmacher et al, 1997). In a study of migrant workers it was found that 51.3% told close male friends, 17.9% told girlfriends and only 1.7% told their wives about the fact that they had an STD (Ijsselluiden, Padayachee, Mashaba et al, 1990).

Many people prefer to seek treatment from traditional healers rather than from the clinics, especially for STDs (Ijsselluiden, Padayachee, Mashaba et al, 1990; Wilkinson, Connolly, Harrison et al, 1997). Some traditional healers claim to be able to cure HIV or AIDS (Warren-Brown, 1999; Rogerson, 2001) or at least to have a significant palliative effect on symptoms (Rogerson, 2001). These treatments are seen to be more effective, less painful and to involve less social humiliation than would occur at a clinic. One further point about traditional healers is that many of the treatments involve the cutting of skin, which involves a risk of transmission of HIV, unless instruments are cleaned or new cutting tools used (Zazayokwe, 1991; Head, 1992a).

Attitudes towards people with HIV

The dominant factor that emerges from the literature about people living with HIV and people with AIDS (PWAs) is that they inspire fear in others. In most of the studies, there was a sizeable number of people who wanted PWAs to be clearly identifiable or to be separated from the rest of the population (Strebel and Perkel, 1991). Most studies also showed a negative attitude towards people with HIV (Strebel and Perkel, 1991, Naidoo, Williams, Knight, et al, 1991). This was extended to gay men (Naidoo, Williams Knight, et al, 1991). Amongst pupils, there was often a strong objection to accepting anybody with HIV into their classrooms (Mathews, Kuhn, Metcalf, et al, 1990). People who are HIV-positive do not want their diagnosis known for fear of rejection. A range of stigmas has already become associated

with HIV, particularly those of promiscuity and being seen as dirty (Strebler, 1993). There is also a contradiction at times as to how to treat PWAs.

In a study of a workplace situation it was found that there was enormous compassion for colleagues who were HIV-positive, together with a wish to know who did have HIV, implying a need to keep separate from those who were infected (Miller and Mastrantonis, 1992). It appears that knowing the person who is HIV-positive encourages greater feelings of compassion. In another study, respondents were given an education programme on HIV, and had their knowledge and beliefs re-tested six weeks later. In these cases there was a dramatic improvement in their attitudes towards PWAs, with significantly more respondents being prepared to act positively towards people with HIV (Jameson and Glover, 1993). One of the problems is that any rejection experienced by someone who is HIV-positive is likely to feed into their own sense of themselves, causing them to feel compromised and to blame for their situation (Isaacs, 1993). This rejection also occurs in gender terms, with the man often blaming the woman for infecting him. With couples, it can lead to the man beating the woman (Strebler, 1993). Another study found that even before the development of symptoms, people with HIV experience a poorer quality of life than the general population, implying that those who contract the disease come from more difficult circumstances to start off with, and so have even fewer coping resources (O'Keefe and Wood, 1996).

In research done in Natal, youth stated that they did not want to know whether they were infected. This was felt so strongly, that the medical personnel were seen as the worst culprits, as they gave out the diagnoses. At the same time, many infected teenagers were stating that since they would be facing rejection, they would try to spread the infection as far as possible so that they would not die alone (Leclerc-Madlala, 1997). This phenomenon illustrated the need for confidentiality in diagnosis, so that those with HIV can be tested with the reassurance that they will still be able to make decisions for themselves, and be able to adapt to the diagnosis (Abdool Karim, Tarantola, et al, 1992). There have also been reported cases of people being killed after acknowledging that they are HIV-positive (Baleta, 1999).

Aspects about the special context of HIV in South Africa

There are a number of particular factors about South Africa that influence the nature of the HIV epidemic. These relate to the history of the country, its position in the world geographically and economically, and the development of infrastructure, especially in education and health. The history of apartheid provides a basis in which the HIV epidemic causes further divisions among racial and class groupings, with each group blaming the others for the spread of the disease. The groups even blame each other for the origin of HIV (Joffe,

1999). Apartheid's legacy has created a context that is ideal for the rapid spread of the epidemic among those groups which were oppressed under that system. Contributing factors include land alienation, migrant labour, dormitory towns with no sense of community, lack of recreational facilities, poor education, high levels of unemployment, and poor quality health services, especially in relation to STD treatment (Wilson and Lavelle, 1992). Abdool Karim, Tarnatola, et al (1992) also raise the problems of political instability, rapid urbanisation, natural disasters and poverty. The high levels of crime and political conflict, particularly in areas like Kwa-Zulu Natal, tend to lead to increased incidence of HIV infection, as family systems break down, traditional sexual codes disintegrate and the youth experience less controls of their life decisions and sexuality (Katijiunajo, 1993).

Legal changes to reverse previous social conditions are important. Many changes eradicating the apartheid legislation have already taken place and policies to rectify previous imbalances introduced, but further change, such as the legalisation of prostitution, and more rapid redistribution of resources, have been recommended (Wilson and Lavelle, 1992). Poverty, with its implications of poor nutrition, high stress levels and the high incidence of other illnesses, has the effect of lowering a person's general immunity, thereby increasing his or her chances of contracting HIV (Head, 1992b). A shrinking economy makes it more difficult for people to enjoy stable sexual relationships. Many couples in South Africa are forced to live apart as they both seek work through migration to neighbouring countries or urban areas (Gordon, 1990). In geographical terms, South Africa has had the advantage of facing the HIV epidemic at a later stage than countries in Central and East Africa. However until the early 1990s SA was cut off from contact with other countries in Africa, which limited the opportunity to learn about dealing with HIV (Wilson and Lavelle, 1992).

Conclusion

From the above evidence, it is clear that the HIV epidemic in South Africa is growing and huge numbers of people have already been infected. The Western Cape, where the research was done, has lower prevalence levels than most other parts of the country, but indications are that these figures are rising rapidly. The conditions facilitating the further spread of HIV, that prevail over the rest of the country, are also present in the Western Cape: namely poverty, migrant labour, endemic levels of STDs, male dominance in social relations, the presence of other major diseases, and high levels of unsafe sexual behaviour. Despite the high levels of knowledge about HIV and AIDS both nationally and regionally, there appears to have been very little change in people's sexual behaviour. Unfortunately the dominant approach is one of denial. Also persistent rejection and fear of people with HIV drives the disease underground and decreases the likelihood of the advocacy and use of safer sexual practices.

Behaviour is a product of many influences, including the contexts in which people live, social values, religious beliefs and beliefs about health and illness. Access to the correct information is clearly not sufficient to change behaviour and further intervention is required. A major problem with the research is that its theory base is insufficient, especially in terms of behaviour theory, so it is unable to inform interventions adequately. A fuller explanation of the attitudes underlying these behaviours is required, plus the factors that inform these attitudes. Social psychology can provide guidance in this arena as to how to intervene. With this goal in mind a range of theoretical frameworks is examined in the next two chapters.

Chapter 3

Overview of Behavioural Theories Potentially Useful to AIDS

The resistance to change that has been found in many HIV related behaviours indicates that persuasive interventions are required. This requires an adequate understanding of the factors that influence and determine behaviour in general, and in relation to HIV in particular. The explanation of behaviour has been a focus for a large part of psychology, with a number of theoretical developments attempting to account for cognitive processes, motivation, decision-making and behaviour. A number of these theoretical contributions will be outlined briefly below, as the full gamut of theoretical approaches obviously cannot be covered here. Each theory that is presented will include a brief description of the model, and in the case of the more important or interesting theories, some evidence of their potential role in addressing the HIV problem will be examined. The theories of Reasoned Action and Planned Behaviour, which form the theoretical basis of this thesis, are discussed in more depth in the next chapter.

A number of approaches to theory can be identified as being useful in the field of HIV prevention. Leviton (1989) outlines five groupings as being important in the construction of education messages about AIDS and in focusing activist efforts. The particular focus of this thesis is on identifying the key factors that influence behaviour, so the theory groupings have been reduced to three, namely:

1. Cognitive and decision-making theories, such as the Health Belief Model and Theory of Reasoned Action.
2. Learning theories, including social learning theory and self-efficacy, as well as theories of motivation and emotional arousal, for example fear arousal and learned helplessness.
3. Theories of interpersonal relations such as lay theory, social representations and scapegoating.

Broadly, two traditions can be identified within the above theories (Leviton, 1989). Firstly, there are the cognitive, learning and motivational \ emotional arousal theories which operate on an individual level, and so provide explanations of how individuals increase or reduce their health risk (Leviton, 1989). These theories operate on the basis that the individual person is in control of his or her own decision making. In developing theory, they focus on behaviour and then move backwards to find the factors that influence decision-making. This framework draws considerably on attitude theory. The cognitive dissonance theory was a further key development and remains central to this understanding (Festinger, 1957). Foster and Nel (1991) extend this to refer to the principle of cognitive consistency, which is given as a feature in a number of the theoretical models. Learning theories operate from a similarly

individualistic framework. Secondly, theories of interpersonal relations deal with populations as well as with individuals, and can be used to explain what is happening in population groups or communities (Leviton, 1989). These social theories draw on systems of belief and are based more on the person's position as a part of society. Their focus draws on a different tradition of research and moves away from the individualistic approaches. The theories attempt to comprehend how people interpret phenomena and how these understandings fit together to form systems of meaning. Such systems are in turn guides to behaviour and action in the world, an ideological component of key importance in this category of theory.

Stephan and Stephan (1991a) extend the above discussion to look at the history of the separation of the two social psychologies. They see the separation as being between those that, on one hand, focus chiefly on internal factors, the emphasis being on cognition and affect, while on the other, the emphasis is on the reciprocal influence between the individual and society. These divisions are gradually being reduced, especially as the first perspective moves out of a dominantly quantitative methodology. Many findings do interact and each helps explain the results of the others, so in reality the split may be quite superficial. Stephan and Stephan (1991b) see the barriers to unity as being stereotyping, the use of common terms without shared meanings, misconceptions about each others' work and theories, as well as differences in goals. Greater unity is possible and would be aided by focusing on real world problems, preferably through interdisciplinary and problem-focussed professional work and training (House, 1991). Great benefits would be gained from unity between the two schools of thought, in terms of compensating for each other's weaknesses, but a greater level of precision in definitions is required (Schooler, 1991).

It is clear therefore that these approaches are obviously not mutually exclusive and have had considerable influence on one another. However, knowing their philosophical bases does provide some additional understanding. It is important to note that no one theory will be sufficient to account for the phenomenon of HIV, and different theories will play different roles in the process. This thesis is aimed at understanding how people make decisions in relation to HIV, so theories that inform this will be highlighted. Further theories, not covered in depth here, are directed more exclusively at education and behaviour-change methods' which is the next step once the determinants of the behaviours have been identified.

Cognitive and Decision Making Theories

Within the cognitive and decision making theories there is an underlying assumption that cognitive or information processes direct human behaviour. In the case of health behaviour, the focus falls on the biases in these cognitive processes which turn the person away from or

towards rational behaviour. The space for emotional and other interventions is directed via the cognitive decision making processes. A number of models exist to explain these cognitive processes, which use mainly common sense in their development and construction. Examples include the Health Belief Model (Janz and Becker, 1984) and Decision theory (Eiser and van der Pligt, 1988). The theories of Reasoned Action (Fishbein and Ajzen, 1975) and Planned Behaviour (Ajzen, 1988), although part of this family of theory, are examined in the next chapter.

Decision Theory

Decision theory draws on the assumption that people are inherently rational in their actions, i.e. that they make decisions which they believe will enhance their lives and enable the avoidance of negative experiences. In the case of HIV, people would, on the basis on this theory, take decisions to avoid being put at risk of infection. However, other aspects of behaviour also have to be taken into account. The shortcoming of the theory is that any behaviour may have both positive and negative outcomes, and these need to be considered in particular individual contexts; some outcomes are uncertain; people often struggle with probabilities of whether behaviours are safe or unsafe, rather than on a continuum; and many find it hard to delay gratification (Leviton, 1989). Many of these critiques can be extended to all the theories in this section. The use of decision aids, like balance sheets and cost benefit analysis, assists in this process (Eiser and van der Pligt, 1988). Many of the other theories in this group try to break down the decision making process in order to examine how each of the components may influence the final decision. Decision Theory continues to be used in the applied setting. More recently it has been used on a weight-reduction programme to assist women to maintain their weight loss (Sbrocco, Nedegaard, Stone, et al, 1998). Decision Theory was also adapted into a Quality of Well-Being Scale which accurately predicted mortality, plus a number of other key health statistics, in a group of HIV-positive men (Kaplan, Patterson, Kerner et al, 1997).

The Health Belief Model

The Health Belief Model (HBM), one of the dominant health behaviour models, is based on the hypothesis that behaviour draws its influences from four variables. These are the values placed by an individual on a particular goal; the individual's estimate of the likelihood that a given action will achieve that goal; specific cues for this behaviour; and demographic variables, which are also seen as contributing to the results. The first two variables, which are usually the primary consideration, are further split into two components each (Janz and Becker, 1984). The different aspects of the model for illness can be defined more clearly and are set out below.

The value placed on a particular goal attached to a behaviour would be determined by the following:

Perceived severity, which refers to the evaluations of "both the medical / clinical consequences and possible social consequences." (Janz and Becker, 1984 , p2).

Perceived benefits, which are "beliefs regarding the effectiveness of the various actions available in reducing the disease threat." (Janz and Becker, 1984 , p2).

The estimate of the likelihood that an action will achieve that goal would be determined by the perceived susceptibility which is the person's "subjective perception of the risk of contracting a condition." (Janz and Becker, 1984 , p2)

Perceived barriers, in which the potential negative aspects of a particular healthy action may act as impediments to following the recommended behaviour guidelines.

Cues to action include factors such as doctor's recommendations or health education.

Demographic, structural and social \ psychological factors enable or limit behaviour, e.g. membership of a group where there may be peer group pressure to take part in risky behaviour (Leviton, 1989).

The HBM is very specific in stating that a person will compare perceived costs against gains when deciding on behaviour. However, it does have the shortcoming of not defining and therefore not addressing sufficiently the broad range of factors that may influence any given behaviour. It also assumes a rationality and order of thinking on the part of the person making the decision. Finally, many of the variables are left undefined, particularly the cues for action and the demographic variables. Even the perceived values and effects are left loosely defined, without a clear methodological approach. The results from the HBM have been consistently less useful in the study of HIV than other theories, such as Reasoned Action and Self-Efficacy (Lewis and Kashima, 1993). In a more recent study among those attending two HIV intervention trials, it was found that those were more inclined to perceive AIDS as highly dangerous were associated with an increased risk of dropping out of the intervention, a finding contradictory to the HBM. The authors felt that this may be due to the excessive fear that AIDS provokes (Di Francesco, Kelly, Sikkema, et al, 1998).

Heuristics

Heuristics have come under study within the areas both of psychology and computer science. Broadly, heuristics cover the investigation into creative thought, and how known solutions and patterns of operation are used in the attempt to solve new problems (Pospelov, Pushkin and Sadovski, 1969). Heuristic activity arises in problem situations which are characterised by a conflict between the task to be performed and prevailing conditions which do not permit implementation of the required action (Pushkin and Saltykov, 1969). Thus, heuristic search,

as a specific form of human activity, is always generated by some restrictiveness of the conditions. Bogoyavlenskaya (1969) sees heuristics as a problem of incomplete analysis. Heuristic problem solving is generally understood as being a method or trick for reducing exhaustive search, i.e. instead of checking every possible option, the person will use some previous association of method to solve a problem and thereby, on occasion, obtain a less than optimal solution. Hewstone (1983) sees heuristics as being automatic strategies, which reduce complex inferential tasks to simple judgmental operations. These strategies will vary from individual to individual, so different systems may result. “The study of heuristics and biases tends to be dominated by attempts to expose systematic errors and inferential biases in human reasoning” (Eiser and van der Pligt, 1988, p89). Factors likely to influence decision making include the availability of information, especially well publicised information, associations with information, past experience of making similar decisions, the drawing of links and associations between different pieces of information, and the application of personal values to the situation (Eiser and van der Pligt, 1988). Many of the factors have much in common with the elements of lay theory and attribution theory, discussed elsewhere in this chapter.

Heuristics do provide some explanations as to why people are poor decision-makers when it comes to behaviour selection, and rational approaches are occasionally subverted in the real situation. Heuristics were found to operate in decisions to continue high-risk sexual behaviour, especially in situations of uncertainty. The researchers felt that these heuristics could be adapted to increase the use of safer sexual practices (Kaplan and Shayne, 1993). It remains a tool to be used in conjunction with other theories rather than a complete approach on its own. Further research into the role of heuristics and HIV has examined perceptions of who is vulnerable to infection (Triplet, 1992), and perceptions amongst physicians of their vulnerability to infection (Heath, Acklin and Wiley, 1991).

Learning Theories

Use of learning theories allows the health educator to identify the environmental conditions leading to the acquisition and maintenance of behaviour. In the case of HIV, it provides the activist with tools for encouraging behaviour change. The two dominant theoretical frameworks are those of operant conditioning (Skinner, 1953) and social learning theory (Rotter, 1954; Bandura, 1977). Operant conditioning works by the manipulation of the environmental factors that pertain to risk and safe behaviours (Skinner, 1953). For interventions into HIV, operant conditioning would prescribe the changing of aspects of the environment that encourage risk behaviours, such as ending migrant labour schemes that break up families for a long portion of the year, or encouraging safe behaviours, by making condoms and treatment for STDs more accessible. Social learning theory adds a cognitive component to learning theory by identifying the fact that people can also learn through the

experiences of others, as well as taking into account how people's perceptions about their environment affect decisions (Rotter, 1954; Bandura, 1977). These theories on their own are important in work on the HIV epidemic. Interventions guided by social learning theory have been found to be useful, for example in Thailand (Elkins, Maticka, Kuyyakanond et al, 1997) and among African-American and Hispanic-American adolescents (Schinke, Botvin, Orlandi et al, 1990). In addition, further developments important to health advocacy have arisen out of this school, including self-efficacy and locus of control amongst others. These specific theories are examined below.

Self-efficacy

Self-efficacy refers to the perception that a person has of their capacity to perform a behaviour. A higher self-efficacy increases the chances of a behaviour being performed, both for the good of the person and for others. This perception of self-efficacy is adjusted over time by the person's experience in attempting different tasks, by seeing other similar people performing tasks, by persuasion, and through personal changes. Success or failure is attributed to four factors, namely: ability, effort, difficulty of the task or situation, and luck (Leviton, 1989). A person's sense of their own self-efficacy can influence their of their ability in maintaining safe behaviours. Self-efficacy is important when people want to try to change their own behaviour, or when they want to adopt safe behaviours in relation to HIV, many of which are socially complicated, e.g. condom usage. For HIV interventions, self-efficacy can be increased by providing education on how to perform safer behaviours, and by providing support in the performance of such behaviours (Leviton; 1989, Sanderson, 1999; Soet , Dudley and Delario, 1999). Greater self-efficacy also facilitated disclosures of HIV-positive status to partners (Kalichman and Nachimson, 1999), and influenced women's capacity to insist on safer sexual practices (Soet, Dudley and Dilario, 1999). One problem with self-efficacy in relation to HIV is that while it does improve the person's capacity to perform the behaviour, it does not necessarily change their desire to use safer sexual practices. Self-efficacy is also potentially easily damaged when someone is faced by a situation over which they have less real control, as does sometimes occur in sexual relationships.

Locus of Control Model

The Locus of Control Model examines the extent to which people believe that events happening in their lives are under their own control, i.e. an internal locus of control; or are determined by forces outside themselves, such as luck, fate or manipulation by others, i.e. an external locus of control (Krause and Stryker, 1984). In many respects this model builds on the concepts outlined above in the discussion on self-efficacy, and the same problems pertains here as well. An external locus of control has been seen as contributing to a range of

pathologies, most notably a person's ability to cope with stress. The model is useful when examining the AIDS syndrome, as individuals with an internal locus of control are more likely to use their knowledge about a disease and take the necessary preventive measures (WHO, 1988). Someone with an external locus of control will put their chances of contracting HIV down to fate, or reject practising safer behaviour with the excuse that they may be hit by a car or a bus next week, so why change their behaviour in relation to HIV? Locus of control overlaps with learned helplessness, meaning that if a person feels that they are helpless in a situation, they have an external locus of control. It is important to note that the locus of control can change by providing the person with positive experiences which reduce the feelings of helplessness (Leviton, 1989). Once again, the problem lies in the limited range of the theory and the poverty of definition of the terms. A strong locus of control has been found to be useful, generally along with several other variables, in lowering depression among persons living with HIV, (Metts, Manns and Kružić, 1996) and also in encouraging women to initiate and maintain sexual practices (Morrill, Ickovics, Golubchikov, et al, 1996). Attending at a support group was found to be of assistance in the bolstering of an internal locus of control among HIV-positive gay men in Britain (Fontaine, McKenna and Cheskin, 1997).

Theories of Fear Arousal, Motivation and Emotion

Theories of fear arousal, motivation and emotion revolve around the inner processes that cause a person to behave in a particular way. Fear is one of the key factors that need to be examined and has become one of the key emotional issues in health education and decision-making in the HIV epidemic. Fear has, however, to be used very carefully, as while it is necessary in providing motivation for behavioural change, it can cause dysfunction, especially if levels are raised too high (Leviton, 1989). If this happens, the person may become fatalistic and perceive him or herself as being unable to prevent the consequences. Alternatively, they may explain the fear away by condemning it as political manipulation, e.g. an attack by the HIV educators on their community. There may also be irrational responses, and in order to reduce the risk and fear, people may try to exclude all HIV-positive individuals from their community. Responses to fear fall into two categories: behaviours that will protect the person, and responses that will assist in coping with the unpleasant associated feelings (Leviton, 1989). Each of these responses will have very different implications for future behaviour and for our understanding of that behaviour.

Therefore, theories related to fear do provide some additional understanding about how people make decisions in relation to HIV, but they need to be used with extreme care by health activists as intervention models. In a general review of the role of fear in health education campaigns, it was found to have some effect if accompanied by a possible

recommended action that could change the health risks for the person for the better. The review also threw into question the theory of the inverted U-shaped relationship of fear appeals to behaviour change, so discounting the idea that increasing the fear may produce a counter productive response (Sutton, 1992). In an intervention among drug users in the UK, the use of fear arousal educational material did not appear to have an impact on anxiety levels relating to their risk behaviour (Sherr, 1990).

Theories of interpersonal relations

Theories of interpersonal relations examine the social context in which people find themselves growing up and living. Control factors of importance include class position, value systems, family systems, and religion as well as other central societal forces. It is assumed that the cognitive world is sensitive to and is a reflection of the outside world (Gergen and Semin, 1990). Of key importance is the shared nature of what is in people's minds. This is in contrast to attitude theory, which is individualistic in nature (Furnham, 1988). While private explanations may exist, these need to be linked with other more commonly shared explanations in order to facilitate communication (Draper, 1988). The actual belief systems develop as a result of interaction between people and become shared constructs. A number of overlapping theories can be incorporated into this family of theories. These include attribution theory, lay theory, social representations, urban legends, psychologic and scapegoating. The individual contributions of the different theorists in this arena are less able to be clearly defined into distinguishable and separate theories. A general criticism of this grouping of theory is that the link of the cognitive processes to behaviour is inadequately defined. This appears to be an intentional construct, as the link is seen as being beyond the scope of the theory (Gergen and Semin, 1990). It means that clear intervention may be difficult to construct for changing behaviours.

Attribution theory

Attribution theory has concerned itself predominantly with lay or causal explanations of events or behaviour. It is not a coherent theory as such, but a set of models, of which the unifying feature is a pursuit of such causal explanations (Hewstone, 1983). Attribution theory tends to cross over the individual/social divide between the two families of theories addressed in the introduction to this chapter, but it has been included here due to its overlap with other theories in this section. Explanations can have an effect on a person's motivation in completing certain acts, especially if they distinguish the locus of control, the stability of the cause, and the controllability of that cause for the person concerned (Antaki, 1988a). A number of consistent influences arise in the literature. Actors and observers, for example, assign different importance to dispositional and situational factors, and people will tend to

select explanations that are more positive for themselves (Finchilescu, 1991). One of the key observations made is the fundamental attribution error, which states that an observer will tend to overemphasise the role of dispositional factors in the behaviour of another person and underestimate situational factors (Finchilescu, 1991). This has been challenged by Miller (1984) as being a factor of culture and socialisation, by work done on the different attributions assigned to the same situations between a sample of American and Indian respondents. Cross-cultural interpretations therefore have to be made with care.

A particular concern is the attempt to map out the full attribution processes, by which a person seeks to establish their view of causation. An early example of this was the Correspondent Inference Theory (Jones, 1979; Jones and Nisbett, 1972). This approach has been criticised as having a number of limitations and has become less used. In its place, Kelly's models of covariation and configuration (Kelly 1972; Kelly, 1973) have become more accepted. These models are both attempts to develop a more complex schema for understanding how causal attributions are made, using a range of different variables. The covariation model uses the variables of consensus, distinctiveness and consistency, within a framework adapted from the statistical model of ANOVA, to make the causal attribution for the action. The possible causation that has the most reliable association with the effect is taken to be the cause (Finchilescu, 1991). This understanding has been subjected to criticism, as it is not clear whether a person will be able and prepared to do this complex calculation in their head every time they have to assign attribution (Hewstone, 1983).

Finchilescu (1991) makes the point that when the context is changed from an individual to a group one, the mechanisms of the process have to be adjusted to incorporate a theory of intergroup relations. This change is particularly strongly affected if the actor and the observer are from different groups. It also depends on which group is used as the reference group. Intergroup considerations force the theory to look beyond simple cognitive factors in order to incorporate concepts of stereotyping, prejudice and intergroup hostility. The relative importance of each of the factors will vary from situation to situation. Two examples of attempts to extend attribution theory into the group situation include the use of social identity theory, and the use of cross-cultural psychology, together with the application of cultural attributions (Finchilescu, 1991). There have been attempts to look at social attribution theory, but much of the work appears to be an extension of the individual level to that of the societal level.

Attribution theory may be seen as having an influence on HIV work, for example by giving workers in the area a framework for understanding how causal attributions are developed and

attached to individuals with AIDS. This will provide some insight into the processes used to scapegoat individuals or groups of people who are perceived to be in "high risk categories". Also of significance is the way in which they think HIV is contracted. Of particular importance in people's understanding of HIV are the theories of attribution of blame, for example, the just-world hypothesis and the defensive-attribution theory (Finchilescu, 1991). The just-world hypothesis, in terms of HIV transmission, allows the viewer to continue believing that it is safe to continue behaving as they have in the past. Because of the severity of AIDS the defensive attribution theory is more prevalent as it has the potential for blaming HIV on a number of "out groups". Conspiracy theory is a particular form of attribution theory, and has great significance in the HIV epidemic. In the first chapter, a number of conspiracy theories were outlined. These derive from the nature of the threat and the lack of clear information on its origins. Such theories\perceptions allow the blame to be placed on a target group, whose suppression or destruction would make all other people safe.

In more recent research, attribution theory was used to predict men's possible violent response to requests to use a condom and subsequent refusal to do so. It was found that men who had greater tendencies towards violence were more likely to refuse to use a condom, and to react violently to the suggestion (Neighbours, O'Leary and Labouvie, 1999). Medical students were found to be more willing to treat patients who were HIV-positive if they felt that the person was not to blame for their illness (Ladany, Stern and Inman, 1998). In a sample of Australian students it was found that they attributed the problem of AIDS to out groups using negative stereotypes of those out groups, to assign the blame (Pittam and Gallois, 1997). Rudolph and Stein (1998) found that people with AIDS were more likely to attribute their condition to factors of existential attributions, such as "poetic justice", and "personal destiny" than were uninvolved observers.

The strength of attribution theory is also its weakness. It allows the complexity of causal explanations to be reduced to a small set of clear conceptual categories. However, it simultaneously excludes the contextual and background information that allows a full and applied analysis to be done. It also does not provide the space for assessing how the different explanations or systems of meaning interlink and affect each other (Antaki, 1988b). The major body of attribution theory has also been criticised for not taking social forces sufficiently into consideration. However, there have been some responses to these critiques, and some attempts have been made to look at the role of social forces. For example, Bains (1983) examined the issue of control in attribution theory, and Bond (1983) examines cross-cultural variations in relation to the process of attribution.

Scapegoating

In many respects, scapegoating is an extension of attribution theory. Historically, certain people were selected in a community to serve as scapegoats for the sins of the rest of the community, especially for those in power (Douglas, 1995). In the modern world the position of the scapegoat is different, but it is still a process commonly used to explain away problems and to assign blame, especially in the case of those who are more powerful. For the latter individuals, or for a community in general, it plays a useful role. Problems are blamed on another individual or group, thereby allowing the remainder of the population to continue as they did before. It also allows people to develop explanations for events otherwise inexplicable.

It cannot be stressed too often that this basic ingredient of obscurity is the main factor in precipitating the scapegoating process. It tends to be observed as bewilderment and frustration. There is some understanding that things have gone wrong – a feeling that is powerful and creates tension, but has no immediately obvious focus. Human beings seem to be more or less incapable of accepting the inexplicable, and if no realistic proof – i.e. having some logical explanation for events that are emotional, behavioural or situational – is forthcoming, then explanations are concocted in order to relieve the cognitive dissonance of there being an event with no logical explanation. Thus scapegoating takes place. It is a form of explanation.

(Douglas, 1995, p 179)

The basis on which the scapegoat is selected is primarily that of being different, either in terms of some physical characteristic or particular behaviour. Other characteristics of selected victims include the following: their having relatively less power; their having been successfully blamed for problems in the past; an inability to fight against being blamed; and by their proximity to the event, which makes blaming possible (Douglas, 1995). The HIV syndrome lends itself readily to scapegoating. There is no clarity as to the origin of HIV. It is spread silently and the way in which this happens is not immediately obvious to the person on the street. In addition, in a society like South Africa, with its history of divisions and prejudice, it is easy to find people to blame. HIV has been blamed on blacks, whites, gays, terrorists, the apartheid government and the godless (van der Vliet, 1996). While the scapegoating phenomenon does make a useful contribution to understanding the HIV epidemic, especially the processes of blaming, it is insufficient to explain fully the reasons for people's behaviour in their intimate relationships.

Lay Theory

Lay theory is the study of the layperson's implicit, informal, "non-scientific" explanations of behaviour (Furnham, 1988). Lay theories in society play the role of helping to make the world understandable to those living within it. They do interact with the established scientific

theories, but will often differ from or reinterpret these theories (Sherr, 1989; Sherr, Strong and Goldmeier, 1990). Lay theory can be seen to represent the knowledge and beliefs used by people in constructing their own thinking about a subject. It is also used by a society in constructing and developing its ideas. These ideas become the factors that facilitate communication between the members of that society and become the basis on which new ideas may become part of it.

The actual theoretical arena, of which lay theory is a part, is a contested arena and includes a number of different theorists and sets of terminology. These contributions include lay theory (Furnham, 1988), ordinary explanation (Antaki, 1988a), common sense (Giorgi, 1990) and naive science (Finchilescu, 1991). These areas often do not constitute structured theories, but rather collections of contributions. Furnham (1988) has attempted to put some structure into the concept of lay theory. To achieve further definition he has compared lay theories to the formal scientific theories. For this comparison, he uses a set of criteria normally associated with scientific theories. He makes the point that these criteria should not be seen as rigid, and that there is considerable overlap between lay and scientific theories. The following differences are drawn out:

1. Lay theories are often more implicit than explicit, with tacit, non-specified assumptions or axioms. In contrast, scientific theories are generally formal in the sense that they are set in a logical, internally consistent manner.
2. As lay theories are seldom formally presented, they are frequently ambiguous, incoherent and inconsistent. Two mutually incompatible or contradictory ideas or beliefs can be held at the same time, without the person being troubled by the inconsistency. Scientific theories should be, and usually are, both coherent and consistent.
3. Lay theories are often supported by using the approach of verification, rather than Popper's principle of falsification, which is more commonly accepted in scientific circles. In this sense, lay theories are based on the principles of induction rather than deduction, the latter being more usual in the scientific approach.
4. Lay theories often confuse cause and effect, and so infer cause where it may not necessarily exist. There is a reliance on correlational evidence, which is insufficient to infer causation. These "causes" are also often unidirectional, and are based on what makes intuitive sense to the lay theorist.
5. There is a tendency for lay theories to be orientated more towards content than process, as in the case of scientific theories.
6. Lay theories more often see factors internal to the person, rather than external events, as being causative.

7. Lay theories tend to be more general in their application with one theory serving a multitude of functions. Scientific theories on the other hand have far more tightly controlled specifications for application.
8. Lay theories are less likely to fulfil a set of definable criteria for measuring the strength of a theory.

Many of the factors mentioned above have been drawn from a range of pre-existing theories and findings, for example, point six is drawn from the fundamental attribution error theory (Furnham, 1988).

The actual origins of lay beliefs have been difficult to determine and understand, and a lack of clarity exists in this area. Furnham (1988) extracts four possible sources, namely: induction or experience; construction or inference and deductions from observations; analogy or extrapolation from specific encounters; and authority or acceptance of ideas from others such as the media. These ideas are very loosely constructed and are not well developed, so this does remain an area which is very incomplete. Lay theory is informed by a broad range of sources which often overlap, including language, ideology, culture, science, tradition, chance observations, contacts with other people, educational experiences, etc. (Furnham, 1988; Brandstader, 1990; Gergen and Semin, 1990). In many cases the average person does not have direct access to scientific information, and so relies on the mass media and friends and family for information. Given that AIDS has become an emotive, political and moral issue, this information is not always accurate, as a number of studies of the British tabloids have shown (Williamson, 1989).

One area of commonality across the theoretical field is that new lay theories are constructed out of or on top of existing theories. People's explanations are coherent wholes, more or less well structured in and of themselves. Any explanation, for example of the causes of AIDS, will be fairly well anchored in the network of beliefs about life in general. In this light, the relationships between different lay theories need to be understood, both within conceptually similar areas and across different conceptual areas. In addition, any belief that is developed and acted upon is likely to have ramifications to a greater or lesser extent on the entire system of beliefs (Antaki, 1988b). This is important when considering people's attitude towards AIDS, as it is likely to be implanted on top of other belief systems which pre-exist it in the historical development of the person, such as illness, disease, sex, death, morality and politics. The stability and consistency of lay beliefs varies according to different situations and this is an important consideration for both intervention and research. It is particularly important to understand what makes certain lay beliefs more solid and consistent than others. Many lay theories have been found to be very difficult to change, for example racism and religious

prejudice (Furnham, 1988). Furnham (1988) offers an important point of warning in relation to the function of lay theory, namely that any particular person may have hidden functions, which need to be understood before change is attempted.

A major question concerning lay theory lies in its link with, and potential influence on, behaviour or action. Ideas about this are mixed. The connection to behaviour is considered by many to be an underlying assumption (Furnham, 1988; Gergen and Semin, 1990), but at the same time the link is suggested to be a conservative one. The perception is that the connection is complicated, but that a subtle relationship does exist which may allow certain predictions to be made (Furnham, 1988; Antaki, 1988a). The relationship of cognitive systems to behaviour is best understood when emphasis is laid on description rather than prediction. The research tradition within which this approach arises has focused not on proving a tight relationship of cognitive structure to behaviour, but on explaining this relationship. The difficulty lies in determining how intentions can be translated into bodily movements: whether attitudes as cognitive states determine behaviour and whether actions are often driven by motivational sources beyond conscious comprehension (Gergen and Semin, 1990). Many argue that lay theories have a prime influence on behaviour (Groeben, 1990; Sherr, Strong and Goldmeier, 1990). The notion that people behave in terms of their conceptualisations of the world, and in terms of how they see the world operating, is at the basis of the importance of the lay theory approach to HIV. Therefore in an area such as AIDS, people will tend to formulate theories from their own experiences, their history and from whatever knowledge they can glean from other sources. It is towards these theories that some key activists in the arena of HIV intervention are turning for direction in future campaigns (Sherr, 1989).

Lay theories provide a means of access to people whose behaviour the health educator may wish to adapt. This gives an explanation of how health education messages are being received, and assists in the design of messages so that they can be better accepted (Offer, 1989; Aggleton, Homans, Mojsa et al, 1989). Evidence for the usefulness of lay theory already exists in the area of HIV related behaviour (Aggleton, Homans, Mojsa et al, 1989; Sherr, 1989; Sherr, Strong and Goldmeier, 1990). Lay theory may also throw a particular light on the problem of slow changes in health behaviour in response to health education. People have established behaviour patterns that are derived from a range of sources of knowledge, and supported by habit (Hunt and Macleod, 1987).

Two levels of criticism can be directed at the lay theory model. Firstly, at a practical level, the test of a theory is its usefulness. The critique here lies in the lack of a set connection with behaviour. As argued above, this connection does exist as an assumption, but to have practical

value, particularly for health education work, this connection needs to be more clearly established. A second criticism at a practical level lies in the complexity of many of the theoretical frameworks, which makes the theories less generally useful to people who do not have a sophisticated academic training. The final problem area lies in the methodology, for which there is no fixed approach. More importantly, there is no clarity on how, in practical terms, it is possible to reach a subject's lay beliefs, given that language is not a perfect mirror of the cognitive system, and that misinterpretation is a potential danger. Dialogic consensus does provide some assistance, but is not a full answer (Gergen and Semin, 1990).

Many theorists and AIDS activists are now arguing that the lay theories which people carry around with them are actually more important than the formal knowledge that they may receive from AIDS educational material (Sherr, 1989; Aggleton, Homans, Mojsa, et al, 1989). In a study done by Sherr (1991a) on a group of STD clinic attendees, she found that the greatest predictor of condom usage was the conscious desire on the part of the person to have unprotected sex. She understood this attitude to derive from myths that the only acceptable form of sex is unprotected sex. "Safe sex" as a term has been incorporated into lay beliefs as well, but it is often with incorrect content being attached to it, as many people who claim to be practising safe sex, are still indulging in risky behaviour (Sherr, 1991b). A study done in France showed that those who supported coercive measures for prevention of AIDS held similar opinions on other controversial topics that have split French society politically. Such topics include issues such as the restoration of the death penalty, restrictions on immigration and repression of homosexuality. These attitudes were, in turn, connected to prior ideological and ethical values, such as political and religious conservatism (Moatti, Manesse, le Gales, et al, 1988). More recent research on lay theory has covered the issues of satisfactory relationships between friends (Cole and Bradac, 1996) and perceptions of child development (Furnham and Weir, 1996). Using a related concept of common sense, some interesting lay theories associated with initiating the discussion of safe sex appeared. Among 19 discussion groups of youths aged between 16 and 25 years, there was the perception that if a man raised the issue of safer sexual practice, it meant that he could not be trusted. If a woman raised the issue, it meant that she could no longer be considered a trustworthy or low-risk partner (Gavin, 2000).

Social Representations

Social representations can be defined as a structured system of beliefs, images, and classifications which are widely shared, and which constitute an ideational environment. They are located in social systems or formations (Foster and Nel, 1991). Social representations attempt to build a theory of the origins of common sense and are concerned with a socially

shared reality that can influence individual behaviour (Jaspers and Fraser, 1984). The two major functions of social representations are to establish an order for the individual, which help him or her to understand and master the social world, and to facilitate communication with other members of a community on the basis of a shared conception of reality (Hewstone, 1983). Moscovici saw this as happening through the dual roles of representations as conventional and prescriptive. Representations “conventionalise” the objects, persons and events that an individual encounters, locating them within a category. Representations are also “prescriptive” in that they impose themselves on people through tradition, and determine what is perceived and conceived (Moscovici, 1984). The further role of social representations is to transform specialised knowledge into common sense, or turn the unfamiliar into the familiar. The understanding of this process developed largely around Moscovici’s work on the integration of psychoanalysis into French society. There are two processes by which this transformation happens: “anchoring” and “objectifying”. “Anchoring” refers to the integration of the represented object within the individual’s pre-existing cognitive system. “Objectifying” refers to the process by which something abstract is made to appear almost concrete, i.e. in the mind it has an almost physical existence. The latter occurs, by virtue of two processes, which happen in turn, namely: personification, which is the association of theories, ideas or scientific concepts with an individual who comes to represent that approach. Secondly, through figuration, which refers to the process by which common sense substitutes metaphors and images for complex concepts (Moscovici, 1984).

Some recent research using social representations as applied to AIDS in South Africa, has shown how those with AIDS have been labelled as “the other”, and somehow different, thereby allowing most people to distance themselves from the epidemic (Joffe, 1996; 1999). This perception of “not me – other” with regard to people affected by HIV has common ties with the manner in which many risks to life are perceived (Joffe, 1999). If investigated it may show why the myths which obstruct safer sexual practice in the areas of condom use and STDs, as described in the previous chapter, have appeared. One of the main problems with social representations as with many of the other theories in this section, is that the method of intervention is less obvious. It is often not clear what to do or how to act on the information. While this information does precipitate certain actions, the connections appear to be more complicated. The theory and its application to the methodology is a complex matter.

Urban Legends

Urban legends are a particular form of construction of social reality. They occur in story form and appear to develop out of the urban society. Such legends are invariably repetitions of stories that supposedly happened to a “friend of a friend” (Goldstuck, 1990). They have an

aura of credibility, supported by the source which is an important aspect in enhancing the validity of the story (Draper, 1988). Goldstuck (1990) describes urban legends as an alternative oral tradition. The major difference is that, instead of being passed down via the elders, as in traditional folklore, the legends filter from the bottom upwards. The sources range from adolescents, barflies, gossips and rumourmongers, to what are evidently reputable sources (Goldstruck, 1990). They "are the oral culture of the modern relatively sophisticated city person. They may have roots in traditional folklore, but are not the same thing." (Goldstuck, 1990, p7).

They serve a number of functions which illustrate their importance in this context, the predominant one being the reinforcement of the moral codes of the society. Horrible and bizarre fates await the actors in these legends when they step beyond the narrow confines of the moral boundaries of their peers. They also warn of the dangers of potentially destructive influences, which generally exist outside the storytellers' and hearers' immediate frame of reference. In this context, AIDS and the HIV epidemic provide an ideal base for the development of such legends, as the story below will emphasise. Other functions of urban legends are that they provide a means of working through old emotionally traumatic scars and feelings; they are a form of catharsis; and also of entertainment in the storytelling tradition (Goldstuck, 1990). The following urban legend is an example:

"It's a story about a woman who becomes very promiscuous and sleeps around. She picks up men in clubs and places, and then goes home with them for the night. The man wakes up the next morning and she's gone. He walks into the bathroom and there, written in red lipstick on the mirror, it says: 'Welcome to the world of AIDS.'" (Goldstuck, 1990, p155)

The point of the story is that it acts as a warning to men who go into bars and have sex with any woman they "pick up". On a more sinister level it carries overtones of some far more dangerous messages. These are already part of the daily discourse, namely that people who get AIDS deserve it because of their behaviour, and that some people with AIDS are deliberately trying to get other people infected (Watney, 1988; Goldstein, 1989; Watney, 1989; Goldstuck, 1999). In South Africa AIDS has been combined with a range of political issues, and this is represented in other urban legends. One legend circulating amongst certain black communities was that AIDS could be cured by having sex with an Indian woman or with a white virgin. Another claimed that black domestic workers could and were transmitting HIV to the white employers' children (Goldstuck, 1990, 1999). Another urban legend that has developed more recently out of some of the political discontent that exists tells of a black woman spreading HIV in revenge against white men (Goldstuck, 1999). In many cases, urban legends will have a role both of reinforcing existing thinking or lay theories and acting as a

form of proof that they are correct, as well as incorporating new ideas or concepts into the systems of meaning. As with the theory of scapegoating these provide a useful explanation of a particular societal phenomenon and provide insights into some of the problems associated with the HIV epidemic. However they are unable to and do not claim to answer questions of how decisions are made about safer sexual practice, which is the focus of this thesis. A similar critique applies to psychologic, which is described below.

Psychologic

Smedslund (1990) enters the concept of "psychologic" into the psychological discourse as part of the arena of common sense psychology. Propositions in psychologic are explications of psychological common sense and have the form of logical implications. In order to be acceptable, they must be regarded as correct by all speakers of that language. They indicate what must be the case if certain conditions have been established. Implicitly, the inference is that if the consequence does not occur, then the necessary prior conditions cannot have been established (Smedslund, 1990). They are conceptual definitions that have been drawn from embedded semiotic and cultural patterns. In this sense they are not open to empirical investigation, as they exist by definition and so are a priori correct or incorrect. They therefore have more of a normative than an explanatory function, are reinforced by social sanction, and as indicated above, cannot be proved incorrect. The only way in which they can be called into question is if a particular proposition does not take all possible nuances into account, or if the context is different, or changes. These are part of a set of constructs that allow interaction and communication between people in similar contexts, i.e. culture, language, geography etc. (Smedslund, 1990).

Psychologic is potentially useful in the context of AIDS and HIV infection in that AIDS enters the semiotic system at a particular point and will become defined in terms of a range of other semiotic terms. An example is the early linking of the AIDS syndrome to homosexual men, as is illustrated by its being called Gay Related Immune Deficiency or GRID in the early days of the epidemic (Shilts, 1987; Watney 1989). In areas such as Africa, where the context is different, the nature of the psychologic propositions will be different.

Conclusion

Numerous studies in the arena of AIDS have already shown that although people have key items of knowledge, both about the threat of AIDS and how to prevent its transmission, there have not been changes in behaviour (Clark, 1988; Mathews, Kuhn, Metcalf, et al, 1990; Friedland, Jankelowitz, de Beer et al, 1991). Scientific knowledge about HIV is clearly not the most important influence when decisions on sexual behaviour are made. Given this

contradiction, additional explanations of how people do make decisions about behaviour need to be examined. In this chapter a range of theories has been outlined from the following groupings: cognitive and decision-making theories, learning theories, and theories of interpersonal relations. In some cases their potential contributions to the debates on HIV have been suggested. All the theories can make contributions to the explanation of behaviour, and are able to give some direction for interventions which influence it, but each does appear to have its limitations. Very few of the theories have been concretely applied to activist work in HIV, so this role still bears investigation. The theories draw on different traditions, so will have different vantage points in relation to the contexts. By selecting the more useful theories for each behaviour and having them provide commentary on each other and the behaviour in question, greater understanding and direction can be achieved. However, one key theoretical approach should be adopted as a central focus and for this research, the theories of Reasoned Action and Planned Behaviour will be used. The outline and potential for use of these two theories are the focus of the next chapter.

Chapter 4

REVIEW OF THE THEORIES OF REASONED ACTION, AND PLANNED BEHAVIOUR

The Theory of Reasoned Action (TRA) as introduced by Fishbein and Ajzen (1975), develops out of a tradition of attitude theory and draws heavily on cognitive and behaviour theory. They entered the field at a crucial point when attitude research was being thrown into question. The essence of TRA is based on a number of apparently simple ideas, while pulling together contributions from a range of other theories including Cognitive Dissonance Theory, Locus of Control Theory and the Health Belief Model (Fishbein and Ajzen, 1975). Besides the innovations of thought it incorporates, one of its major contributions is a tighter definition and operationalisation of variables and predictive powers. The Theory of Planned Behaviour (TPB) is an extension of TRA developed by Ajzen (1988) in an attempt to incorporate into it behaviours not under volitional control.

Selection of TRA / TPB

The theories of reasoned action and planned behaviour were selected over and above others discussed in the previous chapter on the basis of a number of criteria. These include the following:

1. The theory should have been applied in a range of settings, and have achieved positive results and some established credibility.
2. It should be sufficiently developed to allow for comparisons to be made with research from other centres.
3. It should hypothesise a relationship between cognitive factors and behaviour.
4. There needs to be a clear methodology, which can be feasibly applied in the South African situation.
5. There should be an openness and adaptability to the needs of the subject matter and the context being investigated.
6. For the purpose of intervention the final results should be easily interpretable so that community organisations and people who do not have a sophisticated knowledge of psychological theory can understand them.
7. It needs to be broad enough to be able to incorporate all or most of the factors that may have an influence on HIV related behaviour.
8. There must be a previous history of attempts to apply the theory to HIV related behaviour.

History of Attitude Theory

For a fuller appreciation of TRA, an understanding of the history of attitude theory is needed. The concept of attitudes within social psychology has always been important. As Gordon Allport indicated in the opening of his historically important paper "the concept of attitude is probably the most distinctive and indispensable concept in contemporary American social psychology" (Allport, 1935, p 798). The literature has described attitudes in a number of ways, from cognitive structures through to fixed behaviour patterns. Allport (1935) described attitude as a behavioural disposition, or more fully as "a mental state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related." The crude basis of the dominant approach to attitude theory implies that it is individual in its perspective and that attitudes are seen to be causing or at least directing behaviour (Foster and Nel, 1991).

The nature of attitudes as a theoretical construct has also changed over time, but has remained a key term (Fishbein and Ajzen, 1975). Much of the confusion centred around what could be considered to be the essential nature of an attitude, and in turn, what is its possible contribution to our understanding of behaviour and mental functioning could be. Already at the time of Allport's 1935 paper, the concept of attitudes was confused and had begun to signify many different things to different writers. As part of the process of developing his own definition, Allport (1935) drew out sixteen definitions for attitudes and related concepts from the literature. At a later stage, Campbell (1963) drew together some 75 concepts in regular usage in psychology, all referring to the central idea of an acquired behavioural disposition. These included concepts such as belief, value, conviction, expectancy, opinion, intuition and personality trait as well as attitude. The uncertainty was resolved by establishing the three component structure of attitudes, which suggest that they consist of cognitive, affective and conative aspects. Many theorists postulated that these three components were organised in a consistent fashion, i.e. that positively evaluated traits lead to positive feelings towards the object and in turn, positive action. The "three component concept" has led to confusion over components and definitions, in that the definition incorporates so much that it is in danger of becoming meaningless.

The model of the Theory of Reasoned Action (TRA) appeared in the literature during a period in which the relationship between attitudes and behaviour was coming increasingly into question (Ajzen and Fishbein, 1980). The criticisms of attitude theory were based on the increasing number of studies being done that showed a poor or no relationship between attitudes and behaviour. A review by Wicker (1969) concluded that correlations between attitudinal and behavioural measures rarely exceeded a value of 0.30. Fishbein and Ajzen

perceived TRA as a correction of the poor image that attitude theory had attracted. They argue that the negative image is based on poor methodological and theoretical development and is not necessarily a fault in attitude theory itself (Fishbein and Ajzen, 1975). Expectancy value theory and TRA sought to correct the problem. The theories were developed in an attempt to put structure and meaning into the concept of attitudes. The expectancy value theories were important in developing the relationship of traits to feelings (Jaspers, 1978). TRA drew the expectancy value theory into a connection with behaviour.

Fishbein and Ajzen's (1975) major criticism of attitude research, which they hoped to correct with their model, was the absence of a clear definition of the terms being used in studies. This was on two levels: definition of theoretical terms, such as behaviour and attitude; and variables being used in research. In early references on TRA, it became clear that it was not only attitudes that lacked clear definition in experimentation, but a number of terms that were related to it, including the construct of behaviour itself (Ajzen and Fishbein, 1980). For example, in a number of the studies, behaviour was confused with outcomes, which may or may not have resulted from the behaviour (Ajzen and Fishbein, 1980). A related problem was the poor linking between the attitudes and the behaviour being tested. In many cases, respondents were asked their attitude towards an object in general, and then asked about a specific behaviour that may or may not have been affected by the general attitude (Fishbein and Ajzen, 1975). For example, a particular attitude may be a general measure of racism while the behaviour may be employment of a black person by a white boss. This behaviour will be influenced by many other attitudes apart from racism.

The more recent work on attitude theory has been directed at attitude structure and functions. The issue of structure is particularly important, as this has relevance for the strength and durability of an attitude. Intra-attitudinal structure examines the dimensions of the attitude structure and, relationships of beliefs to attitudes, as well as the complexity and consistency of the beliefs. Inter-attitudinal structure examines attitude in the light of how other people, who are reference points, feel in relation to an individual's ideological position (Eagly and Chaiken, 1998). One important finding stemming from the work on structure is that attitudes showing a greater consistency between evaluative content of beliefs and attitudinal evaluation are less vulnerable to change when a variation in context occurs (Eagly and Chaiken, 1998). An impact of the different functions of attitudes is that at different times they would be serving different purposes. Included under functions is object appraisal, a utilitarian function, a means of expressing values, a means of social adjustment, and an ego defence (Eagly and Chaiken, 1998). Attitude structure is particularly useful because of its potential to find ways of changing attitudes that may otherwise appear resolute. For example, if one aspect of the

structure of an attitude can be changed, its overall strength will be weakened. If these small changes to structure continue, then ultimately the entire attitude becomes undermined and will be more susceptible to further change (Eagly and Chaiken, 1998). The more multiple structure of attitudes begins to take the complexity of the variable into account, but there remains no easy way to describe and measure attitude structure effectively. The notion of latitudes of acceptance provides some access, but is also simplistic. It takes the same basic tools of attitude measurement such as the Likert scale and semantic differential, and then adds complexity, which may just increase confusion and cost, rather than aiding explanation.

Attitudes are most recently defined as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour” (Eagly and Chaiken, 1998, p 269). The current view on attitudes, or at least attitude responses, tends to see them as comprising three aspects: cognitive, affective and behavioural. These advances in defining structure and functioning have important implications for TRA and TPB. One approach to attitude theory that would increase its usefulness may be to look at attitudes as a simple evaluative dimension. This is particularly useful to a lay person working in the field. At the same time, behavioural scientists who are involved in the project would be able to look at the deeper complexity of the attitude structure and function and be able to extract further information and use from the data gained from research for theory development.

The Theory of Reasoned Action

To avoid the above confusions Fishbein and Ajzen (1975) began by grounding TRA in a firm base of theory, and established clear assumptions and definitions of key variables. TRA is seen as being progressive with beliefs (cognitive) informing attitudes (affective) which in turn lead into behaviour (conative) (Fishbein and Ajzen, 1975). This uses the constructs of the three component structure of attitudes, but takes it further to make the theory more process-orientated. An explanatory base is also introduced in order to resolve the earlier confusion. The full model is outlined below. The description begins by explaining the definitions of terms and then describes the structure and process of the model. The theoretical background (Fishbein and Azjen, 1975; Ajzen and Fishbein, 1980; Ajzen, 1988) is available in the following chapter, so is not covered here. TRA involves an assumption that people process and use the information available to them in a systematic manner in order to arrive at their decisions. This is not to say that their behaviour will always be reasonable or appropriate from an objective point of view. People's information is often incomplete and at times also incorrect or affected by biases and false ideas (Fishbein and Ajzen, 1975; Fishbein, 1990).

Definition of terms

Each of the components of the theory needs to be defined in more detail. Behaviours are seen as being "observable acts that can be studied in their own right". (Fishbein and Ajzen, 1975). The researched behaviour needs to be defined in terms of the four criteria of action, target, context and time. The definition should be used at all other levels of the theory. This is referred to as the principle of compatibility (Ajzen, 1988). Secondly, it is important to distinguish between behaviours and occurrences that would be the goals or outcomes of behaviour; and between behaviours and behaviour categories. Ajzen and Fishbein (1980) identify this as being one of the key factors that has caused confusion in the area of attitude research, as any particular outcome can be influenced by a number of behaviours. A specific behaviour performed by an individual has to be defined clearly enough so that it can be determined whether or not it has been performed (Ajzen and Fishbein, 1980).

Intentions (I) refer simply to a person's intention to perform various behaviours. In many respects, intentions may be viewed as a special case of beliefs, in which the object is always the person himself and the attribute is always a behaviour. As with a belief, the strength of an intention is indicated by the subjective probability that a person will perform the behaviour in question. (Fishbein and Ajzen, 1975). Important to TRA is the assumption that most social behaviours are under volitional control. Therefore TRA would view a person's intention to perform, or not to perform, a behaviour, as the immediate determinant of the action. This assumption is important as it provides a basis for selecting what behaviours the model is able to explain. Both Fishbein (1991; Fishbein and Middlestadt, 1989) and Ajzen (1988) acknowledge that this does not apply in all situations. So the assumption does not imply absolute correspondence, but barring unforeseen circumstances, people will usually act in accordance with their intentions.

The definition of Attitudes (A) has changed over time from one more grounded in its theoretical origin, "a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object." (Fishbein and Ajzen, 1975, p 6), to another which is directed far more towards a practical use of TRA, "a person's general feeling of favourableness or unfavourableness for that concept" (Ajzen and Fishbein, 1980, p54). The latter is very close to the more recent definition of attitudes given in the Handbook of Social Psychology (Eagly and Chaiken, 1998). Fishbein and Azjen (1988) do acknowledge that their latter definition does not capture the full complexity that has come to be associated with the attitude concept, but it does contain the most essential and practical aspect of the concept of attitude. The two definitions do not contradict each other and both are useful. Attitudes should be seen as overall evaluations of a person's judgement as to whether or not they are in favour

of performing a behaviour. This lends itself to a measurement procedure that locates respondents on a bipolar evaluative dimension (Ajzen and Fishbein, 1980).

Subjective norms (SN) are probably best considered as being a special case of attitudes, but still warrant separate analysis and study. Subjective norms are defined as being the respondent's perceptions that "most people who are important to him think he should or should not perform the behaviour in question." (Ajzen and Fishbein, 1980, p57). Subjective norms attempt to deal with the influence of the social environment on intentions and behaviour. The subjectivity of the perception is important as it takes into account the fact that a person's view of the world is unlikely to be objective. According to the theory, the more someone believes that others who are important to him or her think he or she should or should not perform a behaviour, the more likely it is that the behaviour will or will not be performed. Once again this can be measured on a bipolar evaluative dimension (Ajzen and Fishbein, 1980). In a later research paper, Fishbein acknowledges a need for normative pressure as an addition to normative beliefs, as many people are affected by what important others do (Albarracin, Fishbein and Middlestadt, 1998). Ajzen later defined the subjective norm as "the person's perception of social pressure to perform or not to perform the behaviour under consideration" (Ajzen, 1988, p117). This defines the term more explicitly as a social force existing within society, rather than as a set of attitudes in each member of a group of individuals who are important to the person concerned.

Beliefs represent the attributes a person accredits to an object or behaviour (Fishbein and Ajzen, 1975). In Ajzen and Fishbein (1980) the definition was extended by stating that people form beliefs about an object by associating it with various characteristics, qualities and attributes. Automatically and simultaneously, an attitude is acquired towards that object. The universe of beliefs in existence is narrowed down by the cognitive constraints of human functioning. So although a person may hold a large number of beliefs about any given object, it appears that only a relatively small number can be attended to at any one time, perhaps between five and nine. These are considered to be the salient beliefs and are the immediate determinants of the person's attitude. The top of the mind beliefs separate those which are the most salient and those likely to have an effect, given a person's limited cognitive capacity, from those that are less open to recall and thereby also less likely to have an influence on attitude (Fishbein, 1990).

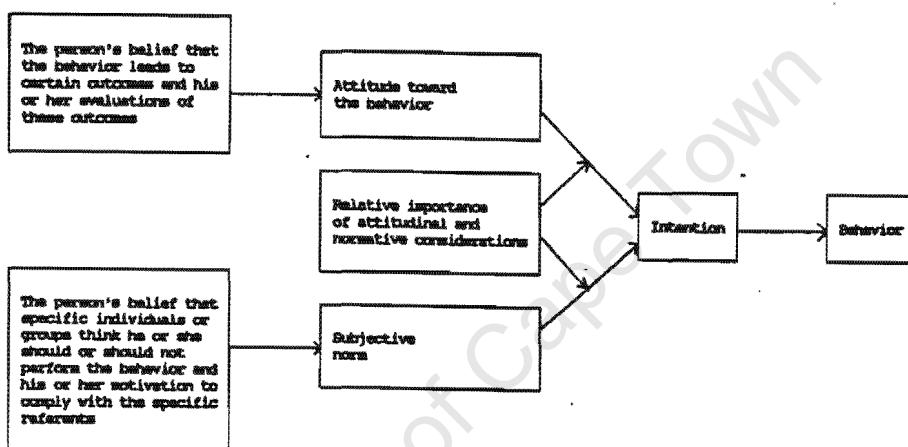
An evaluative component is attached to both sets of beliefs in order to establish the importance of the belief for the respondent. The behavioural belief comprises, firstly, the belief strength, which estimates the perceived likelihood that the object is linked to the

attribute in question, and secondly, the importance of that belief for the respondent. The normative beliefs comprise, firstly, the respondent's perception of the other person or group's attitude towards their performing the behaviour; and secondly the respondent's desire to do what that other person or group wishes them to do. (Fishbein and Ajzen, 1975).

Description of the model

With the definitions established, it is important now to explain the relations between the variables (Fishbein and Ajzen, 1975). The graphical outline of the model is provided below (Ajzen and Fishbein, 1980).

Figure 4.1: Theory of Reasoned Action



Ajzen and Fishbein, 1980

The ultimate aim of the model is to predict and understand an individual's behaviour. At its most basic, Behaviour is seen as being predicted by Intentions. Intentions are in turn predicted by Attitudes and Subjective Norms. A and SN are seen as arising from an interaction of the beliefs held by a person, and the strength of those beliefs. These, in turn, are seen as arising from a set of external variables, including factors such as culture, ideology, language, life experience, religion, morality, and beliefs of friends and family, amongst others. The external variables have an influence only via this linear process and enter the equation structurally via the beliefs. The first step therefore is to define, identify and measure the behaviour of interest as outlined in the definition above. While all four criteria need not be specified on a particular level, it is important that all the elements have the same level of specificity for different stages of the model (Ajzen and Fishbein, 1977). In a detailed review of studies that have attempted to relate attitudes to behaviour, Ajzen and Fishbein show that there is an increase in the accuracy of the predictions as the constancy of the relationship in terms of the four criteria is increased (Ajzen and Fishbein, 1977).

Intention is the prime predictor of behaviour, a common-sense notion that has been backed up by research. In the definition provided for the TRA, the time space between the measurement of I and B should be short. However, a meta-analysis showed the models to be considerably more robust, allowing for long periods of up to fifteen years, without a significant change in the I-B relationship (Randall and Wolff, 1994). The link between intention and behaviour has also been questioned. Sutton (1998) raised a number of reasons as to why the correlations are sometimes lower than expected, namely: intentions may change, or be provisional; there may be a violation of the principle of compatibility, or of scale correspondence; an unequal number of response categories for intention and behaviour; random measurement error in the measures of intention and/or behaviour; restriction in the range/variance of intention or behaviour; marginal distributions of the measures may not match; and intentions may not be the sufficient cause of behaviour. Gibbons, Gerrard, Blanton et al (1998) raised a further problem, in examining the distinction between intention and willingness to participate in a behaviour. The logic is that a person may not intend to behave in a particular way, e.g. have a drink, but if presented with the opportunity, would be willing to do it. In studying adolescent health risk behaviours they found that willingness to complete a behaviour operated as an independent construct and showed strong predictive capacity. Having a choice between behaviours can also put limits on intention, especially if these behaviours are mutually exclusive (van den Putte, Hoogstraten and Meertens, 1996). This has a number of implications for research into safer sex where there are a number of options, including the use of condoms and the practice of monogamy, as well as the less safe options, such as finding "clean" partners, reducing the number of sexual partners, and not performing anal sex. Separate intentions will exist for each, but in reality each can exclude the other. Gold (1993) raises a distinction between on-line and off-line cognitions. He claims that when a person is entering a sexual encounter a different set of processes operate, and that these will affect intentions, due to the development of excitement and desire.

In turn, intentions are seen as a function of two basic determinants, one reflecting individual feelings or attitudes and the other reflecting social influence, the subjective norm. These operate alongside each other. The relative importance of the attitudinal and normative factors is a straightforward statistical decision using multiple regression. Finlay, Trafimow and Jones (1997) found in a survey of 32 health behaviours that not only do behaviours vary, being mainly under either attitudinal or normative control, but this will vary between subjects as well. Behaviour tended to be more under attitudinal control, about 80% to 90% of the time.

The theory of Reasoned Action up to this point can be summarised as follows

$$B \cong I = f[w^1 Ab + w^2 SN]$$

where B - behaviour of interest; I - intention to perform the behaviour; Ab - attitudes toward performing that behaviour; SN - subjective norm concerning the behaviour and w^1 and w^2 - weights of the attitudinal and normative components respectively (Fishbein and Middlestadt, 1989).

Attitudes and subjective norms are a function of the person's top of the mind beliefs.

Fishbein's expectancy value theory (Fishbein and Ajzen, 1975) is used to outline the process by which beliefs about behaviour are translated into attitudes towards a particular object and how normative beliefs become the subjective norms. By the processes of classical and operant conditioning, a person comes to hold one or more beliefs about a behaviour; or expressed in terms of learning theory, the behaviour may be seen as being related to a range of attributes, such as related objects, characteristics, goals, etc. In turn, there is an implicit evaluative response attached to each of these attributes. These responses are drawn together in the Expectancy Value Equation (Fishbein, 1963; Fishbein and Ajzen, 1975).

This is expressed algebraically in the following manner for attitudes and subjective norms.

Firstly for attitudes

$$A_O = \sum_{i=1}^n b_i e_i$$

where A_O is the attitude toward some object, O; b_i is the belief about O, i.e. the subjective probability that O is related to attribute i; e_i is the outcome evaluation of attribute i; and n is the number of beliefs (Fishbein, 1963; Fishbein and Ajzen, 1975).

Secondly, for subjective norms

$$SN = \sum_{j=1}^n b_j m_j$$

where SN is the subjective norm; b_j is the normative belief concerning referent j; m_j is the person's motivation to comply with referent j; and n is the number of salient normative beliefs (Fishbein and Ajzen, 1975).

A number of studies try to apply a shortcut to the process by using the results of the Expectancy Value Equation in correlations and regressions, rather than as a separate measure of attitude or subjective norm. This is not valid unless the expectancy value measure is highly correlated with an independent measure of attitude (Albarracin, Fishbein and Middlestadt, 1998).

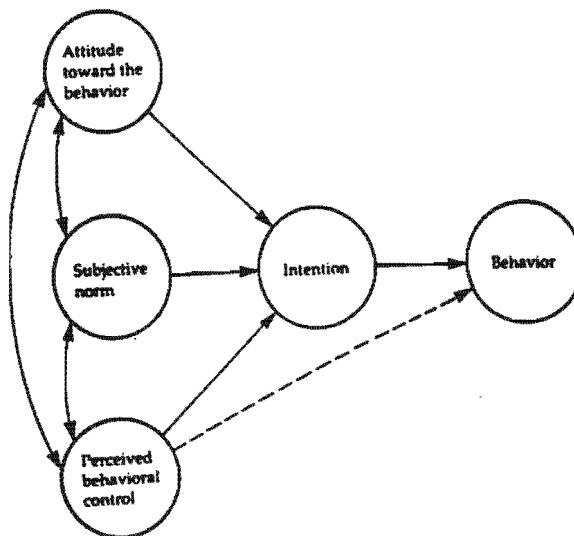
A range of external variables which are seen as being of potential importance are also incorporated into the full model. These are perceived as having an indirect effect on the

process via beliefs, outcome evaluations, selection of normative influences, and motivation to comply with felt norms. The external variables include demographic variables such as age and sex, attitudes towards the targets, such as racism and benevolence, and personality traits such as introversion and dominance. Many of these factors were the central elements of previous attitude research projects (Ajzen and Fishbein 1980). Overall this theory postulates that any behaviour is ultimately determined by the behavioural beliefs concerning its consequences and the normative beliefs concerning the prescriptions of relevant others (Fishbein and Ajzen, 1975). In fact one of the advantages of the model is that it makes it possible to study the locus of effect of one or more of the external variables (Fishbein and Middlestadt, 1989).

Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) is directed at behaviours not directly under the control of the subject. The obvious change in TPB is the inclusion of an additional contributing factor towards the determination of intention and behaviour, namely Perceived Behavioural Control (PBC). PBC refers to "the ease or difficulty of performing the behaviour and it is assumed to reflect past experience as well as anticipated impediments and obstacles" (Ajzen, 1988, p132). PBC draws on factors which either encourage or inhibiting the behaviour, which in turn influences intentions. Ajzen (1988) argues for the inclusion of PBCs on the basis that TRA was developed only for behaviours totally under volitional control. Like attitudes and subjective norms, Ajzen views the issue of control as a continuum, with some behaviours having little or no controlling influences, e.g. voting with a hidden ballot, while others may be prohibitively controlled, e.g. giving up a powerful drug like smoking. It is in this light that Ajzen also slightly adapts the definition of intention and states that, "most intended behaviours are best considered goals whose attainment is subject to some degree of uncertainty. We can thus speak of behaviour-goal units, and of intentions as plans of action in pursuit of behavioural goals." (Ajzen, 1988, p128). To look at these logistical issues in more detail it is useful to examine the modified form of the Theory of Planned Behaviour (TPB). This is shown on the next page.

Figure 4.2: Theory of Planned Behaviour



(Ajzen, 1988)

Ajzen considers the conceptual framework to be an extension of the TRA, with PBC being a third antecedent of intention. It has motivational implications for intentions, in that people who believe that they have neither the resources nor the opportunity to perform a certain behaviour are unlikely to form strong behavioural intentions to engage in it. This will apply even if they hold favourable attitudes towards the behaviour and believe that important others would approve of their performing the behaviour. Ajzen therefore argues that there is an association between perceived behavioural control and intention which is not mediated by attitude and subjective norm (Ajzen, 1988). The perception that one has high control would seem to strengthen an intention only in the context of a positive attitude toward the behaviour, and the perception that one has little control weakens the intention to engage in the behaviour (Eagly and Chaiken, 1998).

There is also the potential for a direct link between PBC and behaviour. In this case PBC is used as a partial substitute for a measure of actual control. The arrow is broken because the link between PBC and behaviour is expected to emerge when there is some agreement between perception of control and the person's actual control over the behaviour, and/or the behaviour is in fact not under voluntary control (Ajzen, 1988).

PBC captures factors the person feels may obstruct or facilitate the achievement of certain behaviours. It does not attempt to claim that the individual will necessarily have an objective view of reality. In examining the factors that may influence control, Ajzen extracts two internal and two external control factors. The internal factors comprise issues of information, skills and abilities, and emotions and compulsions. He maintains that it may be fairly easy to gain control over information and skills-type controls, depending on the complexity of the situation, for example by getting appropriate training. Other factors, such as intense emotions,

stress or compulsions, are more difficult to neutralise. External controls are referred to as opportunities, and there is the problem of dependence on others for the performance of a task.

Lack of opportunity and dependence on others may lead only to temporary changes in intentions. When circumstances prevent the performance of a behaviour, the person may wait for a better opportunity, and when a partner fails to co-operate, a more compliant person may be sought. However, when repeated efforts to perform the behaviour result in failure, more fundamental changes in intentions can be expected (Ajzen, 1988). There are obvious links and overlaps among the four factors. PBC draws considerably on the theories of internal-external locus of control and self-efficacy, and is considered to be superior to the internal-external locus of control, due to TPB's greater adherence to the principle of compatibility (Ajzen, 1988). The theory of self-efficacy and PBC are more congruent and both adhere to the principle of compatibility. PBC as a variable has been subject to debate, as there have been a number of attempts to separate it into more constructs or to add other aspects of control (Kasprzyk, Montaño and Fishbein, 1998).

As with attitudes and subjective norms, PBC also has a set of underlying beliefs termed control beliefs (Ajzen, 1988). A major difference is that they do not use the expectancy value equation, which is applied to attitudes and subjective norms. One possible explanation is that these do not fit into the expectancy value theory, as controls are an imposition, and not a motivational factor. The added dimension appeared in TPB later when the perceived power of the control factor in the facilitation or inhibition of the performance of the behaviour was suggested to be an addition, which would also be measured on a scale (Terry, Gallois and McMamish, 1993).

Points of contention

The addition of PBC has a number of influences on the theory. These need to be addressed, as they do affect some of the fundamental bases of TRA. Firstly, can the dimension of PBC be explained or addressed by an existing part of the theory? Fishbein claimed that many if not most of the possible factors listed under PBC could be incorporated under attitudes. However as Fishbein (1991) himself stated, the addition of subjective norms may also have been negated by such a requirement, as their contribution could also be incorporated by attitudes. Later he reinforced this perspective by noting that in the more recent uses PBC had acquired a more affective component (Fishbein, 1993). Specific experimentation on the relationship between attitudes and PBC by Trafimow and Duran (1998) found that there is a real distinction between the two variables in the tests that they conducted. In that case, TPB may answer some of the criticisms raised by Eiser and van der Pligt (1988) against TRA, such as

prediction of addictive behaviours and other non-voluntary behaviours. In a theory-based community intervention study aimed at reducing AIDS risk behaviours, Fishbein acknowledged the role of control factors by advocating the supply of condoms and bleach kits to nullify problems of access, and the incorporation of the theory of self efficacy into TRA for the construction of the intervention model (Fishbein, Guenther-Grey, Johnson et al, 1996). There is a lack of clarity concerning the exact definition of PBC, with varying opinions being found in the literature especially its relationship to self-efficacy, which compromises its position in theory (Terry, 1993; Fishbein 1993). The general structure of PBC has been called into question, with one study advocating that items of PBC should include items for perceived difficulty and perceived control. The construct should also be adapted to incorporate aspects of self-efficacy more clearly (Sparks, Gunthrie and Shepherd, 1997).

Secondly, PBC has to add to the predictive and descriptive capacity of the model. A review of the literature (Ajzen and Madden, 1986; Schifter and Ajzen, 1995 and Ajzen and Timko, 1986, in Godin and Shephard, 1990; Parker, Manstead, Stradling et al, 1992; Godin, Valois and Lapage, 1993) plus the results of specific experiments done by Ajzen (1988), indicate that it does make a significant contribution, particularly when two criteria are met, namely that the behaviour must be determined at least in part by factors beyond a person's control, and that the person has a realistic perspective of the amount of control that they do have (Ajzen, 1988). There may be confusion in relation to the latter assumption, given the insights gained from the theory of fundamental attribution error and its extensions (Kelly and Michela, 1980). Thirdly, PBC has to fit logically into the pattern of reasoning that is being used within the model. For the attitudinal and normative components, Fishbein's Expectancy-Value theory applies. This is considered an integral part of TRA (Fishbein and Ajzen, 1975) and so should at least be addressed if new elements are to be incorporated into the model.

A further aspect of structure concerns the logic of the model. TRA had a number of checks and balances incorporated within it and had a logical functioning. This is undermined to some extent by the addition of the PBCs. Firstly, there is no longer a check on all the second level variables in terms of the expectancy-value calculations. Secondly, the TRA had a process incorporated within it whereby there was a consistent relationship across beliefs, to attitudes, to intentions, to behaviour. While the PBC variable can incorporate this, it does break down the flow of the model by having a direct relationship to behaviour apart from via the intentions. Although it makes logical sense it does imply a change in an aspect of the basic operation of the model.

The Process for Collecting the Data Using this Model

The data collection process will be covered in the methodology section. It is important to note that the research methodology prescribed is very tight, gives detailed direction and attaches considerable importance to operationalisation. It incorporates a number of internal validity checks to ensure that the structure of the theory is being followed absolutely. These are crucial for the useful application of a theory.

Evidence for the theories

There has been strong empirical backing for TRA and TPB throughout their history. A small sample of this is listed below to indicate the breadth of their application. Much of this backing is already drawn together and reviewed in a number of texts by those who developed the theory (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1977; Ajzen and Fishbein, 1980; Ajzen, 1988). These include factors such as exercise, weight loss, voting, drinking, attending class, studying for exams, getting good grades, breast feeding, donating blood, co-operation in the Prisoner's Dilemma Game, having an abortion, using birth control pills, breastfeeding, smoking marijuana, attending Church and having another child.

Further evidence for the Theory of Reasoned Action includes the consumption of garlic (Rosin, Tuorila and Uutela, 1992), the use of self-help groups by training mental health professionals (Meissen, Mason and Gleason, 1991), compliance behaviour of hypertensive patients (Miller, Wikoff and Hiatt, 1992), inner-city mothers in London taking their children for routine medical and dental examinations (Hendricks, Freeman and Sheiham, 1990), prediction of likelihood of breast self-examination (Lierman, Young, Kasprzyk et al, 1990; Powell-Cope, Lierman, Kasprzyk et al, 1991), oral health behaviour (Tedesco, Keffer and Fleck-Kandath, 1991), the structuring of student integration opportunities by special education teachers (Thousand and Burchard, 1990), patients' attitudes to multiple sclerosis (Evers and Karnilowicz, 1996), work values (Abdalla, 1997), college-student drinking (Trafimow, 1996), children's decisions about substance use (Morrison, Simpson, Gillmore et al, 1996), women seeking social support in old age (Albarracin, Fishbein and de Munchink, 1997), women's career behaviour (Vincent, Peplau and Hill, 1998), eating US beef (Sapp and Jensen, 1997), thirty-two health-related behaviours (Finlay, Trafimow and Jones, 1997), the prescription of antibiotics in a managed-care setting (Lambert, Salmon, Stubbings et al, 1997), workers' turnover intentions in British and Japanese commercial and academic organisations (Abrams, Ando and Hinkle, 1998) and screening for cervical cancer (Barling and Moore, 1996).

Evidence in support of the Theory of Planned Behaviour includes the following: exercise behaviour (Godin, Valois and Lapage, 1993; Hausenblas, Carron and Mack, 1997), students' studying and goal achievement behaviour (Ajzen and Madden (1986), determinants of intention to commit driving violations (Parker, Manstead, Stradling et al, 1992), health related behaviours (Schifter and Ajzen, 1995 and Ajzen and Timko, 1986, in Godin and Shephard, 1990), consumer composting behaviour and waste management (Taylor and Todd, 1997), Church attendance in Northern Ireland (Giles and Cairns, 1996) and leisure-time physical activity (Chatzisarantis and Biddle, 1998).

In fact the continued overall interest in the theory could also be said to bear testimony to its importance, value and support. Both theories remain central to the discipline of social psychology, with regular papers and reviews appearing. Even entire journal editions are devoted to TRA and TPB, e.g. Journal of Applied Social Psychology, 1998, vol. 28(15). Regular competition between TRA and TPB appears in the literature, with the results varying according to behaviour, context, target and possibly researcher. Sutton (1998) has written a review of a number of meta-analyses of TRA and TPB. He found that intention is predicted, using an R^2 , fairly consistently between 40% and 50%, and that behaviour is predicted from intention with correlation being obtained of only between 0.44 and 0.62. Conner and Armitage (1998) reported in their meta-analysis that PBC on average added 5% to the variance explained in intention and 1% to the variance obtained in behaviour.

Numerous other additions are made to TRA at different points in time, including self-efficacy (Fishbein, Guenther-Grey, Johnson, et al, 1996), past behaviour (Trafimow, 1996; Albarracin, Fishbein and Middlestadt, 1998), habit (Godin, Valois and Lapage, 1993), the personal normative belief construct from the Triandis model and homophobia (Vermette and Godin, 1996), all the constructs on the Triandis model (Godin, Maticka-Tyndale, Adrien et al, 1996), income and age (Sapp and Jensen, 1997) and emotional reaction (Chan and Fishbein, 1993). These have not been addressed further in this thesis, but may require consideration. A more detailed review of the additional variables that have been tested, plus other extensions to the theories, is provided by Conner and Armitage (1998). In most cases the additional variables make less of an impact than the established variables of attitude and subjective norms. There is also often considerable overlap between these new variables, and attitude and subjective norm, as shown by high levels of multicollinearity. The problem of adding items, while not observing the key philosophy of the theory, is that the process becomes very confused and there is increased competition between variables. Any addition also erodes the parsimony of the theory, so undermines one of the major advantages. It is unlikely that TRA would have

been as popular and as well used if a multitude of variables had initially been attached (Fishbein, 1993).

An additional test of the theory that was felt to be important was the demonstration of the utility of the theory in applied settings as well as in laboratory settings. The theory's role is not only the prediction and understanding of certain behaviours but also the development of programs to influence the incidence of such behaviours (Ajzen and Fishbein, 1980). It has faced some limited testing in influencing behaviour, and has proved useful. However, the methods of education are often poor, which would undermine the usefulness of the experiment. An example is the experiment in persuasive communication done in a alcoholic treatment centre, which was based on the use of a taped lecture. While the results were positive, the method of intervention could be improved upon and even better results obtained (Ajzen and Fishbein, 1980). More recently improved intervention studies have taken place (Fishbein, Guenther-Grey, Johnson et al, 1996). Ongoing tests with adequate interventions need to continue.

Applications of the Theories in AIDS and HIV

Considerable research has been done on HIV behaviour, much of which has occurred since this project was in the field. A brief review of the literature obtainable is provided. Most studies using TRA or TPB seem to have been on students, medical professionals, gay men or people participating in high-risk behaviour. These are summarised in table 4.1. A full critical discussion of the papers could not be provided due to space restrictions. Following the table, studies where either the results were not fully reported or the full method was not used are outlined. The operationalisation of the variables in some of the studies was not done strictly according to the methodology, which may have affected the results. Brief notes on some of the papers appearing in table 4.1 are also provided below the table.

Table 4.1: Summary of TRA and TPB studies on HIV related behaviour

<u>Ref</u>	<u>Sample</u>	<u>Subject</u>	<u>I-B</u>	<u>R²</u>	<u>A-I</u>	<u>SN-I</u>	<u>PBC-I</u>
Middlestadt and Fishbein, 1990	101 female students, USA	Asking partner to use a condom	Not given	0.59	$\beta=0.25$	$\beta=0.44$	na
Fishbein, 1990	women students, Mexico	Asking partner to use a condom	Not given	0.56	$\beta=0.37$	$\beta=0.35$	na
	Male students, Mexico	Using a condom		0.70	$\beta=0.53$	$\beta=0.23$	na
	Male students, USA	Using a condom		0.66	$\beta=0.22$	$\beta=0.52$	na
Reinecke, Schmidt and Ajzen, 1997	1500 students Germany	Use of condom for birth control	Not given	0.62	$\beta=0.20$	$\beta=0.35$	$\beta=0.41$
		Use of condom HIV protection		0.71	$\beta=0.52$	$\beta=0.33$	$\beta=0.19$
Nucifora, Gallois and Kashima, 1993	160 students Australia, 140 at follow-up	Use of condoms	$R^2=0.56$	0.47	$\beta=0.39$	$\beta=0.37$	$\beta=0.14$
Warwick, Terry and Gallois, 1993	138 students Australia 107 at follow-up	Use of condoms	$R^2=0.80$	0.60	$\beta=0.33$	$\beta=0.32$	na
Terry, 1993	151 students Australia, 135 at follow-up	Use of condoms	$R^2=0.37$	0.58	$\beta=0.34$	$\beta=0.19$	na
Albarracin, Fishbein and Middlestadt, 98	428 sexually active residents, West Indies	Use of condoms, pre intervention	Not given	0.24	$\beta=0.36$	$\beta=0.29$	$\beta=0.16$
	178 sexually active residents, West Indies	Use of condoms, post intervention		$R=0.59$	0.58	$\beta=0.52$	$\beta=0.35$
Godin, Maticka-Tyndale, Adrien et al, 1996	343 Latin American adults	Use of condoms, cross cultural study in Canada	Not given	0.61	$\beta=0.17$	$\beta=0.28$	$\beta=0.47$
	354 English speaking Caribbean adults			0.42	$\beta=0.23$	$\beta=0.22$	$\beta=0.31$
	347 South Asian men			0.69	$\beta=0.27$	$\beta=0.10$	$\beta=0.55$
Chan and Fishbein, 1993	312 female college students	Asking partners to use condoms	Not given	0.27	$\beta=0.34$	$\beta=0.19$	$\beta=0.06$
De Wit, Stroebe, De Vroome et al, 2000	395 homosexual men in Amsterdam	Use of condoms with casual partners	$R=0.29$	0.54	$\beta=0.05$	$\beta=0.12$	$\beta=0.74$
		Use of condoms with steady partners	$R=0.79$	0.79	$\beta=0.41$	$\beta=0.31$	$\beta=0.29$

β scores are for the relationship to intention and not behaviour. Where a space is left blank, refer to the most recently completed block in that column. The samples refer to adults of both genders unless otherwise specified.

Some additional information on belief scores and the results of splitting of samples from the studies listed in the table were noted. Middlestadt and Fishbein (1990) found the correlations between the total for relevant beliefs, as calculated by the expectancy theory, was $R=0.50$ for

attitude; and $R=0.64$ for subjective norm. Once the sample was segmented, sexually experienced women were found to be predominantly under normative control, while the inexperienced women were predominantly under attitudinal control. In further analysis of the data from the young male students in the USA, a relationship ($R = 0.59$) was found between the belief-based estimate of attitudes and the direct measure of attitude. Three particular beliefs were found to discriminate between those intending to use a condom and those not intending to, namely that using a condom shows respect for one's partner, that a condom is a nuisance, and that it makes sex less fulfilling (Fishbein, 1990).

A separate study set out to test the TRA in the prediction of the intention to care for AIDS patients among nursing students, but this did not use the methods adequately. No direct measures of attitude and subjective norm were generated, so the summed beliefs scores were used (Goldenberg and Lashinger, 1991). The study constituted a survey, followed by an intervention, then another survey. The multiple correlation between the two components of the model and intentions was significant before the intervention ($R^2=0.39$, $p < .02$) and remained so after the intervention ($R^2=0.43$, $p < .02$).

In a study using TPB, nurses' attitudes to caring for people with AIDS, who were separated into homosexual and heterosexual clients, were measured. The perceived behavioural controls were found to be the most predictive variable of intentions ($R=0.59$), with attitudes ($R=0.51$) and subjective norms ($R=0.47$) also being important. Further new variables including personal norms and homophobia, performed less well, but still made a small contribution to the model (Vermette and Godin, 1996).

In a review of the studies using TRA to assess condom usage in Australia, the following results were identified. Among a sample of gay men, a multiple correlation of 0.44 was obtained between A, SN and intentions, with the bulk of the variance being accounted for by subjective norms. Similar results were found in another sample of gay men reinforcing the role of normative factors. Much lower levels of explanation were attained among a sample of 1720 ninth graders where only 17% was explained (Ross and McLaws, 1993). Research done with university students in Australia found that only 27–29% of the variance for intention was explained. However the use of TRA was very confused in this study, with a number of other variables being included (Moore, Rosenthal and Boldero, 1993). A separate study was done among immigrant populations in Australia. Good levels of explanation were shown in all four of the groups selected, with an R^2 of between 0.57 and 0.62 being obtained for each group. Of the four groups, three were predominantly under the influence of subjective norms and perceived control with one group being influenced by attitude and subjective norms.

However, once again the methods were not properly applied, and this would have influenced the results (Rigby, Dietz and Sturgess, 1993). A book of studies on HIV in Australia using TRA found that most sexual behaviour is under normative control, which was felt to be appropriate given the nature of sexual behaviour (Gallois, McCamish and Terry, 1993). Sneed and Morisky (1998) used aspects of the TRA model in a study of condom use among 1394 Filipino sex workers. They found that condom usage was dominantly under normative control, although attitudes also made a significant contribution. However the method varied from the TRA approach in key aspects, which may have affected the results.

Condom usage was assessed in a study of 201 students in Ghana, using the theory of reasoned action. In this study attitudes were divided into those seeing condom usage as being advantageous and those seeing it as a disadvantage. The adjusted R^2 obtained was 33.33% with the β scores being 0.089 for attitudes seeing the behaviour as advantageous, 0.294 seeing it as disadvantageous and 0.455 for subjective norms (Bosompra, 2001).

A study investigating condom use in a high HIV risk population used the TPB design, adding facilitators/constraints (f/con) as an additional variable (Kasprzyk, Montaño and Fishbein, 1998). Separate analyses were done for permanent and casual partners, and for vaginal, anal and oral sex. A follow-up survey to assess behaviour occurred three months after the initial questionnaire. The sample was 993 for the first questionnaire concerning the PBC variables, and 686 at the three-month follow-up. The full results are given in table 4.2 below.

Table 4.2: Summary of results from study of HIV high-risk population

behaviour	I-B	R ²	A-I	SN-I	PBC-I	f/con - I
<i>Condom use with regular partner</i>						
vaginal sex	0.55	0.41	$\beta=0.40$	$\beta=0.15$	$\beta=0.10$	$\beta=0.21$
anal sex	0.67	0.46	$\beta=0.37$	$\beta=0.20$	$\beta=0.11$	$\beta=0.23$
oral sex	0.44	0.33	$\beta=0.19$	$\beta=0.32$	$\beta=0.09$	$\beta=ns$
<i>Condom use with casual partner</i>						
vaginal sex	0.39	0.30	$\beta=0.26$	$\beta=0.22$	$\beta=0.15$	$\beta=0.45$
anal sex	0.25	0.40	$\beta=0.38$	$\beta=0.19$	$\beta=ns$	$\beta=0.56$
oral sex	0.42	0.34	$\beta=0.40$	$\beta=0.21$	$\beta=0.16$	$\beta=ns$

ns = not significant

A theory-based community intervention done in a number of US cities used TRA together with the Health Belief Model, self-efficacy and the stages of changes model to guide the intervention. The results were positive, indicating that change took place, but it took time to have an effect (Fishbein, Guenther-Grey, Johnson et al, 1996). In another theory-based intervention among gay men in Australia, focus groups were used to impact on normative beliefs which were found to be the major influence on behaviour. In essence the groups used a discussion format for participants to talk through their sexual practices and receive input on

safer sexual practices and life skills. When the chapter was written a formal evaluation had not taken place, but brief evaluations of the sixteen groups that had been through the program suggested that both attitudes and subjective norms had changed in the direction of using safer sexual behaviour practices (McCamish, Timmins, Terry, et al, 1993).

A meta-analysis of condom usage across a number of sites was done using studies that applied the theories of Reasoned Action and Planned Behaviour (Albarracin, Johnson, Fishbein and Muellerleile, 2001). This paper reviewed 96 data sets, covering a total sample of 22 594 respondents examining the behaviour of condom use. Across all the studies, a correlation of 0.446 was obtained between intention and future behaviour. The correlations between attitude, subjective norms and perceived behavioural controls, and intention were 0.576, 0.389 and 0.448 respectively. The role of perceived behavioural controls appeared to reduce considerably when these factors were incorporated into the full models. In the case of the model from the meta-analysis for the theory of Reasoned Action the β s obtained were for attitudes 0.43 and for subjective norms 0.15 to give a final R^2 of 0.56. In the case of the model of Planned Behaviour the β s were for attitude 0.36, subjective norms, 0.14 and for perceived behavioural controls 0.14. However the final R^2 remained at 0.56 Behaviour (Albarracin, Johnson, Fishbein and Muellerleile, 2001). This would support an earlier idea that the concept of perceived behavioural controls being already covered by the variable of attitudes.

Studies done in Southern Africa

Very few studies have been done using the Theory of Reasoned Action in Southern Africa, particularly around the subject matter of AIDS. Projects have used aspects of TRA in the development of their methodology and plan, but did not attempt to use the model as it stands. The Theory of Planned Behaviour has not been tested at all. McKinnon (1993) tested TRA, with the Triandis model, in a comparative study among university students, on their usage of condoms. Unfortunately the method was not fully applied as attitude and subjective norm were assumed from the sums of beliefs scores. An effective sample of 77 was collected. An R^2 of 0.240 was found when the sum of both the behavioural beliefs and the normative beliefs were included and related to intention. The individual correlations were as follows; intention - past behaviour 0.557; behavioural beliefs - intention 0.365; and normative beliefs - intention 0.424. There was very little improvement in the correlations or regression scores when the population was divided by gender or home language.

A study using TRA investigated condom use and monogamy among 191 secondary school students in Malawi. The results are summarised in table 4.3.

Table 4.3: Results for study of scholars in Malawi

<u>behaviour</u>	<u>R²</u>	<u>A – I</u>	<u>SN – I</u>	<u>beh.bel-A</u>	<u>norm bel-SN</u>
using a condom	0.506	$\beta=0.51$	$\beta=0.02$	R=0.44	R=0.40
stick to one sexual partner	0.374	$\beta=0.36$	$\beta=0.03$	R=0.27	R=0.33

These results indicate that both behaviours are strongly under attitudinal influence, which contradicted the findings in other studies from Australia and America. This attitudinal influence remained even when the sample was split by gender. The major behavioural beliefs for condom use centred on prevention of STDs, pregnancy and HIV, and on sexual pleasure second. For sticking to the same sexual partner, the major beliefs centred on limiting STDs and saving money (Bandawe and Foster, 1996).

Major Critiques of the Model

The criticisms of the model are addressed at the basic assumptions and the theoretical underpinning of the model. This discussion will therefore be approached via these assumptions and underlying theories. Moscovici (1984) outlines an essential critique based on the debate as to whether the basis for attitudes or the related concepts lies in the individual or the group. In this case Moscovici uses a social representations approach, and argues that TRA makes the mistake of assuming that causality lies with the individual. He argues that to be able to find the answer, social dynamics and societal structures also have to be examined. While there are attempts to include contextual factors with the concepts of social norms and within TPB, perceived behavioural controls, these still remain at the individual level and do not indicate the process or method of operation of the factors. Kippax and Crawford (1993) make a similar critique from a social constructionist standpoint. They argue that attitudes and beliefs are not individually held but socially constructed. Beliefs need to be grounded in cultural, social, interpersonal context and representations. Even the subjective norms are not seen as social in nature and are seen more as being individual cognitions. These critiques are difficult for TRA and TPB to respond to, other than to point to the success of the models, as these criticisms arise from outside the theoretical framework of the model. The difference is in many respects philosophical, as is addressed in the previous chapter. An extension to this criticism is the assumption of linearity in TRA. In reality the variables could be seen as influencing one another on a more open basis, especially with behaviour often influencing beliefs, attitudes and subjective norms. The variables may also be in contradiction with one another, an option excluded in TRA (Kippax and Crawford, 1993). All these criticisms are designed to get beyond the description in order to look at deeper meaning systems of the variables that emerge, and to examine these variables collectively.

The assumption that people use the information available to them in a reasonable manner to arrive at their decisions (Ajzen and Fishbein, 1980) is also questioned. The use of algebraic formulation in Fishbein's expectancy theory is criticised by Stroebe and Jonas (1988 in Foster and Nel, 1991). They argue that people are not cognitively able to perform the tasks required, such as converting different dimensions to a common scale. Eiser and van der Pligt (1988) refer to these issues, as well as the use of heuristics as being influential in decision-making, particularly when the number of factors required to be considered are large or the person is pressurised. The use of heuristics undermines the basis of TRA and TPB in that the belief system is totally or partially ignored and another process incorporated. However, Ajzen and Fishbein (1980) emphasised that their theory does not assume that people are buried in thought, in the sense that they scrutinise the determinants of their behaviour prior to each and every behavioural act. Rather, their view was merely that people have at some time formed their attitudes toward behaviours by thinking about the consequences of their behaviour. Once such an attitude is formed, people need not review these consequences prior to each and every behavioural opportunity. They may instead retrieve the attitude, or perhaps only the intention, as a prelude to behaviour. Van der Pligt and de Vries (1998) argued that due to a person's incapacity to process a considerable amount of information at once, a measure to determine the two or three most important beliefs should be incorporated into the model. In a study of students' smoking behaviours they found that the three major beliefs were better predictors of intention than a larger set of fifteen, which included those three. In TRA and TPB the beliefs can be noted after the analysis, but van der Pligt and de Vries advocate inclusion into analysis.

A few theorists in the expectancy-value tradition explored the idea that some behaviours may not be volitional at all because they are products of well-learned predispositions to respond that may be called habits. In contemporary terminology, the cognitive processing that controls such responding can be termed automatic, and is thus quickly and easily performed, often in tandem with other activities. These highly routinised behaviours can occur without a conscious decision to act (Eagly and Chaiken, 1998). But habits can also be predicted using reasoned action theory. It is simply another class of intentional behaviours. In this case, the intention is defined in memory. Habits are also another class of behaviour, predicted by virtue of their being habits.

Low or very weak associations are still found between attitudes and behaviour, and a further weak association between knowledge and attitudes (Leviton, 1989). For TRA and TPB, this criticism is generally invalid as it applies mainly to research, where attitudes and the other variables have been poorly defined; this is a problem that the theory of Reasoned Action tries

to correct. There is also a difference between beliefs and knowledge. One of the problems with many of the critiques of this model is that they fail to take into account all the assumptions and the real implications for predictions. In addition, many studies claiming to use TRA and TPB do not apply the method adequately, so predictions are low. However there are occasions where the correlations in TRA and TPB are low, and these have to be examined. Additionally, while TRA and TPB do provide consistently good predictors, these can be improved upon. Some of the problems for sexual contexts is that safer sex is a collective rather than individual process (Kippax and Crawford, 1993). Kippax and Crawford (1993) see TRA as assuming a rationality in the choice of behaviour which is difficult in sexual behaviour as it relies so much on spontaneity and irrationality. This was addressed using the concept of on-line and off-line beliefs.

One criticism of the model is its difficulty with ambivalence, especially for attitudes that change with context. This is particularly relevant to HIV, where a person may have different attitudes, in terms of use of condoms or reporting STDs, towards long-term sexual partners than they have towards a person they plan to have sex with only once. This variation according to context is in fact implicit in the model and Fishbein and Ajzen state as much in their principle of compatibility. The problem is that it makes the theory much more difficult to apply in a practical situation. Theorists may get greater access to an understanding of this ambivalence by examining the beliefs in more depth and by applying unipolar positive and negative scales, rather than the bipolar scales most commonly used (Eagly and Chaiken, 1998). By accessing these aspects of beliefs, which requires additional fieldwork and analysis than what is normally required for the model, activists working on HIV, for example may be able to predict behaviours with greater accuracy and use this information for interventions. An important aspect of the ambivalence is that a negative pressure or tendency to avoidance may ultimately exert stronger effects on behaviour than equally strongly-scoring positive aspects (Eagly and Chaiken, 1998). Attitudes are seen structurally as comprising both valence and extremity. The extremity of this evaluative state is correlated with various structural characteristics that lend attitudes their strength (e.g. ambivalence of associated beliefs and affects) (Eagly and Chaiken, 1998). The bipolar scale may not pick up the extremity as well as the unipolar scales are able to. In fact it could be argued that attitude cannot be measured on a single bipolar dimension as it has a more complex structure (Eagly and Chaiken, 1998).

“Attitude and its associated cognitions could easily be inconsistent even though the attitude is genuine, because the attitude is based primarily on affective or behavioural input whose evaluative implications are different from those carried by the beliefs held about the attitude object.” (Eagly and Chaiken, 1998, p278). This quote draws on the understanding of attitudes

as being either cognitive, affective or behavioural. It throws up a major structural problem for TRA as it draws into question the expectancy-value model. However this implies a larger problem for social psychology to tackle, namely that in some situations there is no direct relationship between cognition, emotion and behaviour. This issue has been approached in a different manner in some of the earlier critiques.

Evidence that attitudes can be activated spontaneously and automatically led Fazio (1986, in Eagly and Chaiken, 1998) to propose an automatic-processing model of the relationship between attitudes and behaviours, a model that departs profoundly from expectancy-value models of the attitude-behaviour relation. This model indicates an attitude that is automatically accessed without active attention or conscious thought, which “biases perceptions of the object in the immediate situation, and behaviour simply follows from these perceptions without any necessary conscious reasoning process” (Fazio, 1986, in Eagly and Chaiken, 1998, p237). Although this approach thus assumes that attitudinal selectivity is relevant to mediating the relation between attitudes and behaviour, it does not take into account the more proximal determinants of action emphasised in expectancy-value models. The person’s attitude toward the behavioural act and their target would need to evoke a positive attitude toward the final action that is elicited, although this attitude-attitude link would be automatic, and neither attitude would necessarily be admitted to conscious awareness. This view is thus consistent with Fazio’s (1990, in Eagly and Chaiken, 1998) claim that attitudes toward targets can impact on behaviours without necessarily evoking a conscious reasoning process.

TRA and TPB do not take some of the recent implications concerning structure and functions of attitudes into account. They may miss some of the information that could be gained by looking at intra- and inter-attitudinal structure (Eagly and Chaiken, 1998). While not directly addressing this point, Morrison, Simpson, Gillmore et al, (1996) offer a method of making the variables of A and SN multidimensional by applying factor analysis to the beliefs. This offers a range of dimensions in which to look at the A or SN.

Recently, researchers have raised questions about whether the evidence produced in favour of the expectancy-value model clearly indicates that beliefs causally determine attitudes. This is because the beliefs elicited by such techniques can serve merely as indicators of an attitude, in the sense that they are determined by it although they are constructed on the spot (Eagly and Chaiken, 1998). More convincing evidence that beliefs may determine attitudes follows from open-ended elicitation of respondents’ idiosyncratic reports, concerning those beliefs that are salient for them personally. Because this free-response method encourages respondents to list

only the beliefs that they actually hold, it lessens the problems connected with attitude-to-belief inferences. The reason for this is that the latter are invited by rating-scale methods that force respondents to rate an attitude object on attributes that they may never have considered ascribing to it. In studies using these free-response methods, which are less contaminated by attitude-to-belief inferences, correlations between expectancy-value products and attitudes are ordinarily positive, although not necessarily high (Eagly and Chaiken, 1998).

A number of criticisms have been raised about the concept of attitude that is used within TRA. It is felt that it is too tied into affect and does not pick up on the evaluative side of attitude, which is separate from affect. Kashima and Gallois (1993) also separated this evaluation role from the cognitive role of beliefs. The evidence for this impacting on TRA is still very slim and to separate out evaluation from the dual affect and cognitive role is conceptually difficult. The current definition of attitude sees cognition, affect and behaviour as working together to create the evaluation effect. A further criticism concerning the selection of attitudes for the questionnaire is that community-wide or modal salient beliefs are selected, despite the fact that a person may have their own personal beliefs. Some research has shown that these personal salient beliefs are more powerful and have more of an impact than the modal salient beliefs. The current methodology does have to take those most commonly selected by the group, which is likely to exclude some of each individuals' personal salient beliefs (Kashima and Gallois, 1993).

Subjective norms were also criticised for being too narrow in their conceptualisation. Kashima and Gallois (1993) suggest the additions of personal norms, which the person has established for themselves, and behavioural norms, which is the behaviour that the person perceives in others. The research evidence for these factors remains generally weak and suffers from definition problems. The distinction that is sought is very subtle and may not be worth compromising the parsimony of the model.

A more general criticism is that the expectancy value formulations have achieved good levels of prediction, but have failed to explain adequately the psychological processes underlying attitudes and behavioural choice (Manstead and van der Pligt, 1998; Sutton, 1998). This created difficulty in all the work done and the choice between prediction and explanation places different demands on the research approaches used; it also has implications for the future development of the model. Both TRA and TPB are designed as causal models due to the path diagrams used, but in many respects falls between the two. A model that offers a full explanation would have additional applications in the field (Sutton, 1998). Fishbein (1993) responds to these comments with the statement that "the mathematical model of the

relationship between beliefs and attitudes was never intended to be viewed as a model of process, but only as a computational model to capture the output of a process that occurred automatically as a function of learning" (Fishbein, 1993, p xviii).

Further meta-theoretical criticisms have been raised against TRA in that it is too narrow, as it focuses only on volitional behaviours, looking at specific behaviours rather than general ones (Kashima and Gallois, 1993). The criticisms however seem to miss the point, as it is these very ideas that were the crucial theoretical advances offered by TRA. Predicting general behaviours was prone to unrewarding results and volitional behaviour is the major area of interest to social psychology. TPB attempts to respond to the latter enquiry by including PBC.

Where TRA and TPB do become very restrictive is in relation to the population that is assessed. The more narrowly defined the community, the more likely it is that TRA will operate. This is an extension of the principle of compatibility (Gallois, McCamish and Terry, 1993). To keep criteria focused and consistent, especially in relation to context, often means defining the population of interest more narrowly.

Conclusion

This chapter outlines the basic structure and functioning of the Theories of Reasoned Action and Planned Behaviour within the context of attitude research. Criteria for the selection of TRA and TPB have been given. The selection is a key process for this thesis as it sets up the methodology and basis for the remainder of the study. Strong evidence showing the successes of the theories both generally and in the case of HIV have been put forward. While a number of criticisms have been made of the models, and there clearly are contexts where they cannot be easily or usefully applied, their robustness, as well as the weight of evidence of their useful application in a multitude of contexts, does support their selection as the theory of choice here. Where necessary, the criticisms will be commented on again in the light of the research. Due to limitations of time and space, not all the criticisms can be addressed. This concludes the formal theoretical background of the thesis and lays the basis for the next two chapters, the first of which outlines the aims and objectives, and describes the immediate context of the study. The methodology chapter will follow this, where the methods of TRA and TPB are addressed in more depth.

Chapter 5

Aims, Objectives and Context of the Research

Drawing on the key issues of the South African context and theory which were raised in preceding chapters, the specific aim and objectives of the thesis are now presented and the particular context of the research provided. In Chapter One, several themes were outlined, centring on the application of psychology in practice. These themes were: the functioning of psychological theory in the context of AIDS in South Africa, the potential contribution of theory-based research to local AIDS interventions, and the application of a fixed methodology. An explanation of the context of HIV in South Africa was put forward in Chapter Two. Chapters Three and Four explored the theoretical options, with Chapter Four outlining the Theories of Reasoned Action and Planned Behaviour. This chapter presents the key aims and objectives of the thesis, and provides the motivation for the selection of youth and the particular communities which are a focus of the research. Finally, descriptions of the communities are provided.

Aim

The aim of the thesis is:

To apply critically the Theories of Reasoned Action and Planned Behaviour to AIDS related behaviour within the South African context, in order to ascertain their applicability and contribution.

Specific objectives

A number of specific objectives arise out of the aim, which emphasises the three themes to be tested. Within these objectives, the specifics of the safer sexual behaviours selected as the basis for the study will be used. By virtue of the requirements of the TRA and TPB, behaviours have to be defined clearly and simply. Therefore, the particular behaviours selected were as follows: the practice of monogamy or sticking to one sexual partner, the use of condoms every time the person has sex, and the obtaining of treatment for STDs every time the person becomes thus infected. The principle of compatibility, central to TRA and TPB, does not allow for the interaction of behaviours or for negotiation of safety to be easily or practically applied.

Theory

- To apply the theories of Reasoned Action and Planned Behaviour within the described context in order to ascertain the potential for the prediction of future behaviour.

- To assess the potential for these two theories to be complemented by other theories, in order to improve the understanding of the behaviours in question.

AIDS

- To ascertain key beliefs that influence AIDS-related behaviours.
- To assess what contribution this information can make towards the prevention of the spread of HIV.

Methodology

- To test the applicability of the methodology within the South African context.

There are obviously some problems in the research in that single behaviours are chosen whereas in reality one behaviour is likely to have an impact on others. For example, a couple who are both HIV-negative and are monogamous or have negotiated a level of safety, may decide not to use condoms. The theories are limited in that only single behaviours can be assessed.

Selection of youth as a focus

The thesis focuses on youth from the ages of 15 to 30 years. Youth have been selected as a focus primarily because they constitute a category in society which is particularly vulnerable to infection. This syndrome has been identified internationally (Liskin, Church, Piotrow et al, 1989). The greater risk factor attached to youth arises as they are often still experimenting sexually, and possess a sense of invulnerability. Also, many have also not yet selected their life partners and so are changing sexual partners more often than is usual in other age groups (Abrams, Abraham, Spears, et al, 1990). Aggleton (1991) however warns against typecasting youth as necessarily self-destructive. From Aggleton's warnings it becomes clearer that a deeper understanding of youth and how they make decisions is required, rather than connecting thinking purely to decontextualised theory, or worse, to ideas created by myth and media images. Taking an alternative perspective, youth are also more open to changing their ideas, as this life stage is one of change. During this period, ideas held previously are often called into question, which means there is the potential for infusing new understandings (Erikson, 1950, 1975; Kenniston, 1965; 1971; Menninger, 1975). Erikson (1968) defines youth as the crucial period during which identity is being questioned. This stage involves the development of an own identity separate from the forces that shaped the earlier life, such as influences of parents and institutions. It is characterised by the conflict between conformity and rebellion. With the development of sexual needs being foremost physiologically, sexuality is crucial in the exploration of identity. As the youth leave behind the influence of their parents, or find that it is reduced, they are in a position to challenge many of the parents'

ideas far more fundamentally than before. It is this process of challenge that has been extended without the youth having to take on the full responsibilities of adulthood. This period can be seen as an extension of adolescent rebellion and identity formation, and since the phase includes sexual experimentation, the chances of unsafe sexual practices are high.

Kenniston (1968, 1971) identifies youth as an additional life stage, generated by the modern era, in which post-adolescent young men and women begin to look at themselves in relation to broader society. The key processes include: maintaining the sense of an intact self in relation to a society that threatens to absorb all; a need to move forward and attain; and a space in which to be critical and challenge the inherent wrongs of modern society. From Kenniston's definition it is clear that not all young people will attain the stage of youth, but within SA there are conditions that encourage people in this age group to enter this critical phase. Both Erikson and Kenniston show the potential that exists for working with youth and for having an influence on their behaviour. Finally, youth as a category are likely to contain representatives of others who, by virtue of their behaviours put themselves at risk. This includes all people who take part in commercial sex, those with STD's, and individuals who are especially promiscuous.

The specific age range for the study, 15–30 years, is the next issue of contention. The lower age limit was set at 15 years, as most people have become involved in sexual activity by then, especially those from the communities featured in this study (Preston White and Zondi, 1989; Bodibe 1994), the finding having been borne out by the results of this investigation. Some youth do start sex at an earlier age, but this was not found to be consistent. The upper limit was deliberately set high, as research results are finding that over time, the period of youth is increasing, mostly due to extended periods of education and delays on the part of young people who are settling into a career path (Kenniston, 1968; 1971). Kenniston (1968, 1971) argues that, as our societies have developed, the phase of youth has become more important and more extended. In SA, factors such as tertiary education and the high average age levels of students at school, especially in communities such as Kayamandi and Mbekweni where the study was conducted, means that many youth remain in educational institutions longer than in previous generations. The deprived status of the schooling system and poverty in general have meant that there are many students in their twenties who are still attempting to finish school. In addition, the high levels of unemployment mean that many youth do not begin their career paths until a later stage in life. Also, there is a major shortage of housing which means that the younger generation in each family experience delays in being able to leave the house, even after they have begun earning their own money. All this in turn delays the formal taking on of the responsibilities of career and family which indicates the closure of the youth stage

(Kenniston, 1971). In this way, the process of sexual experimentation is extended and the formal taking on of the adult role delayed, as is the settling down of the person in a family situation. The final argument for the upper limit is that many youth organisations, especially political structures, use the age of 30 or even 40 as a cut-off point for membership, e.g. the ANC Youth League has an upper cut-off level of 35 years. Many other youth groups in churches etc., will have members up to the age of 30.

Selection of the communities of Mbekweni and Kayamandi

Mbekweni and Kayamandi, both black African communities, were selected as the communities in which to site the study. The selection was based on the epidemiological data which show that the HIV epidemic is spreading most rapidly in black African communities (Padayachee and Schall, 1990). The reasons for this are widely speculated, but appear to centre around three major themes, namely the higher incidence of STDs (Ballard, 1993a), high levels of poverty which lead to depressed immune functioning (Head, 1992b), and higher numbers of different partners taken by each person (Kustner, 1990). The question of numbers of different sexual partners has become a heated political debate (Head, 1992b), but the key issue here is the higher rate of incidence of HIV in African communities and it was on that basis that these communities were selected.

Two communities were selected, as there was to be a separate intervention study to follow the thesis research. For an intervention study to be done effectively, an experimental and a control community were required. The follow-up was cancelled due to a shortfall in funding. The selection of the communities of Kayamandi and Mbekweni was based on a range of functional criteria, which are listed below. The communities had to

1. be within an hour's drive of Cape Town
2. have no or minimal existing and ongoing AIDS education programmes
3. have relatively low in and out migration
4. have some internal civil structures via which access to the communities could be facilitated and a later intervention organised
5. have clear geographical boundaries
6. have been in existence for at least 30 years, so that a community culture would have had time to develop
7. contain within it people living in houses, hostels and shacks

It is unlikely however that any community would have been able to fulfil all these requirements totally. At the time of the fieldwork there was considerable urbanisation taking place with people moving into Cape Town and the surrounding towns from homeland areas of

the Transkei and Ciskei (Platsky and Walker, 1985). In addition, the levels of violence in the townships within Cape Town meant that there were generally high levels of movement of people between areas (Cole, 1987). There were elements of AIDS education happening in virtually all communities, but this was generally happening in a loose and uncoordinated fashion. Most of the local government structures in communities were in disarray. The progressive community organisations had, in many cases, been damaged by the repression of apartheid, while the state structures had been severely discredited by virtue of their co-operation with the apartheid government. A range of communities within the defined radius of Cape Town was examined. Communities within Cape Town were not considered for the following reasons: levels of in and out migration were too high; there were too many as well as inconsistent AIDS education interventions; boundaries were difficult to define; and often there were only one or two housing types. After careful consideration, the communities of Kayamandi and Mbekweni were selected as most closely fulfilling the functional criteria. A brief description of each community is provided in the next section.

Description of the two communities

The information on Kayamandi and Mbekweni is drawn from publications about the area, research observations, conversations with informal sources and qualitative interviews. The methodology for the latter is described in the next chapter. Certain basic information key to the study was collected in both communities and then additional available information was obtained. The literature about the two communities varies in nature and quantity. Both communities are found in the Boland, an area dominated by wine and citrus farming. The towns predominantly serve the surrounding farms, although light industry and tourism are growing economic functions. There are large differences in income levels, particularly across race groups, with the white communities and the farmers being generally more affluent. There has however been considerable growth in the African communities, especially over the period between 1989 and 1991, with a large number of people moving into the area as the apartheid-based influx control law was dropped and the political situation changed (Donaldson, 1990). Normally unemployment is very high; estimates put it at between 20 and 50% in both communities. During the picking season, there is an additional influx into both communities of people wishing to take advantage of the additional seasonal employment opportunities offered by the fruit farming industry. The major problem in both communities is the shortage of housing, resulting in excessive overcrowding, and the development of large squatter settlements (Groenewald, 1992). Both are under-supplied in terms of recreational and community facilities, and basic services such as sewerage, water and garbage removal are very restricted in squatter areas. For both communities the political history is given good

coverage in the summary below, as this is key to defining their identity and the way in which the community functions. This information is dated from 1991, when the research took place.

A factor common to both communities is the history of apartheid and the influences that this would have had on the communities. Firstly, at the material level, these communities are a lot worse off as a result of apartheid. This deprivation has occurred at the levels of housing, income, access to resources, educational opportunities, access to employment, attainable lifestyle, access to leadership positions, and the right to practice their own culture, amongst others. In these communities, as with many others around the country, there has been a history of resistance to the state enforcing apartheid, that brought with it hopes and aspirations as well as state attempts at repression and control. Both political resistance and state repression were key factors in the lifestyle and life experience of people in Kayamandi and Mbekweni. One important area of attempted control was that of black sexuality. Birth control was an important part of the state propaganda and there were many attempts to force it onto the black population. Sexual matters have therefore also been an issue fought for in the area of personal freedom and there has always been suspicion about any kind of interference in this regard. These various factors will also have to be considered in the development of the arguments as the thesis progresses.

Kayamandi

Kayamandi, about 50 km from Cape Town, is situated on the northern outskirts of Stellenbosch, next to one of the major arterial roads leading into the town. Estimates as to the population size vary, with the 1991 census putting the population at 6 711. A macro-plan of Stellenbosch, done by the Provisional Administration of the Western Cape and the Kayamandi Town Council (PAWC and KTC, 1989), gave the population as being 6 524. At the time of this study, the local population and many of the service organisations thought the population count was a lot higher, around 8 000-15 000. The ratio of men to women was 47.5% to 52.5% (PAWC and KTC, 1989). Kayamandi can be divided into three areas according to residential units: houses, hostels and squatter dwellings. The Macro Plan (PAWC and KTC, 1989) reported that there were 148 houses inhabited by 1 152 people, 2 370 hostel beds (between two and six beds per room) for 4786 people and 84 squatter dwellings for 587 people. Since 1991, a rapid increase in population has occurred, primarily in the squatter area. There were estimated to be between 3 000-6 000 squatters at the time of the research. Backyard shacks were also found behind almost every house. There was a high school and a junior school, although the recently established high school was under threat, as the building belonged to the University of Stellenbosch and they wanted to claim it back in 1992. A municipal clinic that provided limited services existed in the middle of the housing

area, but most residents preferred to go into the town to obtain health services (Donaldson, 1990). There was no formal civic hall and the junior school was used for most of the community or organisation functions. The council offices and police station were right at the entrance to the community area.

Community organisations

The civic structure established in the late 1980s was strong and well supported in the community. It was run democratically, based on annual elections. Most of its support was derived from the more affluent residents in the houses as well as the shack dwellers, with the leadership being drawn from the residents of the permanent houses. The hostel dwellers were never really part of the civic structure, but they did not actively oppose it. The civic still acts as the representative for the community in most negotiations. It is very closely aligned with the local ANC branch and much of the leadership is common to both structures. The Kayamandi town council had always been weak and was under severe pressure from the resistance and protest of the community. Attempts were made to set up a community broad management committee which covered all the major organisations, but this never received much support due to the inclusion of the council. Branches of the ANC and ANC Youth League had been established legally soon after their unbanning. They had existed for a considerable time prior to their unbanning under the names of other progressive organisations or as underground cells. Both ANC structures are well respected and have the support of most of the community, but do not draw much activist support. The Pan Africanist Congress (PAC) was present in the community, but relatively weak. A Parent Teachers Student Association (PTSA) had been set up at the senior school. This received good support from the community and student body as well as from half the teachers, and provided a wider base for the management of the school.

History

Kayamandi, which means “pleasant home” (Seeing is believing, 1991) had its first houses erected in 1945\6. At the same time, a number of private companies erected hostels. In the early period of its existence, Kayamandi was seen as peaceful. The permanent residents guarded their space and anybody who attempted to move in was made to feel very unwelcome. The growth of the community was therefore slow (Hamman, 1997). There was very little space for the community to develop, as it was bordered on three sides by a major road, the rest of the town of Stellenbosch and valuable farmland respectively. The Stellenbosch town council was also very quick to act against anybody who began squatting in Kayamandi. At that point, the levels of employment were reasonably high. The growth of the informal settlements began only in the late 1980s, with the first squatters being predominantly

an overflow from the residents of the houses or the wives of the hostel dwellers. The original squatters set up their dwellings on the rugby field in the community and then, in the early 1990s, began to fill all other vacant areas, putting pressure on the community boundaries.

The major political organisational activity in the community, centred in the early phases, on the unions, which were operating in the major local manufacturing industries, the fruit and wine industry and the university. The shop stewards and the youth were the most militant members of the community. The Stellenbosch advice office was established in 1984 and together with the unions gave a strong boost to the politicisation of Kayamandi. The Stellenbosch Youth Congress was set up in 1988 and continued later to become the ANC Youth League. The Kayamandi town council was established in 1986 but was under threat and faced community protest until it dissolved in 1994, although the level of protest only grew from 1989. The council made itself unpopular in that year when it commissioned a raid on the hostels and had 300 women, who were staying in the male-only hostels illegally, arrested. Their motivation for this action was that the hostel dwellers had not been paying their bed rates of R9.60 per month. In the early 1990s the council came under increasing pressure and found itself largely discredited as being a functionary of apartheid. Kayamandi was a particularly significant site of resistance to apartheid, as Stellenbosch was one of the centres of Afrikanerdom, with the University of Stellenbosch producing many of the leaders of the apartheid government.

Conflict existed between the residents of the hostels and the houses for a considerable period. This was due partly to the different social positions within the community. Those in the houses were generally better off and wanted to ensure that their secure position remained intact, while the hostel dwellers were in Kayamandi to earn money to send back to their families. The establishment of hostels saw the development of shebeens and increased levels of prostitution. The hostel dwellers were also more conservative in terms of traditional African tribal values. In 1990 this friction broke out into more open conflict over an incident in which youth from the houses got drunk and showed disrespect for the elders in the hostels. The hostel residents beat the youth and the resultant conflict led to the community being closed off for a day. The dispute was settled rapidly, but tension remained between residents of the houses and hostels. They rarely mixed at the time of the research.

Mbekweni

Mbekweni, about 70 km from Cape Town, is situated about 5 km outside the borders of Paarl and is surrounded by open land. The 1991 census put the population figure at 15 572, but it is likely that this is considerably higher, given that in 1970 the Administration Board estimated

the population to be 14 700 (Needham, 1992). The latter figure was also considered to be conservative. The current estimates from residents and service organisations put the population at between 30 000 and 50 000. Although there is no specific information on this, it is likely that the gender profile would be very similar to that of Kayamandi. Again, the community can be divided up into areas encompassing shacks, hostels and houses. The ratio of people according to accommodation units is also likely to be similar to that in Kayamandi. A significant feature of the housing in Mbekweni is that behind virtually all the permanent houses there are backyard shacks. These shacks often accommodate more people than those living in the houses. There are two junior schools and one high school in the community. The medical services consist of a single municipal clinic and a doctor in private practice. Health services are clearly underprovided (SALDRU, 1984). There is access to the community by road via a single entrance, and on the opposite side of the community there is a railway station. In the centre of the community there is a small collection of shops, a bus terminus, the clinic and the community hall, which is used for large meetings. Near the railway station is a soccer stadium, the police station and the offices for the housing committee and civic.

Community organisations

The civic was clearly the dominant force in the community. Its leadership is elected in an annual ballot. Its usual role is to act as a watchdog for the community and to negotiate with other authorities for facilities. The civic functioned very much as the representative of the people and went to considerable lengths to make itself accountable. At the time of the research, the civic, as part of the housing committee with other community representatives, was assisting in the allocation of land for a new housing development. During this period, the civic chair was being paid for by one of the developers. The council had always been weak and was no longer operational at the time of the research being done. The ANC and the ANC Youth League were strong and had massive support in the community, although they did not have a large consistent activist base. The leadership of these organisations was separate from, although supportive of, the civic leadership, and was well respected in the community. There were generally high levels of support for political campaigns initiated by the ANC. In contrast, the PAC and Azanian People's Organisation (AZAPO) were weak. The reasons for this will be shown in the brief history presented below. The ANC-aligned Congress of South African Students (COSAS) was strong in Desmond Tutu High School. The Azanian Students Organisation (AZASO) also had a small presence there. There were two organisations of traditional healers in the community, set up at different times, and they were trying to join into a single body at the time of the research. A number of small service organisations and unions also worked in or near the community in order to assist the residents or provide avenues for representation in issues of conflict.

History

Mbekweni, which means “Place of Respect”, came into being in 1959, when barracks and hostels were built for single men and 30 small houses for families. Later developments included 300 more houses in 1964, 150 in 1969 and 140 in 1976. In 1970, the community increased considerably in size when the African residents of Wellington were also moved to Mbekweni. At the same time, there was a constant influx of people from the surrounding farms and from the homelands in search of work and access to services. Because of this influx there was a huge shortage of housing, which resulted in considerable numbers of people living in backyard shacks behind the houses (Needham, 1992). A number of squatter settlements developed comprising up to 3 000 people. While the research was being done, a new, very large area was being developed to provide more housing. As a result, even more people were moving into the area. The existing population was getting very suspicious of the new arrivals and divisions were occurring within the community.

Formal political organisation started in Mbekweni in 1962, with the launch of a branch of the PAC and of POQO, the military wing of the PAC. In November 1962, 150 men armed with pangas marched on Paarl and four White residents were killed. A clamp-down on political activity followed and unions were barred in 1965 (Needham, 1992). The state established community councils in 1979 to assist it in controlling of the townships in 1979. The civic, then called the Mbekweni Residents Association, was established in 1981. It was made up largely of PAC members, generally older black males, who controlled it until 1985. They occupied themselves mainly with passive resistance to the state, which consisted largely of taking the community councillors to court to contest their positions (Needham, 1993a). The United Democratic Front (UDF) entered the area in 1982 through the presence of the United Women’s Organisation (UWO) (Needham, 1993b). This strengthened opposition to the community councils.

A number of campaigns followed, including a rent boycott in 1983, student boycotts in 1984 and a consumer boycott in 1985. The rent boycott was still going on at the time of the research being done in 1992. Over time, conflict developed between the UDF and the PAC, which by 1985 was very much smaller than the UDF. In 1986 the UDF intervened and took over the civic (Needham, 1992). Protest became increasingly violent over time. (Needham, 1993a). These organisations and programmes established the solid base of political resistance to apartheid that characterised Mbekweni. On 27 October 1985, a State of Emergency was declared and police killed, arrested or detained most of the UDF leadership. Resistance to apartheid continued however and community councillors’ houses were petrol bombed from 1986. This resistance was increased by attempts to render the community ungovernable and

by the setting up of cells of activists within it to continue the armed resistance. By 1990, most of the community councillors had been killed or chased out of the community (Needham, 1993a). At the time of the research, supported by the community, the civic had taken over the role of the council, in terms of negotiating with the white authorities in Paarl and other elements of the state.

Conclusion

The overall aim of the thesis was established in this chapter as well as a discussion of and motivation for the context. The aim and objectives serve to spell out the way forward for the methodology, results and analysis. This thesis will explore the application of the Theories of Reasoned Action and Planned Behaviour among youth between 15 and 30 years of age in the context of two small African communities in the Western Cape. It will also assess what contribution the theories can make and assess the applicability of the methodology. A motivation for the selection of the youth in the targeted age group and for the selection of the two communities was provided. Finally, the two communities where the research took place were described, with emphasis being given to the social forces operating in them.

Chapter 6

Methodology

To satisfy the aim and objectives stated in Chapter Five, the following research design was prepared. As a first phase, negotiations for access to the communities and permission to do the research took place. These negotiations happened via the organisations that represent the people living there. This process will be described first. Then the qualitative research methods will be outlined. This will be followed by a description of the methodology for the survey that performed followed the approach of the Theories of Reasoned Action and Planned Behaviour Models very closely.

Timing of the research

The fieldwork was done in 1991. Negotiation to obtain access began in January and the fieldwork happened between the months of May and October. The first session of fieldwork, lasting roughly from May until August, covered the qualitative research. Overlapping with the latter part of this research, and starting from the second half of July, work began on the first phase of the survey research, namely the collection of primary beliefs. August and September were occupied with the completion of the design of the questionnaire, the setting up of the sampling strategy for the survey, the selection and training of the fieldworkers, and the piloting of the questionnaire and the sampling strategy. Thus, the qualitative data was used to guide the development of the survey, which was conducted over a three week period in October. It does present problems for the writing of this thesis that a long time period has elapsed between the original fieldwork being done and the final write up and presentation of the thesis.

Negotiation of Access

Negotiation of access is the first phase of fieldwork for any community study. A general introduction is provided, then the mechanics of the negotiations are presented. Details of the negotiation process were different for the two communities so will be dealt with separately.

Motivation for the process of negotiating access

To be able to do any research, especially on the scale that this project required, and given that it covers such a sensitive topic, the permission of the community is essential. Seeking formal access is a matter of respect for the community and their leadership. In addition, much can be learned during this process and this feeds into the research conducted later on. The negotiation process further facilitates the research process in that resources are made more easily available, and some potential hidden problems can be noted. Finally, it would be

unethical to do research that influences communities without first seeking formal permission. By observing the process, the researcher and the research work itself gained the respect of the community, a factor important in all research involving people, but especially in community-based research (Derricourt, 1988; Maso, 1991; Lee, 1993).

Structures through which negotiations had to be made

Initial contacts were made via colleagues who were working in service organisations in the two communities. These were the Resource Centre in Stellenbosch and the Food and Allied Workers Union (FAWU) Medical Fund clinic in Paarl. In both cases, contacts were able to extend the introductions to other key gate-keepers in the communities and allowed their names to be used in order to establish the researcher's credibility when meeting people.

In order to gain formal permission to do the research, it was necessary to work through the civic structures. The civics, especially in politically mobilised areas such as Mbekweni and Kayamandi, act as an umbrella authority and gatekeeper and were in turn answerable, via a democratic process, to the broader community. These civics also acted as an overall governing and protection body for the communities. They were not part of the formal structures of government and, at the time of the fieldwork being done, actually sat in opposition to the legal or state authorities in the communities, namely the councils and the mayors. The apartheid regime was in power at that time, so all state structures were still seen as an extension of that oppressive government. While the civic was the major group through which access needed to be negotiated, it was necessary to consult more broadly in order to deepen the entrance and the acceptance of the research. The additional groups included political organisations such as the ANC, youth organisations such as the ANC Youth League, the schools, the churches, the council in Kayamandi and service organisations such as the Advice Offices. These were the more important contacts. Other contacts were established where necessary to obtain access to people or to do interviews.

Kayamandi

Negotiation of formal access to Kayamandi

The first entry into Kayamandi was via a colleague in the Stellenbosch Resource Centre, a local service organisation. She provided a list of key people plus telephone numbers. The Progressive Primary Health Care Network (PPHCN)¹ also had employed a worker in the community who was able to assist in contacting the leadership. After initial consultation, it

¹ A network of progressive NGOs that provided primary health care services to deprived communities and did advocacy work around primary health care. One project that they were involved in was running a community-based AIDS education campaign.

became clear that the key organisations that needed to be consulted with were the civic, the ANC and ANC Youth League. Contact was also made with the local council and mayor, although this, as previously indicated, was a largely discredited authority structure.

It was extremely difficult to contact the chair of the civic, as he did not have a telephone at home and lived in a backyard shack. Contact was made by visiting him at his home early one evening. The civic in Kayamandi did not consider themselves to be a single gatekeeper as in some other communities, so it was necessary to speak to other authorities such as the ANC. There was a lot of overlapping membership with executives of the ANC often being found in the civic as well. The meeting with the chair went well, but although he felt that there would be no opposition from the rest of the civic association, he thought it needed to be taken to a meeting of the civic executive. The vice-chair of the civic, who also chaired the local ANC branch, was then contacted. The meeting with the civic was delayed because they were planning an AGM, and the chair wanted the new executive to be elected before the issue of the research was addressed. The impending AGM caused a delay in the granting of permission for about eight weeks, as the AGM itself kept being delayed due to a series of local problems. Eventually, a meeting was set up with the chair and vice-chair, and the decision to provide access was taken. For presentation at this meeting they requested a letter outlining the research project and what was expected from the civic and the community. As the two executives held similar positions in the ANC, permission was also given by the latter to do the research.

Access was negotiated separately with the ANC Youth League and a meeting was held with the League's chair. There was some difficulty in contacting him, as he was a health worker at a local reformatory. On phoning him, he requested a meeting in person. He felt his organisation was still under threat from the apartheid government's agents, and did not trust telephonic contact. The process of granting permission involved my giving him my credentials and political organisational base, explaining the project, giving key information on AIDS, answering his questions about AIDS, and listening to his fears about people infiltrating the organisation and acting against it. He gave the support of the Youth League, as long as the support of the civic was obtained. He stated that he trusted the leadership of the civic to make the correct decisions.

Consultation with other organisations and the deepening of access to Kayamandi

Overlapping with the time that formal access was being negotiated, there was a process of deepening informal access into different areas of the communities. These major contacts included selected academics from the University of Stellenbosch, the local Advice Office, the

Health Authorities in Stellenbosch, the local clinic in Kayamandi, the nutrition programme of the Medical Research Council (MRC) who were also doing research in Kayamandi, Koinonia², Stellenbosch Resource Centre, PPHCN Aids Working Group, a number of legal firms who regularly acted on behalf of the residents of Kayamandi, a social worker from the Child Welfare Organisation, an umbrella organisation called the Development Forum, and Kayamandi Junior and High Schools.

Mbekweni

Negotiation of formal access to Mbekweni

The original access into Mbekweni was via two doctors working in the Ray Alexander clinic, which was part of the operations of the FAWU (Food and Allied Workers Union) Medical Fund. Although the clinic is not in Mbekweni itself, it is close by in Paarl, and services workers from Mbekweni (Usdin, 1991). These two doctors provided introductions to two other administrative workers at the union offices. These workers lived in Mbekweni and were in the representative organisations there.

A meeting was set up with the chair of the civic, who felt he had to consult with his civic committee before he could talk to me in any great depth. The civic appeared to have the support of a broad range of groups, as being the official representative of the community, including the ANC, PAC, unions, religious structures, school, youth and sports organisations. The Council no longer existed in a formal sense, because so many of its members had been killed or had resigned that they could no longer constitute a quorum. There was a broad forum convened by the civic, to which all the organisations sent representatives and, which met occasionally to decide on crucial issues and to plan community meetings and events.

When, after some delay the civic committee met, they were generally in favour of the research going ahead, but felt that they now needed to develop a strategy to deal with requests to do research. They asked for a letter of explanation of the research, which was to form the basis of a contract between the researcher and the community, and to give them something to refer back to at a later stage. A meeting with the civic executive followed where the case for the research was put forward. The process of the meeting involved a description of the research and what was needed from the civic. A number of questions were raised and in the end the executive was happy, but stated that the researcher would have to address a mass meeting of the people of Mbekweni to get final permission to do the work. There were a number of delays, including political funerals, other pressing community issues such as

² A small church-based resource organisation that provided skills training and did missionary work.

housing, and a number of political campaigns aimed at undermining the apartheid government. After six weeks, the project was put for consideration to an umbrella structure in the community that represented all sectors of it, via their organisations. They supported the research and requested that the civic set up a community meeting to discuss this in addition to other issues. A meeting was finally held. The research was explained, and a few questions followed. The atmosphere was very friendly and the following day access was confirmed. Prior to that, a separate input on AIDS had been given at an ANC mass meeting. The extent of the support of the other organisations for the civic was shown by the ready agreement of the ANC and the ANC Youth League to support the research following the civic's agreement.

Consultation with other organisations and increasing access to Mbekweni

As in Kayamandi, there was a parallel process in the negotiation of access, in which a range of community organisations were approached for assistance and to contact their members. These organisations were the local FAWU office and clinic, Desmond Tutu High School in Mbekweni, Congress of South African Students (COSAS), Pan Africanist Students Organisation (PASO), Ministers Fraternal, local Advice office, ANC Youth League and two organisations of traditional healers.

What was achieved from this process?

The importance of this extended and detailed process of negotiation was shown in the results achieved from it. In the case of Kayamandi, an office in the local crèche was allocated free of charge and in Mbekweni the use of the school library was provided. In addition, access to further organisations was eased and individuals were rendered more approachable for interviews, given that the project had the support of the civic. One of the agreements made with the civic organisations was that they be kept informed of progress and of the stages of the research. One activity that assisted in the rapid increase of access to the community was the distribution of a pamphlet explaining the nature of the research and giving the permission of the civic to do the project. About 4000 of these were distributed door-to-door in both communities. In addition to easing the process, this resulted in a considerable amount being learned about both communities.

Research Design

There were two parallel components to the research design. The first used a qualitative approach, while the second used a survey methodology as defined by the Theory of Reasoned Action. Each of these methods is dealt with separately below. Due to the sensitive nature of the information being gathered, care was taken that the information be gathered as accurately as possible, without causing offence to the informants. This sensitivity implied greater care

having to be taken when negotiating interviews, in explaining how the information would be used, in the attitude of the fieldworkers to the respondents and the information being collected, and finally in maintaining the confidentiality of the respondents (Lee, 1993). Both sets of data were directed at the objective of finding useful information about HIV. The theory objectives were more closely tied to the survey research. However, the qualitative data aimed to provide a validity check, a contextual base and a perspective from which to examine how different theories and research methodologies interact.

Qualitative Methods

The aim of the qualitative research was to get a deeper understanding of the community and of their knowledge and belief systems in relation to HIV. This would inform the construction of the questionnaire and the behaviours that were applied. It was also expected to be of assistance in providing an explanation of some of the results obtained in the survey. Essentially it was intended to support the survey research required for the theories of Reasoned Action and Planned Behaviour. Qualitative data was obtained using predominantly depth interviews, with focus groups and observation providing additional information. This work extended over a period of three months and was split between the researcher and a hired qualitative fieldworker. The researcher conducted interviews predominantly with the community leadership figures and with members of the youth who had an adequate command of English.

The role of the fieldworker was to do the Xhosa language interviews with youth and other important informants who could not speak sufficient English. In three interviews an interpreter was used. Two focus groups were also run. The first group, which consisted of school students from Mbekweni, was facilitated by the researcher with the assistance of the fieldworker. It was conducted in English. The second group, which consisted of traditional healers, spiritualists and herbalists, was run by the researcher alone, via a translator. Each group interview lasted for about 90 minutes. The two focus groups were conducted for different and separate reasons. The traditional healers felt more comfortable talking in a group so this was accommodated, while in the case of the school students a group was used in order to obtain a perspective on how the youth themselves interacted around HIV. On reflection, using more focus groups among the youth would have added considerably to the information obtained.

Questions

The research interviews all began with the question, "What do you know and understand about AIDS?". From this it was possible to cover most of the areas around which information

was sought, using the techniques of reflection and questions of clarification (Meulenbergh-Buskins, no date). The interviewees had considerable freedom to talk on whatever they liked within a general framework of AIDS and sexuality. If an area of importance was not covered, then the researcher would ask direct questions about it. In addition to exploring the person's understanding of AIDS, focus was given to the key behaviours of serial monogamy, use of condoms and treatment of STDs. There was flexibility to move onto related areas of behaviour as required. Some examples of the latter included courting behaviour, gender relations of power, relations to PWAs, understandings of and feelings towards local health personnel and traditional systems of illness and healing. As the research progressed, new areas of interest and importance arose. As the interviewees expanded on their ideas the aspects that appeared to be important to them became apparent. The added concepts were part of their explanations for AIDS and for their decisions around sexuality as well as other AIDS related behaviours. Interviews lasted for between 20 and 90 minutes.

Fieldworker

The fieldworker had been professionally trained as she had a master's degree in educational psychology and had worked as a teacher for a short period of time. She also received some additional training in depth interviewing and writing field notes prior to entering the field, and was supervised by the researcher. Although her home language was Zulu, she had a very good command of Xhosa and was living in Mbekweni for a short time, as she had married a man from there.

Sampling

A purposive sampling approach (Patton, 1980) was used for the selection of interviewees for the qualitative depth interviews. This sampling approach made sure that with a limited sample size, the broadest possible range of groups within the community would be addressed. The nature of the groupings selected reflected the different sectors of youth within the two communities, as well as those groups who were likely to have special knowledge about the youth. These groupings of youth were not mutually exclusive, and this approach assumed some commonality of ideas within each group. The categories used were political-party affiliation, specifically the ANC and PAC; trade union members; workers; school students from a range of standards; representatives from COSAS, PASO, SRC and the Parent Teacher Students' Association (PTSA); unemployed youth; professional youth; church youth; sports clubs; shebeen attendees and university students. In addition, there needed to be adequate representation from both Kayamandi and Mbekweni, of both genders, all ages and from those living in hostels, shacks and permanent houses. A number of older respondents were also selected for interviews. The reason for this centred on the idea that these respondents would

either have an influence on the youth, or have good information on them, such as teachers, sports coaches or parents. Older interviewees that were seen as having influence included parents, civic leaders, political leaders from the council plus the ANC and PAC, health workers, principals and teachers of the schools, spaza³ owners, religious ministers, sangomas, shebeen owners, advice office workers and trade unionists. A total of 43 individual depth interviews and two focus-group interviews took place. The two focus groups were set up on a volunteer basis: the leader of an organisation of sangomas asked members of his organisation to attend and a teacher approached a class of pupils, of which about two-thirds stayed behind for the meeting.

Process of interviews

Prior to both individual and group interviews, the nature of the research and what would be happening in the interview was explained. Assurances about confidentiality were given. Consent was then obtained from the interviewees and an interview time set. The interview sometimes took place as a separate meeting, as the conditions were generally not appropriate for it to be done immediately, or the interviewee was not available. Permission was also obtained to tape the interview. In only one case did a person request that the interview not be taped, but was happy for detailed notes to be taken. In this case, the person, who was a member of the council, was under considerable political pressure from both the civic and the ANC, and so felt very vulnerable. After each interview the researcher thanked the participants and explained what would be happening to the research and the information from then on. Any questions the participants had in connection with AIDS were explained. Such explanations were avoided during the interview, as they were likely to have an influence on how the person conceptualised the subject of AIDS. A contact number was provided in case they had any additional requests for information on AIDS or the research.

Analysis

All interviews, both group and individual, were transcribed verbatim. Those conducted in Xhosa were translated. The transcribed interviews were formatted, in double spacing with a wide margin on the right side, to facilitate the analysis process. Both the researcher and the fieldworker kept diaries during the research. The diaries facilitated the noting down of observations and contextual factors for later analysis. Both the transcripts of the interviews and the research diaries were analysed. For some of the interviews the respondents were talking in their second language, so the quotes may appear confused due to poor sentence

³ Spazas are small informal shops run from a person's home.

construction or a lack of vocabulary. Where necessary, notes were made about quotes used in the result's section so that understanding was easier.

The analysis took place in two phases. In the first phase, each interview was read carefully on three occasions, firstly to make sure that the meaning was clear, secondly to identify and extract key themes, and thirdly to identify quotes. Prior to this, each interview was analysed separately to make sure that the contextual factors were noted. Quotes that were illustrative of themes were also highlighted at this point. In the second phase of the analysis, the interviews were read again and the themes examined across all the interviews, to look for both shared and divergent understandings of HIV and related behaviour. During this analysis, common ideas were brought out and tested against the data as a whole. Themes and information from the notes in the diaries were also drawn for the overall analysis, and to provide background information that was useful for interpreting what was said. All the interviews were read through a final time to check that no information had been ignored and to make certain that the themes drawn out were representative of the data. Information discounting any of the understandings, which had been drawn out, had to be taken into account and adjustments made to the analysis. The final result contained the dominant themes as well as the variations that were found around them. Checks were also made against scientific knowledge and findings in the literature.

Due to the sample size, sampling method and the nature of the interviews, proportions were not calculated. Within the text attempts are however made to identify the dominant and minority discourses that were found in the interviews.

Survey Methods

The methodology used was defined largely by the requirements of the Theories of Reasoned Action and Planned Behaviour, as sketched out by Fishbein and Ajzen (1975) and Ajzen (1988). This implies a strict two-stage process with fairly rigid design features, although some adaptations were made for the local context. The structure of the questionnaire as well as the nature and structuring of the questions asked is very tightly controlled. The first stage identifies the set of primary beliefs that influence behaviours. In the second phase, the actual survey determines the information required for establishing the relationships for the different variables of the model.

Definition of behaviours

TRA requires that behaviours be strictly defined. Serial monogamy was selected over permanent monogamy as a behaviour to be used for the survey. The importance of the rigid

issues of safe sex is recognised, but some adaptations are required in the local context. From the qualitative research it became clear that permanent monogamy was not an option, other than for a very small minority of the population. Serial monogamy was felt to be a more attainable goal. While this is not a completely safe behaviour, it is hoped that through a structured education programme, youth may take on all three safer sexual practices. It is realised that this decision breaks from established international norms about safer sexual practice, but these were the demands of the local situation and the context of research has to be respected. Serial monogamy was defined as follows: "the behaviour of having sex with only one boy(girl)friend and not having sex with anybody else until that relationship ends and you start a new relationship in which you only have sex with that new boy(girl)friend". In order not to further complicate already complicated definitions, no specific time restriction was given. The fieldworkers were given instructions about how to explain serial monogamy in more detail if it was not initially understood. For the specific behaviours relating to condom usage, men were asked if they would use a condom, and women if they would request their partner to use a condom, every time they had sex. The behaviours for men and women are subtly different so the data cannot be pooled, but will allow for comparison. This differentiation in behaviour is made necessary by the TRA and TPB models, as the use of condoms is not directly under the woman's control. In terms of treatment of STD's, interviewees were asked if they would get treatment if they contracted an STD. Obviously, they would have to be aware of the infection, as some STDs have few visible symptoms. For some respondents this was a hypothetical question, but the qualitative data indicated that many people had considered what they would do if they contracted an STD.

The collection of primary beliefs

Preliminary interviews were done to collect information on the primary beliefs to be incorporated into the questionnaire, as demanded by the methodology of the Theories of Reasoned Action and Planned Behaviour.

Research design of the first phase

The same fieldworker who did the qualitative interviews did the preliminary interviews. Prior to each interview she explained the nature of the research, assured the interviewee of the confidentiality of the information, and obtained consent to do the interview. The interviews were conducted over a three-week period. From the analysis of the qualitative data, it showed that men spoke less fully to the female fieldworker, than did the women. It is therefore possible that less accurate and detailed data may have been obtained from the male respondents, than from their female counterparts. Given the more structured nature of the interview and the increased familiarity of the research process in the community, it had been

hoped that the male respondents would find it easier to be frank.

Design of questionnaire

The structure of the questionnaire for this first phase is defined by Ajzen and Fishbein (1980). (See Appendix 1 for a copy of the questionnaire). Respondents were asked the following, in relation to each specified behaviour: their behavioural beliefs, perceived normative influences and control beliefs. Attached to each of these sets of beliefs were three questions, drawing out in turn the positive influences, the negative influences and finally a check to see if anything else came to mind when thinking about a specific behaviour. The questionnaire began with a model question in which answers had already been inserted, followed by a set of practice questions about alcohol use, to facilitate the interviewee understanding the methodology. The main body of the questionnaire followed, with questions on the behavioural beliefs, perceived normative influences, and control beliefs. Finally, there was a set of questions on monogamy, which were included in case those on serial monogamy did not work and there was a need to change the definition of the behaviour back to permanent monogamy. At the end, the respondents were asked to suggest sets of opposite terms that could be used for the semantic differential and Likert scales used in the questionnaires.

The first-phase questionnaire was piloted with five people prior to use and was found to take too long to complete. The practice set of questions about alcohol use was found to be unnecessary, as the respondents quite rapidly grasped what was required of them. The questions on monogamy at the end of the questionnaire were also excluded if the interview had already taken longer than 30 minutes, and were later dropped altogether. Only three people responded to the questions on permanent monogamy and these responses were found to be very similar to those on the serial monogamy question, so were not analysed separately. The questions under each belief category were also reduced in number, as respondents found it irritating to have to answer fairly identical questions repeatedly, so there was a fall-off in response quality in the later questions. The question about whether anything else coming to mind when thinking about a specific behaviour was also omitted. In addition, the use of the Likert scales were piloted at this point and a good understanding of the variation appeared to exist.

Sampling

A purposive sampling approach (Patton, 1980) was used, aimed at attaining a distribution across a range of categories. The categories used to set up the sampling plan included the following three age groups, 15-19, 20-24 and 25-30 years; gender; the nature of the housing, either shack, house or hostel; and community of residence, Kayamandi or Mbekweni.

Respondents were selected on an ad hoc, or convenience basis initially, but care was taken, especially in the later selections of interviewees, to make sure that all categories within the sampling plan were adequately represented. A total sample of 67 respondents to the first phase questionnaire was obtained. Details of the sample are provided in Chapter Eight.

Analysis

Responses to the first-phase questionnaire were grouped in categories that represented similar beliefs. The number of responses in each category were counted to find the most common categories of beliefs for inclusion into the survey questionnaire. The full results of the first-phase questionnaire are reported in Chapter Eight. These results also add to the qualitative understanding of the data and support many of the findings from this, but subtle differences can be noted, especially on the more sensitive questions. The fieldworker, despite being asked specifically to report on this factor, noted no refusals to complete the first-phase questionnaire. This positive return resulted from the effort put into the negotiation of access and a desire, often noted in research on poor communities, to please or to be seen as hospitable.

The survey

Fieldworkers

A team of ten fieldworkers, five from each community, did the survey interviewing. They were selected in consultation with civic leadership. All fieldworkers had to be fully literate in both English and Xhosa and had to make a commitment to work the hours required. An assessment was also made of their ability to interact with people. Much of the work had to be done in the evenings and on weekends, so local residents were hired. This had the potential for causing bias in the responses, as some community members may have been unwilling to talk honestly to somebody they knew from their own community. Attempts were made to reduce this bias by having the fieldworkers do interviews in areas of the community where they did not live or were less well known.

The fieldworkers received a week's training on how to complete the questionnaire, the sampling approach to be used and basic information on AIDS, in case they needed to answer any questions after the interview had been completed. Each fieldworker had a written fieldwork guide explaining the research, the approach to be used in the interview situation, the sampling strategy, which they could use as a reference point, and copies of the questionnaire.

Design of questionnaire

Most of the questionnaire had to fall into the fixed design as set out by Fishbein and Ajzen (1975) and as extended by Ajzen (1988). Additional questions included demographic variables, knowledge of AIDS and five general attitude questions about AIDS and PWAs. A full copy of the questionnaire is included in Appendix 2. There was a separate cover-sheet with the interviewee's name, address and telephone number on it. This was stored in a different place from the rest of the questionnaire after the interview. The cover-sheet had two major purposes; firstly, it was used to identify the households in order to go back to them if a questionnaire was incomplete, and secondly, to do follow-up interviews if the project continued into an intervention phase.

Key demographic information sought included age (rounded off to the nearest year), gender, educational level (last standard passed or most recent educational qualification), employment status (categories of work were coded according to Schlemmer and Stopforth (1979)), and period of residence in Kayamandi or Mbekweni (rounded off to the nearest year). Knowledge questions were drawn largely from another questionnaire, which had been piloted and used successfully in a study among black school students in Cape Town (Mathews, Kuhn, Metcalf, et al, 1990). The section included the modes of transmission of HIV, the non-symptomatic phase of HIV, the lack of a cure, the mortality rate, protection behaviours and knowledge about condoms. Only the questions on protection behaviours were not prompted. The questionnaire was designed to elicit information on items of common and essential knowledge, and also to identify some of the facts that would be less likely to be known so that discrimination between the highly knowledgeable and those less knowledgeable would be possible. Correct responses were judged on the basis of knowledge generally provided in education in 1991. So for example, in response to the question as to whether a person who contracts AIDS will die of it, a correct answer was considered to be all or most. It should be noted that this was prior to the significant role that anti-retroviral drugs now play in the treatment of AIDS. The full set of correct answers can be found in Appendix 3.

Much of the rest of the body of the questionnaire was based on the structure required by the theory of Reasoned Action. Most of the questions used a seven-point scale ranging from extremely true to extremely false. For example

The other common scale used opposites: good versus bad. The nature of the scale and the terms used were drawn from consultations with other researchers, teachers and youth in the area. Also used were responses from the first phase of the survey research, and appropriate discussion with language academics. Instructions on how to use these scales, plus an example, were provided prior to the initial questions using them. TRA requires that questions be asked in a specific order, so as to reduce the demand effect. In this way, the respondent would be less aware of the key issues in the questionnaire and so would be less likely to make assumptions about what they believed the interviewee wanted to hear, and thus to give answers based on those assumptions. However, the fact that the community knew the study was about AIDS did undermine this approach. The first set of questions concerned intentional behaviour. One question was assigned to each behaviour. Prior to the question on serial monogamy the definition of this behaviour was given.

The respondents' attitudes towards the behaviour were measured using the semantic differential. Five different scales were applied using the following opposites: good versus bad, dirty versus clean, great versus awful, ugly versus beautiful, and important versus unimportant. These scales were arrived at from the first phase results. Key people in the community were also consulted about this, as part of the ongoing conversations that took place throughout the research. In each case, the behaviour was given and the respondent asked to evaluate it along the five scales, the sum of which gave an overall attitudinal score. The next two sections dealt with the behavioural beliefs drawn out of the first phase of the study. These beliefs were split into an affective evaluation of the outcome of the belief, the outcome evaluation, and the strength of the belief that the outcome will result from the behaviour, the behavioural belief. In some cases, the outcome evaluation was the same across two or more behavioural beliefs, e.g. the importance of protection from STDs.

For example

Having sex with only that person will protect me from sexually transmitted diseases
 extremely true ----- extremely false
 Protecting myself from getting AIDS or HIV is
 extremely bad ----- extremely good

The subjective norms were measured using a single question for each behaviour. The different normative beliefs, measuring the perceived desire on the part of the relevant person or group for the respondent to commit the behaviour, were drawn from the first stage of the research. These beliefs were combined with the results of a single set of questions inquiring into their motivation to comply.

The strength of the perceived behavioural controls was measured by two questions. These were added together to arrive at a score. The first of the questions measured the ease of doing the activity and used the scale easy versus difficult, while the second examined the possibility for the behaviour and used the scale true versus false. These scales were drawn directly from Ajzen (1988). Two questions were used to measure PBC instead of the three suggested by Ajzen, in order to reduce the length of the questionnaire and to avoid the problem of a string of similar questions being asked together. In addition, the nature of the remaining question on control, "how much control do you have over whether you do or do not (do the behaviour in question)?" (Ajzen, 1988, p135) was felt to invite a more positive response than was necessarily true for the person. This concern was supported by the qualitative data in which control issues often appeared contradictory in the respondents' comments, i.e. positive answers were given when direct questions were asked about control, but these were less so when questions on the ease of the task were posed. On reflection, this may have been an error. Control beliefs were assessed by a single question which evaluated simultaneously both the validity of the belief for the person and the extent of the problem that they felt the control belief would represent (Ajzen, 1988).

The following section dealt with the respondents' past behaviour. Due to the sensitive nature of the data it was decided not to do follow-ups on their current and future behaviour, so past behaviour was taken as a proxy. This does compromise the internal validity of the method as it assumes that past behaviour is a consequence of attitudes and norms of the present (Albarracin, Fishbein and Middlestadt, 1998), but it was felt to be the best option here. It was decided after the negotiation of access and the qualitative research that to ask direct questions of immediate past sexual behaviour would be extremely difficult. Asking about sexual behaviour had been frowned upon when discussed during the negotiation of access, and during the qualitative research it proved to be a very sensitive area. Even those who boasted about their sexual exploits were resistant to any attempts at establishing. The search for information on past behaviour was safer, as this was only occasion on which the person would be asked the question so the embarrassment was less. To do a follow-up would also have extended the time period of the study further, as another phase of fieldwork would have had to be done to check on the behaviour variable. The latter phase would have focused virtually exclusively on behaviour, which would have heightened the embarrassment of respondents. Also the cost and complications involved in the follow-up would have increased considerably, due to the difficulty of tracking down the subjects again. Finally, the quality of the information gained was likely to be poor.

The use of past behaviour as a variable had certain implications for the analysis of the data. The emphasis of the analysis had to fall on intended behaviour. However, for completeness, statistics for the full model, using past behaviour in the place of future behaviour, will be provided on all the models shown. A more recent paper which did a meta-analysis of the research using the TRA and TPB on the behaviour of condom usage, commented in more depth on the variable of past behaviour (Albarracin, Johnson, Fishein and Muellerleile, 2001). In this paper, past behaviour was found to have often been incorporated into studies, and that generally attitude, norms, perceived behavioural controls and intentions had a higher correlation with past behaviour than with future behaviour. However when incorporated into the model with all the other variables it had a low direct influence on future behaviour. The correlation between past and future behaviour was 0.339, so on the basis of this data it is not an adequate predictor (Albarracin, Johnson, Fishbein and Muellerleile, 2001). No analysis was done in this study to assess the influence of past behaviour on intentions alongside the variables of attitudes, norms and perceived behavioural controls as this would have deviated from the initial models of TRA and TPB, as this was not the focus of the thesis.

The section of the questionnaire dealing with past behaviour began with a screening question covering whether or not the person had ever had sex. The rest of the questions covered the following areas: frequency of sexual encounters in the past four months; the number of different partners in the last six months; use of condoms in the past four months, and with whom condoms were used; previous incidence of STDs and if he or she was treated; protection taken against HIV or AIDS; and personal knowledge of a person with AIDS or who was HIV-positive. The final section of the questionnaire dealt with more general attitudes, particularly respondents' attitudes towards people with AIDS and their personal sense of vulnerability to HIV infection.

Variation in the direction of the scales was introduced in some sections to reduce response bias. This was not done throughout the questionnaire, in order to reduce the time taken to complete it and to limit confusion. The questionnaire was piloted with colleagues and seven people in the community prior to use. Some small problems were corrected, but the major issue was that the questionnaire was too long. On that basis, the questions relating to PWAs were withdrawn with the exception of the three that remained at the end. Initially, questions on the behaviour of relating to PWAs had a similar structure to that of serial monogamy, condom usage and treatment of STDs. A few other questions that were felt to be less important were withdrawn from the knowledge section. This need to shorten the questionnaire reinforced the idea of dropping a question on perceived behavioural controls, mentioned earlier. The questionnaire was translated into Xhosa and back-translated by a person from the

community. Sections were also tested with a comparative comprehension. Any misunderstandings or errors picked up during the checks and the piloting were corrected.

Sampling

A random sample would have been very difficult to obtain given the nature of the community. The reasons for this were that there was no listing of community members, the numbers of youth and their distribution across age and gender were not known and the target group for the study, namely youth between 15 and 30 years of age, were unevenly distributed over the community. A stratified random sample was used instead. The stratifications selected were age and gender. Age categories were broken down into the groups 15-19, 20-24 and 25-30 years. Then to try to account for the assumed uneven distribution of youth across the community, there was a further stratification for housing type.

To do the sampling, approximations had to be obtained for the distribution of age and gender in each of the different housing types. Those defined were hostels (with some variation for size and type), shacks, and houses including lodgers and family members living in shacks on the property. In the hostels, as with those in other areas, a bed was taken to be a unit of accommodation (Ramphele, 1989). The first step was to count every accommodation structure in both communities. This was done by walking through the areas and counting each structure. Aerial photographs did not prove to be useful, although these were obtained for one community. To get an approximation of the population structure, a count of the residents according to age and gender was done in a sample of each housing type. Approximately five percent of the households of each type was counted. From these distributions, some idea could be obtained about the population composition within and between each of the housing structures. On this basis, quotas of the sample were allocated to each of the housing types. These quotas defined the total number of people to be interviewed in each housing type, as well as the number from each age and gender category. Once each housing type had been assigned a quota of the population, a number of specified areas within each housing type were selected, using a random number table and grid over a map of the community. A subset of each quota was assigned to each starting point, for example:

	15-19	20-24	25-30
female	1	2	2
male	2	1	1

The housing unit was the initial sampling unit. Each starting point was sampled, then the fieldworkers moved on, using a systematic approach of selecting every sixth unit from there for up to five units. If there was a problem with any unit, the fieldworkers had instructions on how to continue with the selection process. The interviewer selected a respondent from each

housing unit selected. The fieldworker would begin by listing all those in the household falling into the study population. A random selection was made of one of them, using a set of numbers from a random number table. Each fieldworker had a different random number table to limit any systematic error. The category of the person selected was ticked off on the list of those required in the quota for this target group. When an age and gender category of the quota was filled it was no longer incorporated into the listing of household members from whom a random selection needed to be made. The sample size was set by the logistical factor of the number of interviews possible given the time limits of the fieldworkers. A sample size of 406 was obtained, details of which are provided in Chapter Nine. The stringent sampling methods applied should have reduced the sampling error, although there may still have been some bias. This error would include factors such as people who were away for a period of time longer than a few days, some residents who may not have been mentioned to the interviewer, and possible fieldworker error.

For the survey, only those who formed part of the study population were interviewed, i.e. those who fell within the youth age group and were permanent residents in the community. The definition of a permanent resident was somebody who was considered by the other members of the household to be residing with them and not simply a guest. The fieldworkers reported no refusals to complete a questionnaire, and this was checked with each individual fieldworker on several occasions. This positive return, as in the response to the first phase questionnaire, was the result of the effort put into the negotiation of access, and a desire on the part of the communities to please or to be seen as hospitable.

Process of interview

After a household or living unit had been selected via the sampling process, the interviewer spoke to the people there and explained the nature of the research, the interview and the sampling approach. Confidentiality was also assured. Once the residents of the selected household were in a position to make a decision, consent to continue the procedure was obtained. The second phase of the sampling exercise then took place, meaning that one person from the household would be selected for the interview. A quiet place, either in the building, or outside when possible, was chosen in which to do the interview. The details of this and of the research were again explained and consent on the part of the respondent confirmed. The interview then proceeded, with the respondent being given instructions wherever required. Once the interview was complete, the fieldworker answered any questions that the interviewee may have had, thanked them and provided the contact number of the researcher in case they had any enquiries about the research.

Analysis

The responses for the multiple-choice questions were coded as had been defined. The open-ended questions were assigned into categories that arose out of the data itself. The analysis was done in two phases. In the first phase, mainly descriptive data was drawn out. This served to outline the knowledge, attitudes, normative structure, perceived controls, intentions and behaviour of the community. The Mantel-Haenszel chi square test was done in most cases to assess if there were linear association differences across sections of the population. Where the variables were more categorical, as in housing type and employment status, a standard chi square test was used to assess their significance. The level of confidence used was 95%. The SAS package was used for all analyses unless otherwise stated (SAS, 1985). For some of these categories, the scales had to be collapsed as the cells were too small for a valid analysis to be done using the Chi Square statistical test employed. A total knowledge score for each individual was obtained by assigning a value of one to every correct response obtained in the fixed response questions; nil for an incorrect response. The definition of a correct response was drawn from the basic AIDS education messages used in the community at the time of the research. The results from the two communities were sufficiently similar for them to be analysed together.

A correspondence analysis was done to assess whether the five different scales used in the semantic differential were measuring the same construct (SAS, 1985). The nature of the groupings in the resultant graph supported the idea that this was in fact the case, but a different problem emerged. It appeared that respondents did not show much distinction between the three levels of gradient on the positive side of the semantic differentials. This lack of variation would be expected to have an impact on the correlation and regression calculations. It is likely that the respondents had problems with the Likert scale format of the questionnaire and may have struggled to differentiate between levels of response. For the perceived behavioural controls the McNemar test of symmetry was done, drawing on the BMDP package (Dixon, 1988). The Kappa measure of reliability given by the test showed the relationship between the first and second questions used to collect this information. These scores plus the correlation between the responses are given in table 6.1 below. All the Kappa statistics are very low, indicating that the two questions picking up PBC were not measuring the same construct in this case. This was born out by the correlation scores obtained, especially given that they were meant to be looking at the same factor. For this reason the two questions were applied, separately as well as combined, in the TPB models.

Table 6.1: Kappa and correlation statistics for the perceived behaviour control questions

	<u>Kappa</u>	<u>correlation</u>
serial monogamy	0.133	0.2029
using condoms	0.126	0.3952
asking partner to use a condom	0.211	0.4718
treatment of STDs	0.127	0.3186

The second phase of the analysis was based on the pre-set analyses prescribed by TRA and TPB. This demanded a number of steps in the analysis. Initially, every relevant variable was correlated with all other relevant variables. This provided information on the strengths of all the connections prescribed within the model, and also gave insights into the intercorrelations of different variables. Then regression analyses were done between the variables in a linear relation. A combined regression analysis was done between attitudes, subjective norms and perceived behavioural controls as independent variables and intentional behaviour as the dependent variable. The individual contributions of each of the independent variables were also noted using a stepwise regression programme. The STB option in SAS was used to calculate the standardised regression coefficients (Dilorio, 1991). All the combined attitudinal belief, normative belief and perceived behavioural control scores were summed to calculate the correlation of beliefs with attitudes, subjective norms and perceived behavioural controls respectively.

These final sets of analyses were repeated with the sample split according to gender and a division in the total knowledge score of AIDS each respondent obtained in the survey. This division comprised scores of eleven or lower as opposed to scores of more than eleven out of sixteen. Other divisions according to educational level, community of residence, housing type and period of urbanisation were examined using the provisional correlation data, but little systematic variation was noted.

Given that the questionnaire was of a heterogeneous nature and that there were to be no repeat administrations, reliability was difficult to measure (Guilford, 1956). It had to be done by comparing results obtained from similar questions in order to assess if there was at least correlation in the variance (Kerlinger, 1975). The results showed poor agreement. The K statistics are given in table 6.2 below. Anything below 0.4 shows poor agreement. In the first column, abbreviations of the questions used as tests are given, as well as the place in the questionnaire where they appeared. The second column gives the statistical score.

Table 6.2 Reliability scores for the questionnaire

<u>Questions</u>	<u>statistical score</u>
Protection from STDs / Protection for AIDS (outcome evaluation (OE))	0.153
Showing love for partner / showing trust for partner (OE)	0.344
Sex with one person will protect me from STDs \ protect me from AIDS (behavioural beliefs (BB))	0.137
For males; condoms will reduce sexual pleasure \ will not feel partners' body (BB)	0.325
For females; condoms will reduce sexual pleasure \ will not feel partners' body (BB)	0.322
For males; using a condom will anger my partner (BB) \ my partner would not like me to use a condom (control belief (CB))	0.258
For females; asking my partner to use a condom will anger him (BB) \ my partner would not like me to ask him to use a condom (CB)	0.387
Treatment for an STD will be painful (BB) \ scared of pain of treatment (CB)	0.322
Getting treatment for an STD will be embarrassing (BB) \ embarrassed in front of nurses (CB)	0.243

These poor reliability scores are a cause for concern, although the questions used to measure them were not identical and were set up to measure different constructs. However the problem remains is that the reliability of the survey is not clear, so results will have to be interpreted with this caution in mind.

Conclusion

Stemming from the aims, objectives and context of the research, a detailed methodology has been presented above. Firstly, the process of negotiation of access was discussed. For the formal data collection two sections exist, namely qualitative interviews and a more quantitative approach for TRA and TPB. The qualitative data increased the information on the context of the research and gave overview data. The survey methodology completed the theory side of the objectives. This drew considerably on the TRA and TPB outlines, but included a detailed sampling method to reduce bias. Considerable care had to be taken given the sensitivity of the subject matter and the scientific requirements of the theories being applied. A number of problems with the methodology emerged at various points and adaptations had to be made. This has meant that the final design is not as clean as it may have been in a laboratory or university student setting, but it does present a real-life application of psychological theory to a serious life-threatening problem.

Chapter 7

Results from the qualitative data

The qualitative data reported here increased information about the context into which the rest of the research fits. It also begins to give an understanding of how the members of the two communities understand and relate to HIV and AIDS as a new phenomenon that has forced itself into their communities. For this study, it also informed the nature of the beliefs that would be used in the survey section of the research, and provided guidance on key aspects of fieldwork. The latter have already been commented on and incorporated into Chapter Six as part of the description of the methodology. As with any new phenomenon, but especially with a disease that is as damaging as AIDS, and which invades so many private areas, there are many uncertainties in beliefs and much contested territory. AIDS has particular overlapping areas that impact on established patterns of beliefs and behaviour, namely the key terrains of sex, illness and death. The analysis is limited to the behaviours of interest and factors that directly impinge on these, so will focus on existing knowledge about AIDS, serial monogamy, condom usage and treatment of STDs. First of all the sample is described.

Sample

A total of 43 individual interviews and two group interviews were analysed. I did twenty-seven of the individual interviews and sixteen were done by the fieldworker. The latter interviewed all respondents who could not speak English. The emphasis here was on the youth, although some respondents who were important in the community or who had special access to youth were also interviewed. When these older respondents were interviewed, only those comments that gave information important to the considerations of the youth were included. It was assumed that these older respondents had particular and important information on the youth or held opinions that had an influence over them. The full sample is given in Appendix 4. The names used are pseudonyms in order to protect the confidentiality of the respondents. Key information, if available, is provided on their home communities, as well as gender, age, education, employment status and leadership positions. The gender of the informant quoted is given after the name if the gender is not mentioned in the introductory sentence to the quote. Diary notes were also used as a data source and a validity check. None of the respondents acknowledged having AIDS. No specific search was made for any person who had AIDS, as it was not central to the study and such inquiries may have compromised the fieldwork.

There was some consistent variation between the information obtained by the researcher and the fieldworker. She obtained better and more indepth information from female respondents,

while the researcher obtained better information from male respondents. Surprisingly, there was little real difference in beliefs according to age amongst the youth. The major difference found was in the exposure to the various practices in question. Some differences did occur between the older and younger generations. Where relevant to the analysis, these differences are listed.

Knowledge About HIV and AIDS

In this section the respondents' knowledge about AIDS included what can be defined as factual or scientific knowledge, as well as what they believed to be true, such as local or informal systems of knowledge. The latter in many cases, as is suggested in the earlier theoretical chapters, ultimately has the greater power to influence behaviour. Generally respondents did not make a separation between HIV-positive status and AIDS, and in fact HIV as a concept was not generally understood. For this reason the research focused on AIDS as being the most commonly understood term.

Scientific knowledge

Almost all the respondents knew that AIDS was sexually transmitted and that there was no medical cure. They knew that the main methods of protection were sticking to one partner, abstinence and the use of condoms. Unfortunately, this was confused by a number of misunderstandings. One person mentioned masturbation as being a safe sex option, but this is likely to be rejected by the community in general as an alternative option to full intercourse. A number of respondents also spoke of transmission via use of dirty needles or blood transfusions. One person addressed the circumcision ritual, which is done when a youth enters manhood, as a potential means of transmission. The nursing sisters stated that they had been trying to get those who do the operation to use a clean blade with every youth. Transmission from mother-to-child was not addressed. Also the link between STDs and AIDS was not addressed, although a minority of respondents linked to health professions did spontaneously talk about the similar methods of transmission. Fatyela, a young male student, talked about his knowledge of AIDS, which was typical in the communities.

Hey, what I know about AIDS, is that it is just a fatal disease, which is spread through various ways like sexual intercourse with other partners, it could be male or female. It can also be that it can be spread through these injections of someone who has contracted AIDS. I am also aware that AIDS is incurable. If you have contracted it, you must know that you will end in the grave.

At the same time there was an excessive concern over contracting AIDS via the needles used or operations carried out in health institutions. Kholeka (female) spoke of a news story in

which a dentist infected patients with needles. Others raised similar stories or asked questions about the potential of being infected by an injection in a clinic or via a blood transfusion.

The role of casual transmission became a major area of concern for the respondents. Even many who stated that AIDS could be only passed via sexual or blood contact, later became uncertain about casual transmission. Lucas (male) remembered a news story reported from Italy where a soccer player had contracted AIDS during a soccer match. It is worth noting that the fear of casual transmission allows people to avoid thinking about changing their sexual habits. In Kayamandi the fears of casual transmission were reinforced in a story told by Themba (m), a leading political figure, who reported that the health authorities had not allowed the body of a person who had died of AIDS to be returned to his home prior to his burial. The immediate inference on the part of Themba (m) was that AIDS could be contracted from the corpse:

the authorities never allowed them to come to the township. You see it is the custom that when someone is buried that the corpse must come home where a short prayer will be held with a whole set of sermons, that a dead person will be buried in a dignified way. Those victims were not allowed to come to the township so people only got the coffin on the road to the graveyard.

A number of interviewees stated that they did not feel AIDS had much impact in their community. People wanted to see the manifestations of the disease before they altered their behaviour. Discrimination against those who are infected, in turn, makes it difficult for them to acknowledge it publicly and talk about it. So it will be a long time before the majority of the population will be convinced about the dangers of AIDS. A further area of doubt centred around a cure for AIDS, with about a third of the youth claiming that the sangomas or traditional healers could provide this. This belief was supported by some of the sangomas, during their group interview, some who claimed to have cured cases of AIDS already. Two male youth also spoke of a medicine, which they would take after sex, to provide them with protection against contracting AIDS.

The traditional healers expressed a particular understanding about AIDS. They saw AIDS as the result of blood becoming dirty. This report came from a female sangoma during the group interview and is reported via the interpreter.

Just there right at the womb, there is a nucleus that is white, so immediately when she starts getting AIDS, it changes colour and becomes dirty. The men only get infected during the course of intercourse, meaning that the agent that is carrying the disease comes in from the womb, she says that even the man can be a carrier of the agent.

The sangomas later asserted that men would carry the agent in their testicles. AIDS occurs when the blood becomes too dirty for the person's body to clean it themselves. The cure then becomes a process of cleaning the blood. This concept of dirty blood was raised a number of times in interviews with other members of the community. From a different perspective, the nursing sisters reported that one person with AIDS had considered himself as being bewitched, and hence had become infected. These explanations are important as they were permeating the community and thus becoming more powerful.

Sources of knowledge

The major sources of information mentioned were the radio, talks by health educators such as nurses visiting schools, newspapers, pamphlets and information from the clinic. Other occasional sources included puppet shows, plays, church ministers, TV and public talks. All the education provided was sporadic and there was no sense of clarity or direction. Very few political, community or social organisations had put any emphasis on AIDS or had provided AIDS education. Some of the schools had organised their own education programmes. The guidance teacher in Kayamandi High School stated that she had found that the students to be interested in hearing about AIDS and had heard them discussing the issue in the classroom. Although parents would have been an expected source of guidance, they provided little or no education and appeared to be afraid of talking to their children about sex or AIDS.

One guidance teacher (f) reported that the students sometimes asked her about things related to sex, such as pregnancy, but never about sex itself. She had also not been asked about AIDS thus far. Other sources of advice and information that were mentioned by interviewees were sports coaches, older members of sports teams and health professionals from other communities.

Respondents commonly got information from each other. The regularity of these conversations depended on events happening in the students' vicinity or new facts or ideas that they had heard about. These ideas fitted into general conversations about sex. Rumour and existing belief systems became confused. Some of the youth claimed to have read up on AIDS on their own, so were better informed on the issue, but this was a small minority. Ultimately most of the education happened by chance. Certainly some of the sources do give conflicting information. One major confusion was a result of a nurse educator claiming that AIDS could be transmitted by kissing and by using toothbrushes. A second point of confusion arose from so-called moral teachings on taking a single partner for life and the claim that condoms are unsafe. Some responses showed the ease with which misconceptions arise, e.g. one person claimed to have heard on the radio that 45% of the Mbekweni residents had AIDS.

Some of the education did not relate to the situation in the townships, e.g. statistics from India, which were provided in one lecture, did not help, as information was required on the South African scenario.

An advice office worker put the illiteracy levels in Kayamandi at around 65%, which made education difficult. He argued that AIDS education needs to be ongoing and not once off, as people forget or no longer see it as a priority if they are not reminded. Programmes need to take the specific conditions of the community into account. The dominant sense obtained from the respondent was that more education was essential. Schools were suggested as an important point in providing this. It was however noted by one principal that parents were likely to resist AIDS education in schools, because this would involve talking openly about sex. The interviewees suggested sports, political and community organisations as possible sites in which to do AIDS education. Shebeens and spaza shops were also suggested in this regard. During the research, owners who were asked if they would be willing to have AIDS education on their premises, said they would. Famous people who have AIDS appeared to have a powerful educational impact. Those mentioned included Freddie Mercury and Magic Johnson, as well as unidentified people from Uganda and Ghana. Magic Johnson was particularly important, as he showed that it is possible to have AIDS, while still participating in contact sport. A number of people raised the point that PWAs should be incorporated into educational programmes and should talk about their experiences of having AIDS.

Importance of origin of AIDS

In virtually every encounter, two questions were put to the interviewers. These concerned the origin and symptoms of AIDS. The nurses confirmed that these were the questions that they too were most often asked. Concerning the origin of AIDS, there was a general lack of comprehension as to how something that had not existed before could now provide such a threat to their lives. The key question, "How come it did not affect my fore-fathers who had many sexual partners?" was felt to be unanswered for those respondents who raised the question and this undermined the validity of AIDS as a present-day disease. Its origin remains an empty space, which people fill with their own theories or use to deny the disease altogether. The community needs to fill the gap left by the scientific theory.

The "green monkey" theory was mentioned by a few, but not given any credence. A small number saw it as God's punishment or as being part of the enactment of the Book of Revelations in the Bible. Surprisingly few respondents claimed it was something created by whites to kill blacks, although some did give the story of AIDS having been created by the

CIA to destroy gay and black people. Vusi (m) reported on an article that he had read in New Era, a political education publication:

I know AIDS is coming from America, was made there. That's what I heard from New Era, it's taken from there to Johannesburg and South Africa.

The traditional healers, supported by a limited group of other respondents, saw AIDS as being a result of excessive interference in sexual matters by the use of contraceptives. This was reported via the interpreter during the focus group with traditional healers.

She was asking the question of the various contraceptives, you know, because like you find the blood gets so warm and a lot of things are happening, you know within the body.

This belief, as far as they were concerned, was reinforced by the disease appearing simultaneously with the increasing use of different forms of contraception. The same sangoma continued:

She wants to tell you that since the family planning started you find that the sexual, external things of that happened, this disease started to spread.

The origin remains an unanswered question and, as such, the existence of AIDS is more difficult to believe in and take seriously, especially during the early stages of the epidemic, as was the case during this research. It also allowed for the increased development of varying ideas and beliefs with regard to the disease.

Importance of symptoms of AIDS

The second question that was regularly asked by interviewees concerned the symptoms of AIDS. Again, the reason was the lack of clear information and understanding about the asymptomatic period and the varying nature of opportunistic infections. More important was that the idea behind the question was to find out how is it possible to identify someone with AIDS in order to avoid them. Molefi (m) explained this:

you need to identify a person, by, by, I'm not sure by what, but you must be able to, like eyes, changing in their face, you know, for instance if one, you identify it if they cough too much and all those things, for AIDS, issues each one can identify, there is a possibility of having AIDS, we are not sure how we can identify it, that is it. If one friend can identify me for a friend with AIDS, I won't talk to that girl, no. That is preventing in itself, you know.

A range of potential symptoms was presented by community members, including TB or other diseases, pimples, rashes, sores, especially in the genital area, and a bad smell. The dominant idea was that of a person changing and looking very ill or dying, as Thandeka (f) expressed it:

You can have flu or a cough, all your body becomes limp and also the bones, even hair will like fall down and also get maybe spots, you will not be the same person you were.

The popular idea of the symptoms of AIDS being a rash or sore is to some extent synonymous with the powerful images of decay and bodies covered with sores, found with the images of other diseases. This loomed large in the respondents' descriptions of those with AIDS just before they died. The connection between TB and AIDS was commented on by a number of respondents, but poorly understood. There was considerable difficulty in accepting the existence of a period during which no symptoms are visible. This built on the lack of distinction between HIV-positive status and AIDS addressed earlier.

AIDS tests

There was generally poor knowledge of the existence of blood tests for HIV, with only about half the respondents being aware of it. When the topic was addressed, the dominant mood advocated general testing to identify those who are infected, this being part of a desire to separate off all those with AIDS. At the same time, nobody was really keen to go for a test themselves for fear of the results. Respondents generally showed a low regard for the preservation of confidentiality of others, while exhibiting a high regard for their own. As Thandeka (f) expressed it:

The problem is that people are diagnosed with having AIDS and the doctors just write down the status. We take the same person into society and they don't tell people that so and so has got AIDS. Then people go on having sex with other people. The doctors should do something, kind of segregate persons.

Denial

While the key information about AIDS was generally known by the respondents, there was an undercurrent of feeling that believed that AIDS did not actually exist. A well-educated and informed young woman, Hombile (f), spoke of her interactions with her colleagues and friends.

I became furious and said "Hey, you guys, have you heard that you can get AIDS?" and then all of them, they started swearing at me, said "Ah! get lost. No we have not got it, we are not dying".

Xoliswa (f) whose knowledge was poor, gave a direct account of this felt undercurrent and expressed the following belief.

No I do not believe. because I have not seen a person with AIDS.

A second level of denial involved the belief that AIDS did not exist in their communities. It was instead seen as being a problem elsewhere, such as in America, the rest of Africa, Johannesburg, KwaZulu Natal, among whites or a nearby community. Significantly, some residents of Kayamandi thought AIDS was in Mbekweni, but not Kayamandi, and vice versa. Fatyela (m) expressed this clearly.

I also think that we see AIDS as something very far from us. I mean in South Africa, that was the basic understanding then. I mean it is something that happens in Africa, it is in the Transvaal, not here you see.

Within communities a similar distancing occurs, as Jikani (m) expressed below. This seemed to be directed primarily at hostel dwellers by those living in permanent housing.

It is mainly in the hostel population, but also in the squatter community, but also in the township, because there we cannot say that in the township that cannot happen because there are ladies that are not also employed. Because some of them from the township go to the hostel area because at least at the hostel area most of the men that are there are employed, so it affects the whole of Kayamandi.

Even in a community where somebody had recently died of AIDS, the event was quickly forgotten about and old patterns emerged. Themba (m), amongst others, spoke of one such event in Kayamandi:

After it is gone people forget about it again and they go back to normal life. I just told you, it is very difficult to control this disease because it actually means you must stop being promiscuous which is something very difficult to get rid of.

Bongani (m), a principal, spoke of a politically-inspired denial that had already faded by the time of the interview. In this scenario, AIDS was seen as a myth created by the whites to stop black people having sex, in order to limit the size of the black population. This myth had a foundation in some of the manipulative health messages put out by the Nationalist Party government. Mniniawa (m) raised a more realistic fear that AIDS could be used politically to undermine the African culture. He gave the example of the link between circumcision and AIDS transmission, which if addressed insensitively, could undermine his culture and history. He also expressed the broader fear that it had the potential for the control and abuse of people.

Denial, as implied above, was also found in relation to the AIDS test. Hombile (f) spoke of her friends who were scared to go to the doctor for treatment in case they were diagnosed with AIDS.

He had some pain in the waist and I asked him, why don't you see the doctor, and he said no, what if he say, I could see that I am not the only one, everyone is scared, right, of what he does not know.

Fatalism, an issue related to denial, was also prevalent. Vusi (m) perceived AIDS as something that would happen or not, but that there was nothing that could be done about it.

I mean this is the understanding. "No I don't care, I cannot stop from doing this, I can contract AIDS, that is at least, it is just like having a car accident." This fatalism was increased by the belief that even if you did not become infected via sexual contact, one could contract it via an operation in hospital, a blood transfusion or even casual

contact. Vusi (m) presented this story in his interview. While it bore some of the marks of an urban legend, it would still have an impact on those who heard it. The story went as follows

Last week I was talking to my friend, who said he had a sister-in-law, went for an eye operation and then she got AIDS. I don't know how she contracted AIDS, but it was through the operation, she was sure because she was having only one partner.

This of course fails to take into account the fact that the woman's single sexual partner may himself have had other partners from whom he contracted AIDS, which he then passed onto the woman. This omission could be considered part of the general denial of the full implications of the manner of transmission of AIDS.

AIDS as a joke

Treating AIDS as a joke was common throughout the community. This is largely an extension of denial. Amongst school students, AIDS was treated as a joke or a scare term to tease others. Ayanda (m), a school principal interviewed, told how some of his students behaved:

But at this stage it still remains something that is a scare word to most of the people. In fact they will even go to the extent of saying if there is anything strange on the face of some kids, of saying that that person has AIDS. Or they go to the extent of warning the child that they don't have to sit properly on the pots, on the toilets, because they would encounter the disease.

Other jokes have been made about AIDS. These often have the function of attempting to put the disease at a distance. Jikani (m) repeats this joke:

Yes, especially when the people are drinking, AIDS is called American Idea to Destroy Sex, taking it as a joke, they don't really believe in AIDS.

Andile (m) told one potentially dangerous story in which AIDS was seen as a status symbol:

Ja(yes), there are some people around the township who claim that dying from AIDS is an honour because it proves that you are a playboy.

Competing knowledge systems

Some competing knowledge systems, be they termed lay theories or social constructions, emerged during the interviews. Many of these have already been discussed above. The dominant lay beliefs were in relation to the spread of AIDS by casual contact. Although earlier in the interview the person would state that AIDS can only be spread by sexual or at times blood contact, they would later suddenly give casual contact as being a means of transmission. These forms of casual transmission included teacups, toilets, toilet seats, physical contact, saliva and toothbrushes. Kissing, especially "deep kissing", was raised as a method of transmission and led to intense discussion in the school students' focus group.

Education linking AIDS and TB had led to some confusion about the means of transmission, as this quote from Inutu (f) indicates.

Yes, AIDS is contagious like TB for example. If you have TB and I am sitting next to you then I will also get TB. AIDS too is like that, if we are staying under the same roof with an AIDS sufferer then you will all get it.

There was a strong need to avoid PWAs, for fear of infection. This was even regarded as a means of reducing the epidemic and protecting themselves. A minority discourse called for the government to intervene and separate those with AIDS from the rest of the population.

Competing knowledge systems were also found in relation to various means of protection. Jikela (m) spoke of trusting his partners as being a defence. This quote is difficult to interpret at one level, as it could imply a long-term loving relationship. But in the context of the interviews this was more likely to be an implication that one half of the partnership thought that the other was clean, and had checked that none of their new lover's past partners were sick, and that the person had no other partners at the time of the relationship. Madoda mirrored this when he stated that you got AIDS by sleeping with strangers, also a popular notion in both communities.

Contraception, especially the taking of the pill and birth control injections, such as Depo Prevara, was also thought by some to prevent AIDS. This has obviously been confused with information provided about birth control, but it shows how information given in one context can influence that given in another. It also accentuates the problem which arises because information on AIDS comes from such a range of different sources. Obviously, the belief that AIDS can be cured, especially by traditional healers, is important, and was a fairly widespread belief in the community at the time of the research. As far as treatment was concerned, the influence of knowledge of other diseases could be seen in comments that AIDS could be cured if treated early on.

Single Partner Sexuality

In this protection behaviour there are a number of potential options, namely abstinence, single partner for life, serial monogamy or multi-partner relationships. Based on the evidence listed below it became clear that in the current situation neither abstinence nor a single partner for life was considered as an option and therefore warranted less exploration. Sex is seen as key to living and the perception is that nobody can do without it for even a short period. Virtually every person spoken to felt it was beyond the realm of possibility to wait until the perfect partner was found before beginning sexual activity. There were a very limited number of religious people that followed this precept or even claimed to do so. Generally residents of

both communities expressed doubts that even religious people would remain with a single partner life-partner. This section therefore deals with the choice between serial monogamy and having multiple partners. While serial monogamy is not a safe sexual practice, it is safer than the multi-partner sexuality that dominates at present. Only one respondent, a fifteen-year-old girl, stated that she had not had sex before. She had certainly not made a moral or permanent choice in this matter and spoke of how she would behave during future sexual activity.

The current relationship style according to the respondents

The common tendency especially, amongst the youth, was towards multiple partners. Although there were some moves towards reducing the number of sexual partners amongst certain sectors of the two communities, this change was only just beginning. Estimates were that about half or more of the youth, both men and women, had multiple partners. Of these a high proportion had between one and three regular partners and some had short-term contacts as well. Short-term contacts included weekend relationships, chance meetings and favours. Favours were once-off sexual encounters that happened without courtship or any other binding relationship. Mniniawa (m) expressed this position.

Try yourself to be more student, more teenager, you know, try to be with them, maybe they will get to the point. People know AIDS is dangerous, but the ways it is presented, their (educators) suggestions are academics coming into the school, trying to tell them (students) about AIDS and you must try and stick to one partner, I have a notion they are weird (educators).

Differences in behaviour were expected according to age, with the youth having more partners and those over 30 settling into married life or with a steadier partner. This perception was supported by the older respondents who saw the youth swapping partners on a regular basis, an observation supported in the interviews by the youth themselves. However, in the interviews with some of the adults, especially men, it appeared that they also continued to have many partners. Faithfulness within marriage was not seen as an essential.

Motivation for having multiple partners

A number of arguments were raised in favour of having multiple partners.

Male sexual needs

The dominant motivation given by both men and women was the perceived high sexual appetite of men and therefore the need for men to have more than one sexual partner. This appeared to be accepted and unquestioned by the respondents as Hombile (f) stated:

With us, because our men don't believe to have, it is not the done thing, they don't want one man one woman, they believe they must have somebody else

somewhere, say to relieve themselves, even in marriage he believes that he must have two lovers, I must have one to relieve the other one.

Explanations took on a physiological nature at times, implying that men are physically incapable of going for a long period without sex. Certainly, the need for sex was perceived to be higher in men than in women.

The perceived right of men to have sex when they like emerged at school level and was reinforced by parents. One principal noted that the parents would come to request his assistance in coping with their daughters who spent the night out of the house with their boyfriends, but did not raise such concerns about their sons doing the same thing. This followed the pattern of the rest of the community, where men get status for having multiple partners and women a bad name. Even some of the female respondents appeared to have accepted this as Nomfundo (f) indicated:

I think it is natural because even a happily married man cannot stay without a private girlfriend.

Hombakasi (f) queried that this need was natural and expressed her anger at the idea. She felt that having her own income put her in a far stronger position. She was not financially dependent on anyone and therefore could make her own demands on a man. This is one of the ways in which some women in the community find power.

I am not sure what makes men to be unsatisfied. You can please him by all ways even sexually, but he will still go and sleep outside with other women. You cannot (claim that a man is yours) because today he is yours as he is having sex with you, tomorrow he will be sleeping with someone else who will also be regarding him as hers.

This male sexual need extended to when men travelled and so had to establish sexual relations wherever they found themselves. It was argued that, especially for those who have to travel in search of work, having one partner was not possible. Sometimes this applied even over a weekend trip, as was spelt out by Themba (m):

So also you find you sometimes you spend a weekend in East London or Port Elizabeth, the first thing you actually want is to have a woman.

Nkululeko (f) expressed the social power role between the genders, adding also a physiological explanation:

It is the fact that as a man you have the power of being a playboy if you want and secondly the knowledge that you can satisfy as many women as you have, make men to have more partners. It means that men can have as many women as they choose to because nothing can happen to them. They cannot get pregnant.

Inutu (f) presented the perspective that women also have high sexual desires and some do want to look around for better sexual partners:

If a man womanises a lot, then his partner will do the same. She is also used to having sex, then if her man is not around to provide sex she is then liable to seeking other men to quench her desire. It is important for her then to look someone with even a better penis than her man's. Other women commit suicide if they cannot be sexually satisfied. To avoid that therefore women sleep with more than one partner.

All knowledge and awareness of HIV is forgotten at this point.

Availability of partners

Some respondents, including both men and women, argued that they had to have more than one partner in case one disappointed them, i.e. was not available when wanted, as Mvuyi (m) explained:

Yeah, it's difficult, very difficult because some of us, think of disappointments where your girlfriend disappoint you, by if you go and look for her, she is not available, so you have been disappointed there, you go and look for another one.

Availability of the partner is a specific problem if they live some distance away, which means that the person needs a back-up closer to home. Availability is also complicated by a belief amongst some women that they should not have sex for a year after a baby is born, as the baby will suffer if she does. The way in which relationships develop and break down provides part of the explanation for the development of multi-partner relationships. Also, when a relationship ends, it is often not broken off completely, and even after both parties are in new relationships, they may still get together for occasional sex.

Social conditions in the townships

Some men gave the social conditions in the townships as the reason for having multiple partners, especially in the hostels, which were dominated by single men who had left their families in the homeland areas. Themba (m) described it as follows.

Yes, you see, you can look at conditions like hostel conditions where some people are actually without their families. So it is just natural for any man to have sexual intercourse with any woman he can get in touch with, so those men are now forced to seek someone, to even engage in cohabitation with another woman. They are forced to have sex with one woman this week or today and tomorrow or next week to have sex with another woman.

One popular discourse among the men was that there are more women than men, so men have to have more than one partner in order to keep women sexually satisfied. This statistic was not generally accepted by women and was seen as purely as an excuse for men to carry on as they like. When confronted with the demographics of his community, which gave a different

view, a male respondent, Vusi was not put off, and argued instead that the male-female ratio was still true, because many of the men were not real men.

Cultural arguments

There appeared to be a strong cultural basis for black men to have multiple sexual partners. Even after the interviewer stated that in other cultures men also often took multiple partners, respondents claimed that there is indeed a distinct cultural difference, with black people having more partners than other cultural groups. Support for this notion is consistent, as the statement from Hombile (f) indicates:

In our culture men don't believe to have one that is what we think, but if you are more informed about the other cultures you could see that with other cultures it happens, but it is not as frequent.

Nomsa (f), the school beauty queen, extended on this point during her interview:

We are used to that, that men have many women, as many as he wants, they are used to it, it is kind of part of our culture, that's right that each man should have more than one.

This notion extends to the courting rituals used as described by Jikela (m). The term love was used very lightly in this context and was often confused with sexual passion.

Okay, let me give you this example, you as white when you are interested and attracted to a woman so you ask her out for a date and first of all before you two become in love you as a man have first to demonstrate to that particular girl or woman how much can you love and take it up. So when it comes to our community we are just talking, we just go straight for a girl and tell how you feel about her, okay. It might be possible that she can agree on the first time you telling her - I like you. So that's why I can say, that's why it is so, we as men, we as Africans exploit each other.

Historically, through the well-documented institution of polygamy, men had a cultural right to have many wives. This was a common occurrence, as recently as one or two generations ago, and continues to a lesser extent today. The practice has been adapted to the modern situation by a man having many sexual partners. Vusi (m) makes it explicit in this statement:

I think that its going back to old times and people having two wives, but now the people are having one wife in the Western style and then having girlfriends outside you see.

Blaming women

Some male respondents blamed women for multi-partner sexuality, stating that women go out to seduce men and it is very difficult for a man to resist, especially as women use tricks which they know will attract men. Inutu (f) put the blame on women for a different reason, citing the side effects of contraceptive usage.

It is the things that we use for contraception like the "needle". The man finds no taste in you and then he goes to others who do not use the injection. Again, when a woman is pregnant, men do not like having sex with her because she is tasteless.

No risk if the circle remains constant

Mniniawa stated that having more than one partner made no difference as long as none of the group had AIDS and they remained consistently within the group. This circle would consist of one man and many women, so there existed a clear balance of power in favour of the man. For Kholisile (m), a sixteen year old student in Kayamandi, the major concern was to make sure that he satisfied all three of his girlfriends by visiting them at least once a week. He, however, made it clear that he would not tolerate unfaithfulness on the part of any of his partners. They would probably not all have known about each other.

Objections by women

A number of women raised their objections to and anger at what the men were doing. This was one particular point in which the two interviewers got systematically different responses. The black female interviewer was told far more about women's anger at men's unfaithfulness. Nombulelo (f) expressed the dissatisfaction generally felt by women in this statement:

This is the thing I do not understand because a man does not feel ashamed of leaving you at home and seeking pleasure outside or somewhere else.

Some of the women expressed anger at the men stating they were not trustworthy. Pakama (f) expressed it in this quote:

It is unsatisfaction, and I do not know what causes it. With women it not easy to sleep everywhere. A man can lie to you by saying I am going to this place, and then to find out too late that he is seeing somebody. A man can leave you alone for the whole night and come back the following morning with a different story like "I got drunk".

Hombakasi's (f) partner visits her once a week. Her anger also emerged:

I may leave him as it is now, he is staying with a prostitute where he is working. He comes here on Saturdays and leave on Sundays. We had broken up, but he has decided to come back to me now that I am making money. He only comes on Saturdays. When he begged to for "love – back" I agreed, to my disappointment he has gone back to this woman.

Women are clearly disadvantaged in that the social and cultural forces run against them. In most social relationship women are seen to be subversive to men and in certain common traditions as the property of the men. With a limited number of exceptions this extends to the community and social power as well. Even their power in keeping a check on their partners is reduced. It is particularly in intimate relationships that this difference in power is found. In

both communities, women were found among the political and civic leadership, and in some cases were playing leading and courageous roles in the struggle for democracy. Even in these circles men often exercised considerable power over their partners in intimate relationships. Some of the factors that did give women more power included a higher level of education, independent employment, social status and money. All these factors provided women with a level of independence, but even here such women often complained of feeling abused. This is shown in the quote above where the woman had more money than her partner, but still ended up feeling badly treated.

Nombulelo (f) jokingly considered bewitching her husband and later expressed a slightly different, more angry response:

I really do not know there is no other way. You may try to bewitch him by medicine from traditional healers, the danger may be that he may react and die.

Lindiwe (f) addressed some of the reasons why women would take on extra partners, but went on to state that it is unacceptable in the culture. As stated earlier, a woman with multiple partners is rejected as cheap and dirty:

When I ask some of them they usually say that they do it because they do not get sexually satisfied by their man. Secondly, if they feel that the man is pretending, he does not really love her. She feels like she is being used.

Economic reasons

If a woman's partner has other lovers it has serious financial implications for her, as it is likely that the male will spend money on his other partners. This is especially serious in a situation where poverty is already extremely high. It appears that as love and sex are shared, so are other resources. Inutu (f) raised the issue of money:

A man who sleeps around does not care about his children whether they get food or not. Such frustrations lead to women's sleeping around. If your man is busy with other women, you have to follow suit. You see you can only get money to feed your children from other men if your husband or man is irresponsible.

Recreation and alcohol

Another issue to be taken into account is that there is no other entertainment available in the communities. Sexuality then becomes far more important. As shebeens are the major focus of nightlife in the community, they play a strong role in promoting sexual relations. A number of respondents spoke of shebeens as being places where both men and women go to find partners for sex. The presence of alcohol and the drunkenness of those attending the shebeens accentuated their role in this regard. Alcohol is very commonly abused in both communities especially by men, but also by women. Though alcohol plays a role in life for both genders, sexism surfaced here again on the part of a number of respondents. Andile (m) expressed his

distrust of women, which he linked to alcohol use, claiming that when women get drunk they "get hot" and have affairs. This fed into his notion that if a man sticks to one partner he is still not safe, as women are unfaithful.

Arguments in favour of serial monogamy

Arguments in favour of serial monogamy were generally less sure than those against, and contained considerably less emotion. Protection from AIDS was not generally given as a reason for sticking to one partner. However, in some cases this response may have been given to the researchers due to our formal association with AIDS, and because it was the "correct" response. Regarding serial monogamy, there was a fear here that even if a person did stick to one partner, there was no guarantee that their partner would do the same, so the threat of AIDS would still exist. This undermined the motivation to strive for protection from AIDS. The strength of the argument was further reduced by the very powerful role that sex plays in the community. A common discourse among respondents was to see the situation as a choice between worrying about AIDS or continuing their previous lifestyle of having many partners and enjoying unprotected sex. Given a straight choice, the high attractive power of sex plays a far stronger role than the repellent power of AIDS. Vusi (m) put the issue very clearly in this statement:

"Hey man there is this thing called AIDS, we should try to avoid this thing", but others will say "No man, if AIDS means to stop having many partners then I will just contract it, you see"

Or as Themba (m) puts it:

When I've got a woman, ahhh contracting AIDS is something that very difficult to keep in your mind. It does not even appear. You can think about it, but you can't present it, because the woman is here.

Similar responses, although less direct, were obtained from female respondents. This may have adjusted with the increasing visibility of the AIDS epidemic. However, much of the disease remains hidden.

Love and trust within relationships was spoken of emotively as an important consideration. Drawing on a less common, but still important discourse, love was given as a reason by both men and women for sticking to a single partner. Strong romantic notions of love and faithfulness existed side by side with the demands of sexual desire and male needs. These romantic ideas were linked to the moral argument of not exploiting partners and of being faithful. Motivations concerning love, trust and romance seemed to apply more to women than to men. It is interesting that the importance of love and commitment was never put into the realm of culture by any of the respondents.

In a similar vein, some of the respondents spoke of the problem of exploitation of women by virtue of their men having multiple partners. Those who were politically involved referred predominantly to the issue of exploitation of women. However, these men acknowledged that when given the opportunity to have sex, the principle of respect for women got lost very quickly. Ultimately, there was a clear sense that sexual desire dominated all other feelings.

Sexuality

Sex was very much part of the daily life and experience of people. It begins at a young age. Some respondents put it as low as twelve for a minority, with almost everyone being sexually active by the age of sixteen. This varied according to different respondents, with the youth themselves emphasising the younger starting age and giving higher numbers for sexually active youth. Jongile (m), who explained that celibacy is treated with disrespect, spelled out the importance of sex even further. He felt that as a man if you did not have sex with a girl she would talk about you to others and your name would then be tarnished. This also appeared to apply to women.

Audience of sexuality

Sexuality had a curious double focus in that it was both public and private. It was public in that everybody knew who had many partners. Particularly if a person was popular, a watching public noted their progress through a range of lovers. The number of sexual partners to some extent determines a man's status. At the same time, sex was very private and never discussed. Youth were embarrassed to have it known, particularly by older adults, that they were having sex. This was heightened for those who were younger or at school. No children reported having discussed sex with their parents, other than to receive discipline relating to it or to be told "no". Even when parents were aware that their adolescent children were having sex and they disapproved, they found it difficult to talk to them about it. Those youth who stated that they had received instructions from their parents, reported that this had reflected a very moralistic position, which they simply rejected. So the youth's sexuality was then hidden from the parent. Respondents attached a cultural explanation to this silence.

Varying responses were obtained on the subject of discussing sex amongst friends. Some of the respondents denied having discussions about sex even in their peer group. Others seemed to speak about it openly, or at least about potential sexual partners. Jongile (m) explained the origins of his knowledge about sex, which is likely to be a typical experience:

Sex, I believe sex is a thing that happens by itself, between you. You will know about sex without being told about sex. That is how I learnt about it. I wasn't told about it by someone else, it happened to me. Most of the time I discuss it,

AIDS, with my friends you know, we discuss about girls, and those kind of things and you find out about sex positions, what you call styles.

Conversations about sex with partners seemed to be dominated by arrangements for sex or seduction, but as relationships grew so the discussions became more open. Some respondents had spoken to their partners about condoms, STDs, AIDS and pregnancy. Others found it very difficult to talk to their partners about sex at all. The youth seemed to find it easier than the older generations did.

A further public aspect of sexuality involves living conditions. People live in cramped conditions, so it is often not possible to have a private space in which to have sex. Married couples will often have their children with them in the same room. In the hostels, many families sometimes share a room, with an entire family sleeping on a single bed. In the course of the research done in developing the sampling frame, it was found that one family of nine shared a single bed in a two-bed room where another person also slept with his partner. Inutu (f) also gave her feelings as a hostel dweller:

We are used to it. It does not bother us at all. Once you have the desire to have sex you lose the feelings of being ashamed. Sometimes if your man is working at night then you have no choice but to make love during the day. It is again nobody's business what is going on in my bed.

Influence of peer groups

This mixture of secrecy and publicity creates an interesting picture around the role of sex and knowledge about sexuality both in these communities and within reference groups. Among peer groups, there is considerable pressure to be sexually active, and at least for men, the more sexually active you are, the higher your status. Mniniawa extended this understanding by stating that the more partners a person has the easier it is to get more. Themba (m) gives a particularly strong impression.

It is even limitless, the more they engage in love affairs with young girls the better for themselves, because it will mean that he, they will be recognised by his peers. Cause it can be an embarrassment (to have none or even only one partner), it is an embarrassment and you will be laughed at by other boys and girls. So if you have got more love affairs, if you have four or five girls then as a young man you can be recognised as a person who is attractive to women.

Differences between the social positions of men and women

In terms of gender there was a large power difference in which the male right to sexual pleasure was dominant. This was spelt out by Hombile (f) during the interview when asked, "What would happen if a woman confronted a man and said I don't want you to sleep with any other people, if you sleep with any other people I will leave you?" Hombile's response was that the man would say "leave me". Clear gender discrimination applied to women in

terms of multiple partners, as the commonly cited double standards came into play. As Popololo (f) stated

Those customs of a man is allowed to have more than one girlfriend. That is bad. Instead of being condemned people say "Oh this is a playboy" because he's got medals, because he's got more, he's got many girlfriends. If you are a woman whose got more than one boyfriend and people know about that then you've got a bad name.

If a woman had many partners she was considered to be cheap. Dimakatso (f) described it as follows:

It's bad, it is not accepted, and who will marry you one day. Because by having different boyfriends like a certain girl walking down the street and in the end everyone will say that "I also was there one day, I know her very well". Now what kind of name will stand that?

Another example of the sexism, which prevailed within relationships, was that the pressure was more on women to satisfy the men sexually than vice versa.

There was a perceived battle for supremacy in sexual relations. In this there were assumptions among men that their women were having affairs so they also had to have affairs, and vice versa. These two quotes by a man, Themba, and a woman, Hombile, in turn gave an indication of the processes involved.

Yes, it is so that if a man has not got another lover. Oh he will be laughed at by others. It is felt that at least a wife must have some form of competition. If she is alone then she will undermine you. So she must be suspicious that you are having a love affair with another woman.

Once you find that your man is running around with women you start looking around for another man, so you see we don't wait you see we don't have this thing about a relationship until it's consciously still, but having been not stable we have to run around, kissing a lot of frogs.

On balance the power relations clearly favoured the men.

Some men claimed a vulnerability to women's seductive powers. Women would go out to seduce them, especially if the men were seen to be desirable. Some male respondents claimed that they felt unable to resist these advances. In making this claim some power is assigned to the women, but implicit within the statement was the male dominance again.

The question was raised about the apparent contradiction in which, if it was claimed that the men had many partners and women had few, this could not be possible, especially given that sexual relations were almost exclusively heterosexual. Somebody had to be lying or covering up or perhaps different concepts exist as to what constituted sex. Among the respondents, sex

was seen as full intercourse and nothing else was considered to be a sexual interaction. Suggested solutions to this contradiction, such as that of the men going to other communities, were clearly incorrect, as it would imply that in these other communities, women have more partners than men. Alternatively, there could be a small group of women who service large numbers of men. While this may be partly true, it cannot be the full explanation. This statistic needs to be kept in mind when looking at the data on the number of partners that men and women have. The answer may lie in the perceptions that the respondents wish to create, i.e. of men being play-boys and of women wanting to appear faithful.

There was very often little consideration of women in sexual encounters. One example raised by Madodo (m) shows a situation in which a young girl was taken advantage of.

Ja, for instance to give you an example, there was a child, this child was fourteen years old, she is doing standard five, they realised that she is pregnant, she was indeed pregnant because she had sex with five males, but they didn't know the child's father, she doesn't know what to do I'm saying to you that if you are big and beautiful then I take you. We are not concerned about your age, we are concerned about our feelings.

Role of power in sexuality

Having access to power makes it easier for a man to find multiple lovers. From the interviews it appeared that those with access to political power, via leadership of political organisations, or those who were sporting heroes, or had lots of money, gained more lovers. This power, which was generally translated into having multiple partners, was indicated in a number of interviews. Mvuyi (m) talks of his experience as a soccer player.

In the soccer team, Oh! That is difficult. In the soccer team, you see they are so popular that, they are ball players, understand, all the girls are after them.

This is not to say that all people with political power, or in other leadership positions took advantage of this to attract many lovers. Some seemed to remain with one partner. However, this implication also emerged that women are often attracted to promiscuous men, as they appear powerful and attractive.

As was stated in an earlier quote, the more partners a person had the more powerful and important they were seen as being. Sexuality is therefore tied very closely to power. In one case where a man was in a senior position and did not take additional partners, there was gossip that he was henpecked by his wife. The latter assertion could come from other bases, so a direct causative link cannot be established, but the association remains interesting.

Assertion of power by a woman was also not considered acceptable.

The role of money in attracting partners was also an important source of power as Nomfundiso (f) stated:

Women go for men with money, then they end up sleeping with many different men in order to get more money.

The issue of women getting material gain or prestige from sexual relationships was an important one. This should not necessarily be considered as commercial sex, but they would receive presents from a rich lover or assistance in their own or their children's upkeep. They would not have considered themselves to be commercial sex workers. Ayanda (m) raised a particular issue about female students who are courted by middle aged men.

You find others, particularly girls at the school. They would have boyfriends who are not at school, who are outside, either working or are in love with people who in one or the other way could be identified as distinguished people. Either in a material or another way.

Obviously there were also the commercial sex workers, who are perhaps the group most vulnerable to AIDS. Many of these sex workers have been forced by circumstances to do this work to survive, which made it more difficult to resist unsafe sexual practices.

Courting rituals

Sex was given as being an integral part of any loving relationship, by all the respondents. As soon as the youth start to fall in love, they begin to have sex. Oriba (f) extended this point:

Sex is the first priority in every relationship. Yes, it is like that in every relationship. A relationship between a man and a woman is symbolised by sexual contact or activity.

Some girls in the students' focus group acknowledged and complained about this, demanding that love should not equal sex and that women should be shown more respect.

Mvuyi (m) described the process of courtship as follows:

OK, this is not difficult, because if you see a girl and you like her the only thing you can do is go to her and tell that you love her, because if you go home and sit there she won't know that you love her, you understand, so you have to go there and talk to her, telling her, trying to show that you love her, understand.

This initial process will include compliments and chatting. It may continue for up to a month, but is generally completed quickly as this quote from Xoliswa (f) indicates:

He asked that we fall in love and I agreed. We did not waste a lot of time begging one another.

Peers play an important role, as a peer reference group system is sometimes used to decide on partners. Madodo (m) spoke about this in his interview.

... she is in a stage which she is undecided, now she doesn't know how to make a decision, she goes to her friends and her friends say he is cuteWe are going to talk to our friends and asking advice and then he will give me advice.

This was strongly reinforced in the students' focus group who took it further, saying that ultimately there are few lovers' secrets, as almost everything is discussed. In the light of this, the fear of suggesting the unusual, such as a relationship without sex, becomes more understandable. Madodo extended the point on courtship to talk about the threats that are subtly incorporated into this process.

The problem with us you see, the problem is that I say to a lady which I'm in love with if they don't want to go to bed with me then I will go to the others and then she can be afraid because the others will talk badly about her. But it is naughty, it is one person's decision and at that time he is forcing her to bed.

The man is almost always the one in pursuit and exerting the pressure. It is seen as a good thing and as being masculine to take a woman by coercion and threats; a number of respondents gave stories of such incidents. This behaviour can be regarded as an extension of the male-dominated ideological framework in which sexual interaction takes place. The syndrome has already been addressed above and reappears regularly throughout these results.

Condoms

Almost all the respondents had heard of condoms and many had stories to tell about them. However these were seldom used, and no respondents acknowledged using them on a regular basis. Condoms had not fully entered the lives and consciousness of the two communities. This had an impact on their perspective, especially in relation to their experiences of condom usage and the manner in which this is negotiated with a partner. Often the ideas expressed were not well formed and there were a number of discrepancies in the way condoms were spoken about. The overall sense was that they were not acceptable, either at a cultural or at a personal level. Respondents from both sexes claimed that it was the other gender that did not want to use condoms. Popololo (f) put the position like this

But they haven't changed. Ja (yes). They want their boyfriends not to use condoms. On the other hand their boyfriends don't want to use condoms.

The nurses from the clinic in Kayamandi said that some of the youth came in for condoms, but most did not want to use them. Popololo (f), the receptionist at the FAWU clinic, claimed that those from Mbekweni who came to her clinic did not want to take condoms.

They know about AIDS, but they don't want to use the condom. To use the example of those that come to visit, I say "Take some, they are free". They don't

pay anything, they don't want to take them. I say to them "Are you not afraid, not scared of AIDS?" They say, yes, they are, but they don't want to use the condom.

She went on to give the example of her brother who has lots of girlfriends, but laughed when she suggested that he use a condom. She pointed to a difference between black and coloured patients, saying that the coloured youth would use condoms, but not youth from Mbekweni. Nomfundo (f), could not persuade her partner to use condoms, even when she introduced motivations around her child:

No, I once brought condoms to him, the present boyfriend, because I was still breastfeeding and I was thinking that I will get diseases from him that affect my baby (baby was from a previous lover). He totally refused to use condoms. He said he does not like them. Then I decided to stop breast-feeding the baby, rather than not having sex.

Knowledge of condoms

There was a general superficial knowledge about condoms, but in some cases later on in the interview, respondents acknowledged that they did not know how to use them. The scientific knowledge that was available and mentioned was that condoms could be used to prevent pregnancy and AIDS, that a condom is used as a sheath over the penis, and that it is made of rubber. Other than for a minority of respondents who had special training or who had gone out of their way to find out about condoms, this information remained at an abstract level. It appears that some of the residents had never come into contact with a condom. Some had more knowledge than others and had been shown at the clinic how to put on a condom. Others had touched them and blown them up like balloons, using them as toys. Pakama (f) exemplifies the lower levels of knowledge.

I have never seen a condom, but they say it is like a balloon, but I do not know its usage.

There were a number of incorrect notions about condoms. One particular fear was that the condom could slip off the man's penis during sex and get stuck inside the woman.

Access to condoms

Access to condoms is an important area of knowledge. It was generally known that condoms could be obtained from the clinic, but a barrier in this regard existed for almost everyone; this pertained to embarrassment about sexual matters, especially in the context of the high visibility of the clinic. One of the guidance teachers (f) outlined the problem in obtaining access.

I think maybe if one can sort of,, can sort of provide them with these things (condoms) you know, because I think going to the clinic and asking for condoms they feel, you know, ashamed to ask for something like that.

It was generally stated that it was difficult to go to the clinic, as they were afraid the nurses would ask them questions and mock them. One student, Meshack (m), stated that the nurses would not give him condoms when he had been to the clinic previously:

The problem is that the nurses at the clinic are very unkind. Sometimes they even refuse to supply us with condoms. They say we are troublesome. They think that we are not serious if we want condoms.

Reluctance of the part of the community in going to the clinic for condoms also makes it difficult to provide education on their use, as schools, churches and parents often do not feel comfortable about doing so. In addition, clinics were often not allowed by these authorities to provide education on condom usage in more accessible venues. Respondents were generally not aware of the availability of condoms in shops, which was another factor in limiting their accessibility. Even given the knowledge of availability of condoms in shops, the cost issue was a problem. The cost of buying condoms is out of peoples reach, even when subsidised, especially given the low average income and high levels of unemployment in both communities.

Motivation for using condoms

There were very few positive attitudes towards condoms, apart from the fact that they prevent AIDS and STDs. This message was very clearly known in the community, but as described in the previous section, it has very little influence. From the interviews it appeared that those who had direct contact with PWAs were more likely to use condoms. Some indications of increased usage were noted. Bongani (m), one of the principals interviewed, reported that a Grade 6 boy, brought to him by a teacher for having a pocketful of condoms, claimed he had them so that he could protect himself from AIDS. However, his having been brought to the principal may have reduced the likelihood of his using condoms in the future.

In the student group the exploitation of women by men who wanted many partners was given as a reason for condom usage. Lindiwe (f) felt women had no choice but to get men to use condoms, as they cannot be trusted. She and her partner had been using condoms, as she did not trust him, and they only stopped for a while so she could get pregnant. She was nine months pregnant at the time of the interview. The situation was however unusual and women generally did not have that power.

I do not know, but we have no choice, we as women want to be protected. More so because you can never trust a man. You do not know his activities if he is not next to you. It is therefore good for women to encourage their lovers to use condoms.

Where condoms were used, it was often by couples during a period when one or both had an STD. Then condoms would be used for a couple of weeks until the disease was cured, after which usage would stop. As will be seen later on in the presentation of findings around responses to STDs, even these instances did not happen often, as a person with an STD would seldom acknowledge it. One person spoke about condoms being used as a contraceptive, but this was not commonly reported.

Sexual Pleasure

The major block reported to condom usage is the reduction in sexual pleasure, feeling and sensation. Some of the respondents became quite eloquent in their refusal and disgust. Humour was also used to reject them, as Molefi (m) stated:

..... they tell you won't feel anything of what you are doing, if you are using plastic. People just tell you, "You cannot wear a raincoat when there is sun."

The argument, as Pumla (f) and other respondents expressed it, was that they wanted flesh to flesh and this applied to both men and women. Some of the female respondents also stated that they wanted to feel the man's sperm inside them, and the condom robbed them of that sensation. Nomfundo (f) made this point in her interview:

They say you don't fully enjoy sex. People want to feel the sperms when a man is ejaculating.

Both sexes believe that a condom limits the experience of sex. A number of respondents also spoke of condoms being unnatural. One guidance teacher Nomfuzo (f) reported on a discussion she had overheard among some of the pupils at her school.

There is one class, they do talk about AIDS and some of them they didn't really, a few of them they didn't really like the idea of using condoms because they said its not natural you know and things like that, but for their safety they understand that they should. They don't agree with the idea of using condoms.

The students generally complained that condoms disturbed sex. It was one of the areas in the interviews where there was almost complete agreement across all the respondents. Nobody wanted to use condoms.

Image

Condom usage also has implications for the youth in relation to their perceived sexual image. Wanting to use a condom reduced a person's status. Fears of rejection existed in any case, and wanting to use a condom could add to these fears. Madoda (m) stated that this applied in all situations, but was especially difficult to introduce with a new partner.

It is difficult, I think the reason why it is difficult (to suggest condom usage) they are afraid of ending relationships (rejection), that's the main reason. The

second one is that if I talk about condoms she will think that I only want to use her.

Themba (m) also addressed the above point and then went on to state that the fact that you wanted to use a condom could become generally known and could undermine the person who wanted to use one in other circles as well.

If you use it with one woman and she should tell others so you will find that they will be talking about you and gossiping.

Condoms seen as not effective

One of the students in the focus group felt that condoms were not very secure, were too big or too small, and did not fully protect you from diseases. There was some support for this view. However, when one boy in the group raised these arguments, it was interesting that the response from at least one girl was that he was trying to find excuses. Mniniawa (m) argued that the condoms put in the township were faulty, so it did not matter whether he used them or not, as they would break. He based his argument on a political basis, claiming that reject goods are given to blacks within SA or are passed onto Africa by richer countries.

Political issues in relation to condom usage

Old political arguments may still have an effect on peoples' thinking, as is shown in the quote, giving an additional dimension to the resistance to condom usage. Themba (m), an older member of the community, raised the issue, but without much conviction.

You see these condoms have been introduced long ago for control of birth. They were actually perceived by our communities as a way of trying to prevent or trying to reduce the numbers, so since that time a person thinks that the white government is trying to actually reduce the numbers so in the final end they would permanently be in power. So that is why you will find that the use of condoms is not yet popular.

This perception was no longer part of the general discourse, and so may be fading as a real obstacle to condom usage. When mentioned it was often a red herring, hiding other, deeper reasons for resistance.

Mniniawa (m) raised a similar point, but put additional abstraction and analysis into the issue by reflecting on how it may be seen at a grassroots or cultural level, which would undermine the potential for condom usage.

See I mean, in the Western world the condoms are frequently used by millions, trying to protect themselves from the virus. But when you come to Africa or Africans, it is becoming more difficult for the male to decide to use a condom. It is very difficult, there are a couple of aspects within sex. We feel as if people are, you know most people who are saying these things do not understand our culture. It's customary, well known that to enjoy sex you have to, to have sex

without anything, not with anything. It is becoming difficult to reach these people who are; as you see, condoms to them is something undermining for their sexual strength and spirit, you know. It is becoming like that. It is difficult to ask them to use a condom, maybe not difficult to the people who have been to school and education, who are studied. But the general masses, on the ground, it is difficult.

Trust Issues

An additional problem was that of trust. If one partner insisted on using a condom, it implied that you did not trust your lover, or that you were doing something wrong that required that you use a condom. Nkululeko (m) enhanced this point:

The main reason is that of trust. Sometimes they think you want to use a condom because you do not trust them. To them using a condom is an insult.

The issue of trust was raised as an argument against using condoms. Trust was then extended to love: if you loved and trusted someone you didn't have to use a condom. It was interesting to note that one of the major arguments for serial monogamy, i.e. love and trust, was now used as an argument against another safer sex behaviour, namely condom usage. The option of researching the partner's previous history before having sex, as an alternative to condoms, was raised often and seems to be a regular practice. One person in the students' focus group suggested that one's partners should go for an AIDS test. It was worth noting that he himself was not prepared to go for the test.

Power in relation to usage

The power to initiate condom usage was a controversial issue. Some respondents, both men and women, stated it was okay for women to ask that condoms be used, but the social discourse indicated that it would be very hard for woman to push for a condom to be used. There were very few women who would insist on condoms being used, and they were predominantly in the professional class. The difference in power between the genders was shown more clearly in this quote about negotiation around the use of condoms:

People who are going to use condoms, we don't tell our girlfriends we are going to use this thing, we just unilaterally decide we are going to use this.

This quote from Nombulelo (f) gives an overall perspective on the interactions around condom usage:

My husband will beat me if I suggest that he uses a condom. I know he hates condoms.

In the interview it was clear that she would also want to know why, if he suggested using a condom:

Of course I will ask what has made him to change his attitude towards condoms. I will have to clearly understand the reason what has brought the idea to his mind.

Golomi (f), a young student, was concerned that no protection, such as the condom, existed for women, one over which they had control. The concept of the female condom was not well known in this community and still required a considerable amount of negotiation and education for its introduction.

Other reasons not to use condoms

Mniniawa (m) explained that he did not use condoms, as he was convinced that he did not have AIDS, while all of his girlfriends had been tested and found to be HIV-negative. He recognised that it was still a gamble, as he also had many other partners for one-night stands or short affairs, and did not use condoms with them either. This was an extreme example of the point that if a community keeps its sexual activity to within its own group, and there is no AIDS there initially, they are safe. One older person, Andile (m), gave religious opposition to contraception as a reason for not using condoms. This was uncommon and unlikely to hold much weight among the youth.

Sexually Transmitted Diseases

For almost all the respondents, there was very little sense of a link between AIDS and other STDs. Where this happened it was on a comparative basis only, in terms of severity and cure. The traditional healers' group made a strong connection between STDs and AIDS in terms of methods of infection. Only the nurses appeared to know that having an STD makes it more likely that someone will contract AIDS. The subject of STDs had to be raised by the interviewer rather than the respondent in all the interviews, other than those of the health professionals. Educational campaigns had not yet taken up the issue in any systematic manner, so the lack of information was understandable.

Knowledge

STDs were part of the general community discourse, in particular, gonorrhoea or "the drop". Respondents generally based their knowledge on their own limited experience, so what information there was varied considerably. There had been very little formal education on the subject of STDs. There was however a clear knowledge throughout the communities that some diseases are transmitted sexually, especially through multi-partner relationships and by not using condoms. The general perception was that they are not serious diseases and so do not cause much concern. Fatyela (m) expressed this attitude:

Yes, I think, because I am not quite informed about such things. I think these are minor diseases that can be cured. You will find that they do not have perhaps the deterring effect on the practice of sex and in fact people are aware about those diseases and that they are not scared of those diseases. It appears that AIDS is something much more dangerous than other sexually transmitted diseases.

Misinformation

Some of the information about STDs is confused, even though it is reported to come from an expert or health professional. Mvuyi (m) showed this in the following quote:

I was taught before to call it a "diarou", the drop now they are talking about "diarou", the nurse who taught me, she said that "diarou" does not come from having sex, anyway it comes from having sex, but when one of the two partners is dirty, she doesn't wash, she doesn't look after herself, you understand, then she is going to cause to you "diarou", you have to make sure your girlfriend is clean.

A number of different theories were provided as to how STDs are contracted. From the male respondents, one popular explanation as to how a man gets "the drop" is that his girlfriend keeps her body stiff or is tense during sex. A variation of this was that it occurred if the woman held her breath during sex. Another story was that a man would get "the drop" if the woman wore her jewellery during sex, or put a safety pin under her pillow or pinned one to her night-dress. These common stories that emerged about STDs were clearly part of the local perceptions.

Meshack (m) looked for the clinic's support in this problem:

She should go there so that the nurses and the doctor could tell her the cause of the diseases and they also advise her to stop tightening her body during sex.

Another seemingly common belief was that you can get AIDS from living in dirty or unhealthy surroundings. Oriba claimed to have heard this fact on the radio. One woman, Nombulelo (f) said that

Yes, and again if you urinate where a person with VD has urinated you also get it.

While these stories were not all universally believed, they had considerable support in the communities, particularly among those with a lower educational level. One common tendency was to lay the blame for STDs on women. The notion that STDs resulted from certain habits rather than via an infectious agent, reduced the urgency that women should get medical treatment. On the other hand, as will be seen below, men were often blamed as the carriers of disease due to their being unfaithful.

Treatment

The general sense was that people would go and get their STDs treated, but there were complications that prevented this from happening or limited effectiveness.

Stigma

Having an STD carried with it a definite stigma. All the respondents made it clear that if they had an STD they would want nobody or at least as few people as possible to know about it, especially anyone in their circle. These would be a sense of feeling wrong and dirty. Lulama (f), a 14 year-old, said she would also find it difficult to go for treatment, especially at the local clinic, as it would mean acknowledging to others that she was having sex.

I do not know, but I won't feel comfortable and I would be embarrassed to be seen by others, more especially old people, they will know that we do sex.

Oriba (f) addressed the issue of hiding the infection:

The problem here is that most people hide the fact that they have a disease, and therefore it becomes difficult to tell their partners. What is worse is that a person can hide his problem and yet go on with sleeping around. With our society, men have more than one partner. Women therefore suffer a lot by getting diseases from men.

Pumla (f) explained that it would be difficult even to meet the doctor for treatment of STDs:

It would be difficult because the other people would be too shy to show the doctor what is infected.

For these reasons respondents preferred to go to clinics or private doctors outside their communities for treatment. The nursing sisters were aware of the preference on the part of those with STDs to go to other clinics, and saw it as being a result of their embarrassment at having such a disease. Some respondents raised even more serious issues about the nursing staff, whom they felt would just mock them and ask embarrassing questions. Students in the focus group complained that the nurses would demand that they be accompanied by their parents, which they would not consider. Nomsa (f) spoke of an additional fear in relation to the local nurses:

I don't like the nurses here as the nurses are from here. So the nurses will talk about her disease and spread the news all over. So it would be very difficult.

The nurses generally did not seem to be trusted to maintain patient medical confidentiality. Whether this was true or just a baseless fear was unclear from the data. Certainly, there was no proof in the results that the nurses were guilty of breaking confidentiality.

The stigma also made it difficult for the person who discovered that they had an STD to tell their partner and take them along for treatment as well. The major fear here centred around the potential for rejection. Jikani (m), giving what was probably a representative answer for the community, stated that it would be possible if you were in love with the person to go to the clinic together. However, if it were a once-off affair he would not tell her. Nombulelo (f) raised some of the problems she perceived in telling her partner that she had an STD:

I do not know because he may think that I have been sleeping with other men.
..... Yes, and if I tell him that I've been sleeping with him alone he may then feel that I am insulting him by implying that he has brought the disease to me.

Only one respondent had taken her boyfriend to the clinic to get treated for an STD and to get condoms.

Incomplete treatment

The second problem was a tendency not to complete the full regimen of treatment, which meant often that the STD was not fully cured and developed again, and so continued to be passed on to others. The nurses complained that patients stopped treatment once the symptoms disappeared.

Dual treatment systems

The last issue relates to multi-treatment, by both sangomas and medical personnel. In many cases, respondents reported they would go to both, which might cause complications between the two interventions. The treatment from the sangoma was often claimed to be better, although this perception was not universal. Nkululeko (m) gives his explanation for the use of both.

The doctors are good at making the disease symptoms (like sores) disappear, but they do not clean it from inside. The traditional healers are able to mix medicines that completely finish the disease from your blood.

Mniniawa (m) raised a further issue relating to this factor, where treatment from sangomas is a real preference, especially given the stigmas attached to STDs:

Most of them do not know, but also there are those who prefer traditional ways because in the western treatment every month or every two months you must come for treatment, bring this partner, maybe now this she's not a girlfriend, she's maybe your friend's girlfriend, then by bringing her you're exposing the relationship, that is it. Things like that, but if you go to a traditional healer in the township you can, he will help you easily you bring nobody, you just go there and get out, try to sort out the problem of the disease.

One sangoma, Funeke (f), was very emphatic about her powers:

They do come to me for treatment and I do help them. It is easy to treat it as it has clear symptoms. It shows the sores in front of the private parts. I guarantee myself with such diseases. I give the person something to rub and then I prepare drinking medicine, imbiza, for him or her.

At this point it is not clear how effectively the sangomas do manage to treat STDs. While some research has been done on traditional medicines, much of the treatment approach is shrouded in mystery. There is also not necessarily any consistency between different traditional healers in terms of the treatments used.

Conclusion

This chapter extended the context for this thesis and provided information on how people in the two researched communities saw AIDS and behaviours related to the disease. It also provides a validity check for the remainder of the data and explanations for some of the interactions between variables that will be explored later. The respondents showed knowledge of the basic means of protection, via single sex partners and condoms, and were aware that it was a potentially fatal disease. There was a low level of knowledge about STDs, especially in relation to AIDS, and uncertainty about casual spread; so further educational input is required. An additional level of sophistication in knowledge is also required in order to address concepts such as negotiated safety, the delay between infection and illness, the process of transmission from mothers to babies and other factors that provide some marginal additional protection, such as the use of spermicides. The idea of sangomas being able to cure AIDS and the denial of the presence of AIDS in their communities needs to be challenged. Clearly people draw on a range of sources of information, including those not intended as educational, to obtain meaning and to develop their own lay theories. These are often used to create the meaning that they want for themselves. Open discussion about sex and AIDS, especially across generations, is limited due to the stigmas attached to the subject matter. There are a number of barriers to improving knowledge including illiteracy, lack of access to information, messages between different educators being confused, lack of clarity of the history and origin of the AIDS epidemic, and cultural and individual resistance blocks.

AIDS was seen as something dirty and putrefying like death, so PWAs were expected to appear dirty and diseased. AIDS was generally seen as something to dread and avoid, so PWAs would be avoided and if a person had AIDS themselves, they did not want to know and certainly did not want anyone else to know. At an intra-psychic level this led to considerable denial that the disease even exists, or that it is necessary to do anything to avoid contracting AIDS. Educational messages were often problematic, as the youth could not relate

to the educators. Local educators and parents did not or felt they could not provide AIDS education.

A single partner for life was clearly not a possibility in a community where sex was a key element in relationships and perceptions of self. Explanations for wanting multiple partners revolved around a perceived need to have sex often and not to be deprived at a time such as when their main partner was not available, especially where the men were concerned. Cultural beliefs and practices were often given as an excuse or explanation of this behaviour. Social conditions of poverty, lack of resources, especially for entertainment, migrant labour, and the nature of social interactions, also fed into the need for multiple partners. Sex for men was also equal to power, but for women the situation was confused because of condemnation for perceived promiscuity. Sexuality was often tied into power issues. Some men acknowledged the abusive role that they played, especially with regard to young girls. Women complained about the double standards that applied and the relatively more powerful position that men occupied. They felt that this left them more vulnerable to AIDS and other forms of abuse. At times men tried to avoid responsibility by attempting to take on a victim role, blaming women for seducing them. If these comments are true then it is an area where women do have some power in the sexual encounter. A competitive attitude developed between the genders regarding the numbers of sexual partners that each had. There were few social factors that supported serial monogamy other than that it showed that you loved your partner and were prepared to make a commitment. This was also seen as being more politically correct. Celibacy was treated as a joke and those that advocated it were mocked. Sex starts early on in life, from 12 to 15 years of age, especially for women.

Condoms were familiar, although more as a concept than a reality. Very few people acknowledged using them. Ideas about condoms were still forming, but there was already a systematic rejection of them. This was based predominantly on their interference with sexual pleasure. However, there was still another reason for rejecting condoms; because of their role in helping to prevent both STDs\AIDS, their very use might be seen as proof of unfaithfulness, of that you suspected your partner of being unfaithful. This meant that the person might be rejected by a potential partner of suspicion of having AIDS, or being untrustworthy, or even as insulting the partner. Access to condoms was also a problem as they were provided from a very visible clinic, which went against the privacy associated with sex. There were also complaints that the nurses mocked them. Adults dominantly had mixed feelings about youth having access to condoms and thereby having to acknowledge that young people were having sex. Once again power relations between the genders had an

influence, with respondents stating that women had less right to insist on condom usage than men.

The connection between STDs and AIDS was poorly understood. STDs was a stigmatised group of diseases. People knew about them, but did not like to talk about them. If a person had such a disease it was carefully hidden, which limited proper treatment and often prevented people from notifying their partners. Fear of abuse or embarrassment from the clinic staff was another inhibiting factor where access to treatment was concerned. STDs themselves were associated with a number of misconceptions or lay theories concerning their transmission and treatment.

Overarching conclusions across all aspects of AIDS considered in this chapter include inconsistent knowledge across sectors of the community, the different levels of power, especially between genders, and the central role that sex plays in all social interactions in the community, especially in assessing social power and acceptance.

Chapter 8

Results of the first stage survey questionnaire

The results of the first stage of the survey research process were directed primarily towards the setting up of the questionnaire, but also produced some interesting information that deserves separate mention. This phase of the data collection essentially followed on from the depth interviews. Provisional analysis of the interview data was used to assist in the interpretation of the comments made in this phase, particularly in providing a context for the responses. Space restrictions reduced the reporting of the results to a description of the sample, followed by a listing of the beliefs given by respondents about serial monogamy, condom usage and the treatment of STDs. The responses generally overlapped in content with the results from the qualitative data. Responses were grouped into a category, with only the more frequently reported being given. Many interviewees gave multiple responses, so the total number of beliefs is sometimes larger than the sample size. Some of the responses were excluded when they were either nonsensical or inappropriate for that behaviour. A key point of the analysis is the overlap that was often found between the control beliefs and the behavioural and normative beliefs. However, new and key concepts did often appear in the control beliefs' category.

Sample

The sample was stratified for gender, age and nature of housing, so as to ensure that there was adequate representation from all sectors. A total sample of 67 respondents, 32 men and 35 women, was obtained. The sample is broken down in table 8.1.

Table 8.1 Description of the sample

	<u>shacks</u>		<u>hostels</u>		<u>houses</u>	
	M	F	M	F	M	F
15-19	2	3	2	2	1	5
20-24	5	5	1	5	7	3
25-30	6	3	6	3	2	6
	13	11	9	10	10	14
		24		19		24

There were no refusals to participate in the survey. This was attributed to the effort put into negotiation and the hospitality of the community.

Beliefs about serial monogamy

The behavioural beliefs will be addressed first, followed by normative and then the control beliefs. They are presented in tables, and those included in the questionnaire for the survey are in the first column.

Behavioural Beliefs

The major categories of responses are listed in table 8.2 below. The belief "less trouble and conflict" was left out as it was felt that it overlapped with "showing love for partner" and "partner becoming spoiled and disrespectful". The belief "it is morally good" was not included as it was felt that this was touching on issues that would be covered by the normative beliefs. It was important to include questions on AIDS and on the issue of "a man's perceived right to many sexual partners", because of the focus of the research, and information obtained in the depth interviews, respectively.

Table 8.2 Behavioural beliefs about serial monogamy

<u>behavioural belief</u>	<u>no. of responses</u>	<u>behavioural belief</u>	<u>no. of responses</u>
prevention of disease	24	it shows trust	8
shows love for partner	24	know sources of infections	
fear of being hurt or rejected	19	and pregnancy	7
partner will get spoiled and disrespectful	12	less trouble and conflict	16
boring or less sexually satisfying	12	it is morally good	12
avoid AIDS	11		
greediness / to boost ego / manhood	10		

Normative influences

The major categories of responses are listed below in the table 8.3 below.

Table 8.3 Normative beliefs about serial monogamy

<u>normative belief</u>	<u>no. of responses</u>	<u>normative belief</u>	<u>no. of responses</u>
family	67	other potential suitors	5
my friends	54	girl / boyfriend's friends	4
girl / boyfriend	20		
church	10		

Control Beliefs

There were relatively fewer responses to this question compared with the other inquiries about beliefs for all the behaviours, possibly because people felt that they had answered aspects of the question already as part of behavioural beliefs. The major control beliefs are listed below in table 8.4.

Table 8.4 Control beliefs on serial monogamy

<u>control belief</u>	<u>no. of responses</u>	<u>control belief</u>	<u>no. of responses</u>
love for the person	37	availability of money	2
lack of trust	20	availability of time	2
desire	11		
availability of other partners	3		
loneliness if partner is unavailable	3		

Men's beliefs about condoms

The beliefs about condoms are divided into two sections based on gender, as the nature of the safer sexual behaviour differs between men and women.

Behavioural Beliefs

The major behavioural beliefs are listed in table 8.5 below. All seven categories noted in the original table were included in the questionnaire, although some achieved only very few responses. All the responses were felt to be important to different sections of the community. The question dealing with a partner's anger was included; so as to make the responses between the genders comparative. It was also alluded to in the category "most women do not like condoms".

Table 8.5 Behavioural beliefs of men about using condoms

<u>behavioural belief</u>	<u>no. of responses</u>
avoiding disease	19
prevents pregnancy	13
unnatural / will not feel partner's body	13
loss of pleasure / satisfaction	10
partner will not be satisfied	5
shows lack of trust	3
most women do not like condoms	2

Normative influences

The normative beliefs obtained are listed below in table 8.6.

Table 8.6 Normative beliefs by men about condom use

<u>normative belief</u>	<u>no. of responses</u>
girlfriend	17
friends	16
doctors / nurses / teachers	11
family	8

Control Beliefs

The control beliefs collected are listed below in table 8.7. The first three beliefs were drawn from the top three items on the table. Knowledge of condom usage was included as it arose as an important issue in the qualitative research and was among the behavioural beliefs. It will also provide a comparison point with the female respondents.

Table 8.7 Control beliefs by men about condom use

<u>control belief</u>	<u>no. of responses</u>	<u>control belief</u>	<u>no. of responses</u>
partner will refuse	5	not enough clinics / lack of time	3
shortage of money	5	having VD and wanting sex	2
embarrassing to obtain	5		

Women's beliefs about asking men to use condoms

The behaviour of women asking men to use condoms is now presented.

Behavioural Beliefs

The major categories of responses are listed in table 8.8. Some attempt was made to use similar questions for both men and women for the purposes of comparison. In addition to the

more common responses, the questions on sexual satisfaction were incorporated and the wording for feeling a partner's body was formulated to apply to both genders.

Table 8.8 Behavioural beliefs by women about condom use

<u>behavioural belief</u>	<u>no. of responses</u>	<u>behavioural belief</u>	<u>no. of responses</u>
protection against disease	19	make it easy for him to	
lover will disagree / get angry	15	be unfaithful	5
unnatural \ not feel his body	13	condom may get stuck in body	4
lose love and trust	9		
avoid pregnancy	7		
lover may not enjoy sex	4		

Normative influences

The normative beliefs are listed below in table 8.9.

Table 8.9 Normative beliefs by women about condom use

<u>normative belief</u>	<u>no. of responses</u>	<u>normative belief</u>	<u>no. of responses</u>
family	25	boyfriend's friends	5
friends	24	church people	3
boyfriend	14	boyfriend's parents	2
doctors / nurses / teachers	9		

Control Beliefs

There were very few responses to this question that actually fell within the area of control beliefs. These are listed in table 8.10. The single major concern was over their partners' reaction. This overlaps here with the behavioural and normative beliefs. Based on the number of responses, it was decided to separate this belief into two questions, namely the control the boyfriend has in terms of refusing to use a condom, and the fear of asking the boyfriend to use a condom. These two questions take into account the different aspects of the control belief mechanism. Knowledge of condom use was included, as it received some responses and is a fundamental aspect. It also drew additional responses as part of the behavioural beliefs. Some control beliefs in the survey differed from the questions put to males, as the gender comparison seemed to be very different.

Table 8.10 Control beliefs by women about condom use

<u>control belief</u>	<u>no. of responses</u>	<u>control belief</u>	<u>no. of responses</u>
reaction of boyfriend	21	trust partner, so not necessary	2
poor knowledge of condom usage	3	embarrassment	2

Beliefs about treatment of STDs

The beliefs that the respondents gave about getting rapid and effective treatment for STDs are covered below. The responses from both men and women are included in this section.

Behavioural Beliefs

Table 8.11 lists the major categories of responses. The two categories that dealt with the issue of embarrassment were thought to be covering the same material, so were combined into one statement for the questionnaire.

Table 8.11 Behavioural beliefs about treatment for STDs

<u>behavioural belief</u>	<u>no. of responses</u>	<u>behavioural belief</u>	<u>no. of responses</u>
cure	54	traditional healers better	4
prevent spreading of the disease	28	with an STD you have	
other people finding out	11	to stop sex	2
fear of painful treatment	9		
prevent development of the disease	7		
embarrassment with nurses	6		

Normative influences

The normative beliefs are listed in table 8.12.

Table 8.12 Normative beliefs about treatment for STDs

<u>normative belief</u>	<u>no. of responses</u>	<u>normative belief</u>	<u>no. of responses</u>
family	48	traditional healers	3
sexual partner	43	church	1
friends	31		
medical professionals	10		

Control Beliefs

The control beliefs are listed below in table 8.13.

Table 8.13 Control beliefs about treatment of STDs

<u>control belief</u>	<u>no. of responses</u>
cannot afford treatment	28
embarrassment during treatment	15
fear of treatment	14
lack of transport	2

Conclusion

The results for the first phase of the TRA and TPB methodology gave the question content for the survey and so will be explored in more detail there. In serial monogamy, prevention of disease and issues involved in the relationship were clearly the most important factors.

Relationship issues, such as love and trust, were the most commonly raised control beliefs.

Issues of sexual satisfaction were also raised. Family and friends appeared to be the most common normative influences. For men, the most common behavioural beliefs about condoms reflected issues of avoidance of disease and pregnancy, as well as concern about their interference with sexual pleasure. While these beliefs were also important for women, concern about their partner's reaction was also raised. The most common normative influences for men were their partners and friends, but for women, the family was given more often than either of these two. Men raised very few control beliefs, and those centred on

access to condoms and their partner's reaction. In contrast concern over how their partners would react was expressed by the majority of women. Behavioural responses concerning the treatment of STDs showed concern about cures and for the prevention of further spread of the disease. A smaller set of responses showed fear of others finding out and of the nature of the treatment. Again family, friends and sexual partners were the major normative influences. The major control beliefs covered access to treatment, embarrassment and fear of treatment.

Chapter 9

Results of the Full Survey

Descriptive data from the survey is reported here. It provides a different perspective of the communities' views and an introduction to survey data on behaviours relating to AIDS. The results are presented in the order in which they appeared in the questionnaire. Missing values where these occurred were excluded in the calculation of percentages. Results of cross-tabulations were presented if they add something to the overall picture or were statistically significant. Significance was accepted at the 0.05 level for the chi-square tests. Due to the large sample size significance was obtained at low levels of explanation. The low level of explanation, plus the vast number of cross tabulations done, raises further questions about the value of these significance scores. Therefore only situations of systematic variation are reported, i.e. where a number of cross-tabulations support each other.

Demographics

The total sample for the survey was 406. There were 204 respondents from Kayamandi and 202 from Mbekweni. The sample was split equally between men and women, 203 of each. There were 91 respondents (22.4%) in the age group 15 to 19, 151 (37.2%) in the age group 20 to 24, and 164 (40.4%) in the age group 25 to 30. The mean age was 23.1 for the full population. The mean age for women was 22.9 (st. dev. 4.1) and for men 23.2 (st. dev. 4.1). One hundred and six (26.1%) lived in hostels, 157 (38.7%) lived in shacks, and 143 (35.2%) lived in houses.

Those respondents still studying constituted 133 (32.8%) of the sample, with those at school numbering 117 (28.8%). Twenty four had done or were currently busy with further training, eight were at technicon, four at a teachers' training college, five at university and the rest were split between nursing college, police college, computer courses and private colleges. The educational level of the sample is shown in table 9.1 below. There were three missing values.

Table 9.1 Educational level of the sample, last standard passed

<u>grade</u>	<u>no. completed</u>	<u>% completed</u>
nil	11	2.7
1 to 4	14	3.5
5	14	3.5
6	16	4.0
7	46	11.4
8	62	15.4
9	83	20.6
10	79	19.6
11	38	9.4
12	40	9.9

Educational levels were grouped according to whether the person had reached a standard that would have allowed for the development of functional literacy. Grade eight was suggested as an indicator of functional literacy by the National Language Project⁴ (1992). Grade six is the indicator in most first world countries, but grade eight is felt to be a better indicator in South Africa, because of the problem of apartheid: historically poor education was provided in black schools. In this sample, 101 (25.1%) had not passed grade eight, while 302 (74.9%) had passed this level. The education levels were provided to give a sense of people's access to information and capacity to understand some of the complexities of the HIV epidemic. It was also important to establish levels of literacy, as much of the AIDS education provided is in the written form, and therefore only a section of the population would have full access to this.

From the sample, 121 respondents (29.8%) stated that they were in paid employment. Of those employed the majority, 75 (63.1%), were at the level of unskilled manual labour or menial labour, 21 (17.5%) were employed in a routine non-manual capacity, 10 (8.3%) in semi-skilled manual work, 11 (9.2%) in skilled manual or clerical positions, and 2 (1.7%) in semi-professional positions. There were two missing values. There were 152 respondents (37.4%) who were unemployed. Of these, 99 (65%, 24.4% of the total sample) were seeking employment. Of the remainder, 34 (22.3%), either elected not to work for money, most of those being homemakers, or were unable to work for reasons of disability, illness or pregnancy 15 (9.9%). There were four missing values.

The time of residence in these communities varied from less than six months (figures were rounded off to the nearest year) to all of their lives. In addition, time spent resident in either of the communities was calculated as a proportion of total life-span. Proportion of life-time was calculated by

⁴ The National Language Project is an NGO especially involved in literacy and language translation issues.

the following equation:

$$\text{prop of life} = \text{period in community} / \text{age} * 100$$

Both sets of results are shown in table 9.2.

Table 9.2 Period of time sample resident in the community

<u>period</u>	<u>frequency</u>	<u>%</u>	<u>prop. of life</u>	<u>frequency</u>	<u>%</u>
0-1	72	18	0-10	118	29.6
2	59	14.8	10-20	91	22.8
3	39	9.8	20-30	34	8.5
4	34	8.5	30-40	24	6.0
5-9	62	15.6	40-70	27	6.8
10-14	22	5.5	70-90	20	5.0
15-30	111	27.8	90-100	85	21.3

There were seven missing responses. As can be seen from the data a considerable section of the sample was very settled in the community (26.31%). There was also a high recent influx into the communities, 52.4%, who had lived there for less than 20% of their lives. For the cross-tabulations, those who had been in the community for less than 20% of their lives, were compared to those who had been there for more than 90% of their lives.

Kayamandi and Mbekweni were very similar in terms of gender distribution and educational levels, but there were considerable differences in terms of housing. A higher proportion of people in Kayamandi lived in hostels 63 (30.9%) and shacks 101 (49.5%), than in Mbekweni with figures of 43 (21.3%) and 56 (27.7%) respectively. In turn a higher percentage of people in Mbekweni were living in houses, namely 103 (51.0%) as against 40 (19.6%) in Kayamandi. The age profile of the communities differed as is shown in table 9.3 below.

Table 9.3 Age profile of the Kayamandi and Mbekweni

	<u>age</u>	<u>no.</u>	<u>%</u>	<u>age</u>	<u>no.</u>	<u>%</u>	<u>age</u>	<u>no.</u>	<u>%</u>
Kayamandi	15-19	34	(16.7%)	20-24	77	(37.7%)	25-30	93	(45.6%)
Mbekweni	15-19	57	(28.2%)	20-24	74	(36.6%)	25-30	71	(35.2%)

Considerably more of the respondents in Kayamandi had recently moved into the area, with 143 respondents (61.9%) having spent less than 20% of their lives in Kayamandi, as against Mbekweni, where the figure was 66 (33.0%).

Cross-tabulations of demographic factors with other variables

The demographic variables of educational level, community, period of urbanisation, age and housing were cross-tabulated with all of the other variables in the survey. While some significant correlations were found there were very few systematic relationships uncovered. Most of these individual significant correlations are therefore not covered as it is possible that many of them could be due to chance, rather than being a genuine reflection of the reality on

the ground. Even variables where a difference was strongly expected, such as levels of literacy, no systematic variation was found. The only demographic variable that showed some consistent and systematic variation was gender. The data of the two communities was compared particularly carefully, but was found to be similar, so the data was pooled for all further analysis. The aspect of gender will be addressed at various points in the individual sections and is addressed again in the conclusion of the chapter.

Knowledge

The sample's knowledge about transmission of AIDS was better than expected, given the early stage of the epidemic in the Western Cape and the lack of co-ordinated educational campaigns in these communities. However, there does remain some confusion around casual transmission. Of 406 respondents, 304 (74.9%) were aware that AIDS could not be transmitted via the use of an unwashed cup, nor via kissing a person with AIDS 272 (67%), or touching someone with AIDS 329 (81%). Those able to identify the correct modes of transmission were as follows: via sexual intercourse, 400 (98.5%); and from mother-to-child, 342 (84.2%). Three-hundred-and-twenty-one respondents (79.1%) were aware that you could get AIDS from someone who looked healthy, but had the virus. That there is no cure for AIDS was identified by 273 (67.2%) of the respondents, with 53 (13.1%) being unsure. Two-hundred-and-thirty-one respondents (57%) stated that all people who were infected by the virus would die of it. One hundred and thirty nine respondents (34.4%) stated that many or most people would die, 25 (6.1%) that few or none would die, and 10 (2.5%) were uncertain. At the time the research was done, most or all of the people who contracted HIV expected to die of it. More recently, multi-drug treatments have added hope of a longer life for those infected or that AIDS could become a long-term manageable disease.

In response to the question on appropriate protection behaviours to be used against transmission of AIDS, respondents identified the following: using condoms when you have sex, 225 (55.4%); sticking to one sexual partner for life, 301 (74.1%); reducing the number of sexual partners, 32 (7.8%); treating STDs as soon as they arise, 37 (9.1%); going to see a doctor, 91 (22.4%); going to see a traditional healer, 11 (2.7%); and being tested for AIDS, 54 (13.3%). Unprompted responses included the following suggestions: from five people, that you should not have sex; from two that you should not fall in love; two said "no sex before marriage"; three said it was better "not to have sex with a person who is HIV-positive"; and one that a person should "not use a needle that a person with AIDS has used". Three-hundred-and-sixty-three respondents (89.4%) knew what a condom was; while 41 (10.1%) did not know what it was. In the next chapter, for the purposes of analysis on the effect of differences in knowledge level, the sample will be divided between those that got eleven answers or less

correct, who are labelled “low knowledge”, and those who got twelve or more correct, labelled “high knowledge”. The basis for this distinction was that this score came the closest to dividing the population in half. The division was therefore drawn more on a convenience basis than an analysis of what the different knowledge scores would have meant to their capacity to make decisions on safer sexual practices.

There was very little difference between men and women in terms of levels of knowledge, with only two questions obtaining a significant difference at the 0.1 level. More men knew what a condom was (92.6%) as against 86.2% of women, and had slightly better knowledge about them. More women knew about vertical transmission (88.7%), as against 79.8% of men. Some differences in knowledge about protection are shown in the table below, but this was inconsistent. Table 9.4 below presents the full set of results on the issue of knowledge, comparing men with women. The significance was calculated using a Chi Square test. No significance tests were done on the results of the questions covering protection from AIDS.

Table 9.4 Knowledge scores divided by gender

questions	answers correct		significance
	men	women	
modes of transmission			
drinking from a cup used by a person with AIDS	145 (71.4%)	159 (78.3%)	0.232
kissing a person with HIV	127 (62.6%)	145 (71.4%)	0.159
mother-to-child transmission	162 (79.3%)	180 (88.7%)	0.039
touching a person with the virus	164 (80.8%)	165 (81.3%)	0.588
sexual intercourse with a person with HIV	199 (98%)	201 (99%)	0.604
have virus but look healthy	154 (75.9%)	167 (82.3%)	0.204
can AIDS be cured	139 (68.5%)	134 (66%)	0.856
would a person with AIDS die of the disease	135 (66.8%)	142 (70%)	0.144
protection from AIDS			
using condoms during sex	113 (55.7%)	112 (55.2%)	
one sexual partner for life	142 (70%)	159 (78.3%)	
reducing the numbers of sexual partners	22 (10.8%)	10 (4.9%)	
treating STDs rapidly	185 (91.1%)	184 (90.6%)	
going to see a doctor	159 (78.3%)	156 (76.8%)	
seeing a traditional healer	198 (97.5%)	197 (97%)	
being tested for HIV or AIDS	183 (90.1%)	169 (83.3%)	
knowledge of condoms	188 (92.6%)	175 (86.2%)	0.067

Intentional Behaviour

Likert-type scales were used to collect this information, as for most of the rest of the questionnaire, excluding the questions on past behaviour. For the purposes of clarity, in this descriptive section, the categories “extremely true”, “very true” and “true” will be collapsed into one category of “true”, and similarly for all the categories of the term “false”. Similar collapsing of categories was used with the other response gradings used for Likert Scale-type questions. The collapsing of the categories is supported by the statistical analysis described as

part of the methodology in Chapter Six, in which it was indicated that the participants did not distinguish between the different levels of positivity and negativity. Responses of “not sure” will not be addressed directly, unless these form a significant proportion, but will be incorporated in the calculation of percentages.

The full responses to the questions on intended behaviour are given in Table 9.5

Table 9.5 Intentional behaviour of respondents

<u>behaviour</u>	<u>will do it</u>	<u>not sure</u>	<u>will not do it</u>
serial monogamy	394 (97%)	3 (0.7%)	9 (2.2%)
condom usage, men	149 (73.4%)	7 (3.4%)	47 (23.2%)
condom usage, women	166 (81.8%)	10 (4.9%)	27 (13.3%)
treatment STDs	401 (98.8%)	3 (0.7%)	2 (0.5%)

Of those who stated that they intended remaining faithful to one partner the majority, 204 people (50.2% of the total), gave the response “true”, the least emphatic agreement. This finding may be important as the response is out of line with what was expected in terms of the qualitative data. When the responses indicating that they would comply with serial monogamy were divided according to gender the following responses were obtained: men, 196 (96.1%) and women, 199 (98%). The positive responses to the option of obtaining treatment for STDs were very strong. When divided according to gender the responses were as follows: men, 201 (99%) and women, 200 (98.5%), intended to seek treatment for STDs if they became infected. Again, these positive responses were very different to the results obtained in the qualitative data and what was expected from the reports of this behaviour in the literature. There are a number of possible explanations for this difference drawing on the difference in methodologies used. Two particular explanations will be addressed here, but this variation may require further research. Firstly, it is possible that the two methodologies actually ended up measuring different constructs. In the qualitative interviews the focus may have been around the person’s sexual and social behaviour so the intentions that arose would have reflected this reality dominantly. In the survey the focus fell on their response to HIV, so the intentions would have reflected their genuine intention to avoid infection and to reduce their risk. A second option is that the respondents gave false answers either out of a sense of embarrassment at having to answer questions about their sexuality, or gave answers that they felt the researcher wanted to hear. The second option implies that the qualitative data is correct and the survey data incorrect, which is an assumption, based on the support of the qualitative results in the literature. This variation in results between the qualitative and survey data is repeated for much of the rest of the information in this chapter. It remains difficult to understand what lay behind this difference in results.

Attitudes

There were five attitude items used. These were summed to get a total attitude score. The items were scored from the most negative of 1 to the most positive of 7. These summed scores therefore had a range between 5 and 35. A score of less than 20 indicated that the person had a negative attitude towards a particular behaviour, and a score over 20 indicated that they had a positive attitude. The closer the score was to the extremes, the stronger the attitude. However the problems that respondents had in distinguishing the different points on the Likert Scale may undermine the distinction. The respondents gave very positive attitudes towards safer sexual practices. There was also very little uncertainty, in that very few responses of "not sure" were found in any of the four sets of attitude items; e.g. the range was between 0 and 4 responses (2%). The responses over the five items to questions of serial monogamy showed that fewer than 15 respondents (4%) expressed negative feelings about having only one sexual partner at a time. The mean summed score was 28.18 with a st. dev. of 3.04. The scores ranged from 11 to 35. The attitude of men to condom usage was mildly, but generally positive. The mean summed score was 25.12 with a st. dev. of 6.42. The scores ranged from 5 to 35. The attitude of women to using condoms was more positive than that of the men. The mean summed score was 26.98 with a std. dev of 5.11. The scores ranged from 8 to 35. The attitudes towards the treatment of STDs were extremely positive. The mean summed score was 28.84 with a st. dev. of 2.94. The scores ranged from 5 to 35.

Outcome Evaluation

Results for outcome evaluations provide a measure of the value that the respondents assigned to the potential outcomes of their behaviours. For the purposes of presentation, the questions have been grouped in common categories, and so do not follow the questionnaire strictly. The results of each category are presented in a table and then the variation within each is discussed. The first group of questions deals with protection from disease and pregnancy. The results are shown in table 9.6.

Table 9.6 Value assigned to being protected from disease and pregnancy

<u>outcome protection from</u>	<u>good</u>	<u>not sure</u>	<u>bad</u>
STDs	381 (93.8%)	7 (1.7%)	18 (4.4%)
AIDS	378 (93.1%)	12 (3%)	16 (3.9%)
pregnancy	337 (83%)	24 (5.9%)	45 (11.1%)

The responses indicated that issues of protection were seen as being important.

The results of the questions dealing with love and trust in relationships are given in table 9.7.

Table 9.7 Value assigned to issues of love and trust in a relationship

<u>outcome</u>	<u>good</u>	<u>not sure</u>	<u>bad</u>
having a partner who is disrespectful	34 (8.4%)	14 (3.4%)	358 (88.2%)
showing true love for partner	349 (86%)	7 (1.7%)	50 (12.3%)
protection against hurt if partner leaves	259 (63.8%)	17 (4.2%)	130 (32%)
showing trust in your partner	308 (75.9%)	15 (3.7%)	83 (20.4%)
having partner angry with you	50 (12.3%)	17 (4.2%)	339 (83.5%)

The results of the questions dealing with sexual satisfaction are given in table 9.8.

Table 9.8 Value assigned to sexual satisfaction

<u>outcome</u>	<u>good</u>	<u>not sure</u>	<u>bad</u>
getting maximum sexual pleasure	367 (90.4%)	16 (3.9%)	23 (5.7%)
satisfying my partner sexually	378 (93.1%)	13 (3.2%)	15 (3.7%)
masculine right to many sexual partners	46 (11.3%)	16 (3.9%)	344 (84.7%)
feeling partner's body without a condom	130 (32%)	39 (9.6%)	237 (58.4%)

Sexual satisfaction was valued highly by almost all of the respondents, both for themselves and for their partners. The positive attitude to sexual satisfaction did not extend to the masculine right to many sexual partners. The strange results indicating that respondents apparently did not want to feel their partner's body without a condom is likely to be an extension of the clash with the qualitative data and first-phase responses noted earlier with similar explanations standing. There may also have been some confusion due to the phrasing of the question, despite the clearance that the questionnaire received in the piloting phase.

The results of the questions dealing with the treatment of STDs are given in table 9.9.

Table 9.9 Value assigned to treatment of STDs

<u>outcome</u>	<u>good</u>	<u>not sure</u>	<u>bad</u>
being healed of an STD	387 (95.3%)	8 (2%)	11 (2.7%)
preventing the spread of STDs	371 (91.4%)	2 (0.5%)	33 (8.1%)
preventing damage caused by STD	362 (89.2%)	12 (3%)	32 (7.9%)
embarrassed about being known to have an STD	122 (30%)	21 (5.2%)	263 (64.8%)
injections and pain from the treatment	226 (55.7%)	45 (11.1%)	135 (33.3%)

The sample was very strongly in favour of treating STDs. Again, the responses to questions about being embarrassed and the treatment being painful appear to be confused. Similar explanations relating to a concern to avoid infection or an attempt to show agreement with AIDS education messages are likely to apply. There may also have been confusion as many of the respondents had not had an STD before so would not really know what the treatment entailed.

Behavioural Beliefs

Behavioural beliefs were asked about in sections. The behavioural beliefs relating to serial monogamy are presented in table 9.10 below.

Table 9.10 Behavioural beliefs relating to serial monogamy

<u>behavioural belief</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
will protect them from STDs	372 (91.6%)	13 (3.2%)	21 (5.2%)
will protect them from AIDS	351 (86.5%)	23 (5.7%)	32 (7.9%)
partner will become disrespectful	137 (33.7%)	24 (5.9%)	245 (60.3%)
will show love for partner	365 (89.9%)	17 (4.2%)	24 (5.9%)
will be hurt if that person leaves	294 (72.4%)	27 (6.7%)	85 (20.9%)
will get sexual satisfaction	367 (90.4%)	18 (4.4%)	21 (5.2%)
will undermine male "right" to many partners	185 (45.6%)	37 (9.1%)	184 (45.3%)

The results indicate a high acceptance of the following: that serial monogamy would provide some protection against disease; would indicate love for one's partner; and would not undermine sexual satisfaction. Respondents were less certain about the following issues: fears of one's partner becoming disrespectful; being hurt; and the male right to have many partners.

The behavioural beliefs relating to condom usage for men, and requests by women that their partner use a condom, are presented in table 9.11 below.

Table 9.11 Behavioural beliefs relating to condom usage

<u>behavioural belief</u>	<u>gender</u>	<u>true</u>	<u>not sure</u>	<u>false</u>	<u>sig. level</u>
will prevent pregnancy	men	197 (97%)	2 (1%)	4 (2%)	0.539
	women	195 (96.1%)	6 (3%)	2 (1%)	
will protect from diseases	men	184 (90.6%)	8 (3.9%)	11 (5.4%)	0.562
	women	187 (92.1%)	6 (3%)	10 (4.9%)	
will reduce sexual pleasure	men	113 (55.7%)	22 (10.8%)	68 (33.5%)	0.004
	women	80 (39.4%)	29 (14.3%)	94 (46.3%)	
will mean partner is not sexually satisfied	men	123 (60.6%)	25 (12.3%)	55 (27.1%)	0.000
	women	80 (39.4%)	32 (15.8%)	91 (44.8%)	
will mean they do not feel partner's body	men	122 (60.1%)	18 (8.9%)	63 (31%)	0.000
	women	75 (36.9%)	22 (10.8%)	106 (52.2%)	
will show lack of trust in partner	men	106 (52.2%)	19 (9.4%)	78 (38.4%)	0.092
	women	95 (46.8%)	11 (5.4%)	97 (47.8%)	
will make partner angry	men	99 (48.8%)	21 (10.3%)	83 (40.9%)	0.363
	women	90 (44.3%)	21 (10.3%)	92 (45.3%)	

Both men and women were confident that condoms would prevent pregnancy and disease. On the questions as to whether condoms interfered with sexual pleasure for themselves and their partners, or reduced the ability to feel their partner's body, there were significant differences between men and women. Men felt that their pleasure would be compromised, but women were more divided. Both men and women were split in terms of their opinions, with generally similar distributions, on the issue of trusting their partner and concern over making them angry.

The behavioural beliefs relating to the treatment of STDs are presented in table 9.12 below.

Table 9.12 Behavioural beliefs relating to treatment of STDs

<u>behavioural belief</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
will get healed if treated	377 (92.9%)	17 (4.2%)	12 (3%)
will limit the spread of the disease	378 (93.1%)	15 (3.7%)	13 (3.2%)
will prevent further damage by the STD	371 (91.4%)	21 (5.2%)	14 (3.4%)
getting treatment will be painful	151 (37.2%)	42 (10.3%)	213 (52.5%)
getting treatment will be embarrassing	179 (44.1%)	23 (5.7%)	204 (50.2%)

There was general confidence that treatment for STDs would be beneficial, but there remained uncertainty about the costs, in terms of pain and embarrassment. No distinction was created between going to a clinic and a private doctor in these questions, so the responses, especially on embarrassment, may be slightly skewed.

Subjective Norms

Responses to the questions on subjective norms are detailed in table 9.13 below.

Table 9.13 Subjective norms of respondents

<u>behaviour positively viewed</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
sticking to one partner	375 (92.4%)	9 (2.2%)	22 (5.4%)
using condoms	145 (71.4%)	13 (6.4%)	45 (22.2%)
asking partners to use condoms	194 (95.6%)	2 (1%)	7 (3.4%)
treatment of STDs	395 (97.3%)	4 (1%)	7 (1.7%)

The attitudes of the respondents felt towards safer sexual practices were overwhelmingly in favour of these behaviours, but again the results were unrealistically positive when compared with the qualitative data.

Normative beliefs

The data on normative beliefs for all the behaviours is given here. Data in relation to serial monogamy is shown in table 9.14 below. The role of the church may have been confusing, as they teach that there should be no sex before marriage and one partner for life, options not provided for in the questionnaire.

Table 9.14 Normative influences on serial monogamy

<u>normative group</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
boy(girl)friend	388 (95.6%)	5 (1.2%)	13 (3.2%)
friends	308 (75.9%)	17 (4.2%)	81 (20%)
family	377 (92.9%)	13 (3.2%)	16 (3.9%)
church	337 (83%)	32 (7.9%)	37 (9.1%)

The data on normative influences on males and females about condoms is detailed in table 9.15 below.

Table 9.15 Normative influences on males and females around condom usage

<u>normative group</u>	<u>men</u>			<u>women</u>		
	<u>true</u>	<u>not sure</u>	<u>false</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
girl (boy)friend	128 (63.1%)	6 (3%)	69 (34%)	128 (63.1%)	15 (7.4%)	60 (29.6%)
friends	150 (73.1%)	11 (5.4%)	42 (20.7%)	133 (65.5%)	14 (6.9%)	56 (27.6%)
family	149 (73.4%)	20 (9.9%)	34 (16.7%)	147 (72.4%)	19 (9.4%)	37 (18.2%)
doctors / nurses	193 (95.1%)	2 (1%)	8 (3.9%)	199 (98%)	1 (0.5%)	3 (1.5%)

The normative influences on going for treatment are shown in table 9.16 below.

Table 9.16 Normative influences on getting treatment for an STD

<u>normative group</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
boy(girl)friend	401 (98.8%)	2 (0.5%)	3 (0.7%)
friends	380 (93.6%)	10 (2.5%)	16 (3.9%)
doctors / nurses	403 (99.3%)	3 (0.7%)	0
family	382 (94.1%)	21 (5.2%)	3 (0.7%)

These results show a strong normative influence towards going for treatment for STDs, with all groups giving consistent support on the issue.

Motivation to comply

The relative weights of the normative influence of each of the groups mentioned in the previous section are given in table 9.17.

Table 9.17 Motivation to comply with normative influences

<u>normative group</u>	<u>will comply</u>	<u>not sure</u>	<u>will not comply</u>
boy(girl)friend	348 (85.7%)	5 (1.2%)	53 (13.1%)
friends	218 (53.7%)	25 (6.2%)	163 (40.1%)
doctors / nurses	393 (96.8%)	6 (1.5%)	7 (1.7%)
church	295 (72.7%)	38 (9.4%)	73 (18%)
family	344 (84.7%)	21 (5.2%)	41 (10.1%)

It would appear from this table that doctors and nurses exercise the strongest influence over the respondents. This contradicts the qualitative results where the nurses were often disregarded as being unimportant or as a rejected invasive influence.

Perceived behavioural controls

There are two questions about responses to each behaviour. The first deals with whether the behaviour is easy or difficult, and the second asks the respondent whether they could perform the behaviour. In all cases, the response of "not sure" was seldom used, the highest rate over these four behaviours being 3.9%. The responses to these questions as shown in table 9.18, with only the counts for respondents who indicated that the behaviour was easy or that they could do the behaviour being indicated.

Table 9.18 Perceived behavioural controls

<u>behaviour</u>	<u>is easy</u>	<u>can be performed</u>
serial monogamy	382 (94.1%)	383 (94.3%)
men using condoms	138 (68%)	176 (86.7%)
women asking for condoms	132 (65%)	171 (84.2%)
treatment of STDs	363 (89.4%)	383 (94.3%)

The results above are slightly mixed. There seems to be general agreement that the behaviours listed are possible, but in the case of condom usage, it is not as easy or possible as in the other behaviours.

Control beliefs

A number of control beliefs are attached to each of the behaviours. These are explored in this section. The control beliefs concerning serial monogamy are outlined in table 9.19 below.

Table 9.19 Control beliefs concerning serial monogamy

<u>control belief</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
desire makes me want many partners	79 (19.5%)	8 (2%)	319 (78.6%)
lack of trust makes it easy to have many partners	107 (26.4%)	20 (4.9%)	279 (68.7%)
love for partner makes monogamy easy	372 (91.6%)	14 (3.4%)	20 (4.9%)
easy to find sexual partners	156 (38.4%)	27 (6.7%)	223 (54.9%)
need to have sex with others while partner is unavailable	89 (21.9%)	9 (2.2%)	308 (75.9%)

In two beliefs desire to have sex appeared to be a motivating force in 20% of the sample. There is a contradiction between the results of two of the beliefs: 91.6% found it easy to be monogamous while 26.4% found that lack of trust makes it easy to have many sexual partners. These two beliefs should be mutually exclusive. There were significant differences between men and women for the first two and the fourth and fifth of the control beliefs. All four indicate that control factors influence men to want to have more partners. Their responses of true are given in table 9.20.

Table 9.20 Differences in control beliefs across gender

<u>control belief</u>	<u>men</u>	<u>women</u>
desire makes me want many partners	58 (28.6%)	21 (10.3%)
lack of trust makes it easy to have many partners	83 (40.9%)	24 (11.8%)
easy to find sexual partners	95 (46.8%)	61 (30%)
need to have sex with others while partner is unavailable	62 (30.5%)	27 (13.3%)

The control beliefs of male and female respondents regarding condom use are described in table 9.21 below.

Table 9.21 Control beliefs concerning condom use

<u>control belief</u>	<u>gender</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
my partner would not like me to use one	men	98 (48.3%)	14 (6.9%)	91 (44.8%)
	women	94 (46.3%)	30 (14.8%)	79 (38.9%)
do not know how to use a condom	men	77 (37.9%)	13 (6.4%)	113 (55.7%)
	women	95 (46.8%)	15 (7.4%)	93 (45.8%)
condoms cost too much money embarrassing to get condoms from clinic	men	45 (22.2%)	11 (5.4%)	147 (72.4%)
	men	80 (39.4%)	14 (6.9%)	109 (53.7%)
scared to talk to my partner about condoms	women	81 (39.9%)	14 (6.9%)	108 (53.2%)

For both genders these control beliefs are appreciably high, especially the perceived attitudes of partners, knowledge of condom usage and embarrassment. This is one the few results where the difficulties in implementing these behaviours appears.

The control beliefs that respondents felt in relation to the treatment of STDs were as listed in table 9.22 below.

Table 9.22 Control beliefs concerning the treatment of STDs

<u>control belief</u>	<u>true</u>	<u>not sure</u>	<u>false</u>
not enough money for treatment	115 (28.3%)	23 (5.7%)	268 (66%)
scared of pain and injections	156 (38.4%)	44 (10.8%)	206 (50.7%)
embarrassed about what nurses will say	185 (45.6%)	15 (3.7%)	206 (50.7%)
difficult to get to the clinic	53 (13.1%)	13 (3.2%)	340 (83.7%)

Again, responses to some questions indicate important blocks in terms of controls, especially relating to embarrassment about and fear of the treatment.

Behaviour

The opening question acted as a screen for all but one of the remaining behaviour questions. Three-hundred-and-ninety-two (96.6%) responded that they had had sex in the past, men, 199 (98%) and women, 193 (95.1%). The remainder of the sample, 3.4%, were then excluded from answering most of the rest of the behaviour questions. Of the remaining 392 respondents, 186 (47.4%) had been having sex more than once a week for the last four months, 119 (30.4%) about once a week, and 87 (22.1%), had sex less often or had not had sex in the last four months. Most people 309 (78.8%), claimed to have had one sexual partner over the past six months with 9 (2.3%) claiming not to have had sex in the past six months. Forty-two respondents (10.7%) had had only two partners. The remaining 32 respondents (8.2%) had had more than two partners in the past six months. The highest number of partners in the past six months was seven, reported by one person. It is significant that only 7 women claimed to have had more than one partner in the past six months, compared with 67 men.

The breakdown, according to gender, of regularity of sex in the last months is given in table 9.23 below.

Table 9.23 Regularity of sex in the last four months by gender

<u>regularity of sex</u>	<u>men</u>	<u>women</u>
more than once a week	103 (51.8%)	83 (43%)
about once a week	55 (27.6%)	64 (33.2%)
once or twice a month	33 (16.6%)	34 (17.6%)
less than once a month	8 (4%)	12 (6.2%)

Fifty-four respondents (13.8%) had used condoms constantly over the past four months, while 320 (81.6%) had never used condoms. The remaining 18 respondents (4.6%) used condoms some of the time. Forty-six respondents (11.7%) claimed to use condoms with all partners, 26 (6.6%) with some partners, and 320 (81.6%) had never used condoms. The inconsistency in the above figures is probably due to the fact that no time frame was specified in the question relating to partners. This was an error in the questionnaire. Reasons respondents gave for not using condoms included: not knowing what a condom was, 27 people; "we are truthful with each other" "we trust each other", 30; wanting children, 8; single partners, 23; their partner does not want them to use condoms or they are afraid to approach their partner about using condoms, 15; it is inconvenient and reduces pleasure, do not want to use condoms, 21; have never spoken about condoms to partner, 6; and difficulty in obtaining condoms, finding them to be too expensive or not knowing that they are free at clinics, 5. One or two people mentioned some misperceptions around condoms, such as that there was an age restriction on using them, or that they were only for old people and that regular check-ups for yourself and your partners would protect you. Reasons for using condoms included not trusting their partner, 9; and preventing pregnancy and disease, 49. The breakdown, according to gender, of use of condoms is in tables 9.24 and 9.25 below.

Table 9.24 Regularity of use of condoms over the last four months by gender

<u>use of condoms over last four months</u>	<u>men</u>	<u>women</u>
all the time	40 (20.1%)	14 (7.3%)
more than half the time	6 (3%)	5 (2.6%)
less than half the time	5 (2.5%)	2 (1%)
never	148 (74.4%)	172 (89.1%)

Table 9.25 Regularity of use of condoms with different partners by gender

<u>use of condoms with range of partners</u>	<u>men</u>	<u>women</u>
with all partners	35 (17.6%)	11 (5.7%)
only with some partners	16 (8%)	10 (5.2%)
never	148 (74.4%)	172 (89.1%)

Of the 390 people who responded to the question about having had an STD, 29 reported, "yes" and one responded, "rather not say". In 5 (19.2%) cases the STD infection had occurred in the past year, a further 12 (46.2%) had occurred in the past three years, and the remainder

were further back in the past, up to more than eight years previously. Looking at the 29 respondents by gender, 22 were men and 7 were women. Of the 29 affected respondents, 27 claimed to have gone for treatment. The nature of the treatment varied, with most attending a clinic and receiving either pills or injections; five had been to a traditional healer, sangoma or herbalist, and one had treated himself using a solution of permanganate of potash.

Ninety-six respondents (24.5%) claimed to have done something to avoid contracting AIDS, of these 67 were men and 29 were women. The major protections that people claimed to have used were: using condoms every time they had had sex, 42; using condoms with some partners or with partners they could not trust, 5; having sex with only one partner, 39; trusting their partner, 5; having a blood test, 8; going to see the doctor or getting regular check-ups, 11; getting education, 2; not fooling around anymore, 1; using traditional herbs, 1; or doing exercises, 1. This contradicts some of the results on past condom usage and potentially also the question on numbers of sexual partners. Only nine acknowledged having met a person with AIDS. Of these nine, four felt sorry for that person, five felt unable to speak to them because of not knowing what to say or being afraid, and one encouraged and supported the person.

Responses to general attitude questions

The questions dealt with the issues of "attitudes towards people with AIDS" and the respondents' "personal sense of susceptibility to AIDS". In relation to PWAs, 329 respondents (80.7%) felt that it was good to show that you accepted them, while 60 (15.1%) felt it was bad. In terms of normative influences on contact with a PWA, 224 respondents (54.3%) thought that those people important to them felt that they should sit next to a PWA in a taxi; while 138 (34.7%) disagreed with this sentiment. Forty-four respondents (11.1%) were uncertain. In 122 cases (28.6%), the respondents stated that they would fight against anybody who tried to make them sit next to a PWA. Two hundred and fourteen respondents (53.9%) felt that there was a chance that they could get infected with AIDS; while 140 (35.3%) felt this belief to be false. Three hundred and eighty two respondents (96.0%) were worried about AIDS and 14 (3.5%) were not worried about it.

Conclusion

This chapter reported on the frequency data from the survey, which provides a good initial description of the survey results. Most of the people in the sample appeared to have the basic medical knowledge required to protect themselves, although there was room for improvement, especially concerning condoms and how to use them. These results have been presented in detail so will not be repeated and summarised here. Some discussion on the role

of gender however is important. Some differences are noted in the text above, particularly relating to knowledge and behavioural beliefs about condom usage. Other differences that appeared included the greater intention on the part of men to use condoms. By contrast women showed a more positive attitude towards their use, felt stronger normative pressure in this regard and reported higher use of condoms in the past. It appears that the biggest differences between the two genders are in relation to condom usage, which may tie into the fact that it is an essentially different behaviour for the two genders. In the other behaviours, women reported a significantly more positive attitude towards serial monogamy, valued protection from pregnancy more, regarded the sexual satisfaction of their partner as more important than men did, and felt less concerned about the pain and cost associated with getting treatment for an STD. Past behaviour introduced some interesting contrasts with men claiming to be having sex more often and with more partners, but also claimed to be using condoms and other safer sexual practices more often.

Given the positive attitude towards safer sexual practices and being protected from AIDS, and the conflict that this presents with the results of the qualitative data and literature as presented in Chapter Two, further discussion is indicated. Earlier in the chapter two possible explanations were raised. Firstly, that these are genuine intentions based on the person being confronted with AIDS as a potential reality for themselves. In response to the immediate felt threat of the disease the person may have tried to find the responses to the questions that were most likely to protect them from this horrible prospect. It is also possible that the survey interview could have challenged the respondents to face the issue of AIDS more clearly, as the questions were structured especially for them. This could have induced an anxiety around the disease, which in turn would have produced a temporary set of intentions to use safer sexual practices in the future. The qualitative interviews allowed the respondents to contextualise themselves more fully in their life situations, which may have reduced the anxiety about AIDS that the interview produced. Therefore, the responses could in part be idealised intentions for the future in relation to AIDS. This idea is expanded upon in the next two chapters.

Alternatively, the respondents may have felt pressure to answer in a way that would please the interviewer. There are a number of possible explanations for this. The sensitive and private nature of the information may have made the respondents feel vulnerable, especially with the interviews being done on a one-to-one basis. A group-based interview structure may have allowed them more freedom and anonymity as they would not have been responding directly to an interviewer. The fact that the interviewers were from their own community would further have reduced anonymity, as the respondents may have known them, or at least

had a fear of running into them again. This is supported by mention of the fear of embarrassment, which appears on several occasions in the results. In addition, the nature of the questions may have produced a particular demand effect. Most respondents knew what the "correct" and safe sex responses were, so would have felt pressure to comply with these norms. This may have been accentuated by the project being well recognised by sections of the community. An argument could also be put forward that the community members showed particular politeness, which made them more likely to want to agree with and support the person who was asking the questions. This occurs particularly if that person is assumed to be trying to make a positive contribution to the community and has been supported by the community leaders. This level of politeness would drop once the community members became more familiar and at ease with the person asking the questions, which may be why different responses were obtained in the qualitative section. As was stated in the methodology chapter, there may also have been problems with respondent's understanding and responses by means of the use of Likert scales, which were unfamiliar to many.

The incorporation of this data into the Theories of Reasoned Action and Planned Behaviour will be discussed in the next chapter. In relation to the variation of the survey results from what was expected there is at least a consistency in the responses throughout, so the TRA and TPB models can be applied. The small numbers who had experienced an STD may make the analysis of the treatment of these diseases more complicated.

Chapter 10

Results for the Theories of Reasoned Action and Planned Behaviour

Following the chapters on the relevant theories, and a general description of the research results, the data from the survey is now incorporated into the models generated by the theories of Reasoned Action and Planned Behaviour. This is the central application of the data and the research. In each case, the model for the full population is presented first, followed by the divisions according to gender and respondents' knowledge of HIV. A provisional analysis was done on the divisions of the population according to age, type of housing, community, education level and time spent resident in the community, but as these showed minimal additional information, models for them have not been included. Four behaviours are examined in this chapter, namely serial monogamy, males using condoms when they have sex, women requesting their partners to use a condom, and obtaining treatment for STDs.

The problems raised in the previous chapter have to borne in mind. As noted earlier, respondents' answers about safer sex varied considerably with the results from the qualitative data and the literature. This positive attitude was maintained throughout indicating consistency. The results appear to reflect either a desired position or what a person believes is necessary to protect themselves from HIV. As such, there is validity in the analysis. It is at any rate important to keep in mind the problems with the data in the analysis, interpretation and use of the information. There may be additional complications with some of the beliefs where the responses to the survey may have influenced the results further by rendering some responses potentially meaningless. Examples of this problem, identified in the previous chapter, include believing that feeling your partner's body during sex without a condom was negative, and that feeling pain during treatment for an STD was positive. These responses appear to be compromised, with the respondent struggling with the perceived demands of the researcher or what they felt was required to maintain their own safety. Such bias may influence the individual correlations for a small number of beliefs. They will also have a diluted impact on the correlations for the summed scores with A, SN and PBC.

Another problem is that past behaviour was used as a proxy for ongoing behaviour. This was an inadequate measure, so the resultant correlations were lower than would have been expected. The correlation was further reduced by the heightened intentions in favour of safer sexual practices. These correlations between intended and past behaviour are reported in the text, but will generally not be commented on due to the problems with the information.

The structure of the reporting is as follows. First, the summary of the correlations found between the individual belief scores and those of the next stage variable is given. For the behavioural and normative beliefs, these are the product scores. The individual scores for the control beliefs are used. The first column lists the beliefs, and the second gives the results for the full sample, which is then divided into sub-samples on the basis of gender and knowledge in the subsequent columns. The full models follow. The abbreviations used in the tables and figures for the theories of Reasoned Action and Planned behaviour or in the text are as follows:

A = attitude

SN = subjective norms

PBC = perceived behavioural controls

IB = intended behaviour

B = behaviour

BB = product of the behavioural belief and relevant outcome evaluation

NB = product of the normative belief and relevant motivation to comply

CB = control belief

Σ BB = sum of the products of the behavioural beliefs

Σ NB = sum of the products of the normative beliefs

Σ CB = sum of the products of the control beliefs

n = sample size used in the calculations

All the figures in the figure using normal script are correlation figures. Those in italics are regression statistics. The figure β indicates the Beta coefficient of the regression equation. Two figures for the sample size are given on each figure. On the top right of the figure is the full sample size for that behaviour. The second sample size given just below the symbol PB gives the reduced sample size of those subjects who, on the basis of their past behaviour, were qualified to answer the question, e.g. have had sex before or have had an STD before. The variable PBC was also split into its two component parts, as the two questions drew on different aspects of control. These results are also given below the figure. PB1 examined the ease or difficulty of the behaviour, while PB2 looked at the perceived possibility of the behaviour.

Results for serial monogamy

The results for serial monogamy are given in the figures below. The phrase "with only that person" refers to a partner in a monogamous relationship.

Table 10.1 Summary of correlations of beliefs with the next stage variables for the behaviour of serial monogamy

	A (full sample)	A (male)	A (female)	A (low K)	A (high K)
	406	203	203	219	187
Having sex with only that person will protect me from getting an STD	0.265***	0.254***	0.271***	0.308***	0.209**
Having sex with only that person will protect me from getting AIDS	0.188***	0.171*	0.212**	0.136*	0.255***
If I have sex with only that person (s)he will become spoiled and disrespectful	-0.238***	-0.240***	-0.217**	-0.246***	-0.214**
Having sex with only that person will show that I love him(er)	0.189***	0.185**	0.195**	0.253***	0.119
If I have sex with only that person I may be hurt if that person leaves me or is unfaithful to me	0.065	0.187**	-0.080	0.070	0.060
I will get enough sexual satisfaction if I have sex with only that person	0.237***	0.207**	0.251***	0.289***	0.170
Having sex with only that person undermines the masculine "right" to have many sexual partners	-0.203***	-0.158*	-0.214**	-0.177**	-0.219**
Boy(girl)friend	SN (full sample)	SN (male)	SN (female)	SN (low K)	SN (high K)
Friends	0.288***	0.310***	0.255***	0.319***	0.252***
Members of respondent's family	0.130**	0.100	0.155*	0.123	0.132
Members of respondent's church	0.310***	0.225**	0.405***	0.302***	0.324***
	PBC (full)	PBC (m)	PBC (f)	PBC (1 K)	PBC (h K)
Desire makes me want to have sex with many (wo)men	-0.118*	-0.107	-0.120	-0.160*	-0.094
My lack of trust in my boy(girl)friend makes it easy for me to have many sexual partners	-0.020	-0.065	0.112	-0.113	0.091
My love for my boy(girl)friend makes it easy to only have sex with him(er)	0.211***	0.247***	0.166*	0.214**	0.199**
It is easy to find other (wo)men to have sex with	0.005	0.033	0.038	-0.059	0.106
I need to have sex with other (wo)men while my boy(girl)friend is unavailable	-0.116*	-0.155*	-0.042	-0.146*	-0.085

* 0.05 ** 0.01 *** 0.001

It is interesting that the beliefs about STDs achieved a higher correlation to A than those about AIDS. This would imply that STDs were seen as more of a threat than AIDS. Male domination issues, covered by the issues of male "rights" and fear of being treated badly were significantly, but negatively correlated. The only other belief regarding fear and domination issues dealt with a fear of being hurt, which was significant only for male respondents. Issues such as love and obtaining sexual satisfaction were also significant except for those with a high knowledge of HIV. Generally, the partner and the family were the most important normative influences. The only control belief that appeared to have an influence was the strength of the person's love for their partner. Surprisingly, there was a higher correlation for the male respondents than for the females on this variable. As was stated in the introduction, a number of these beliefs produced results that were contrary to expectation, given the qualitative data and the review of the literature.

The figure below shows the level of explanation provided by the Theory of Reasoned Action.

Figure 10.1: Reasoned action model for serial monogamy

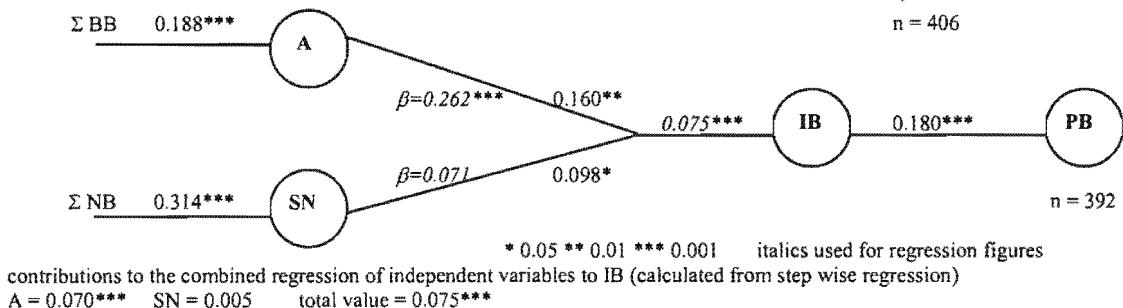
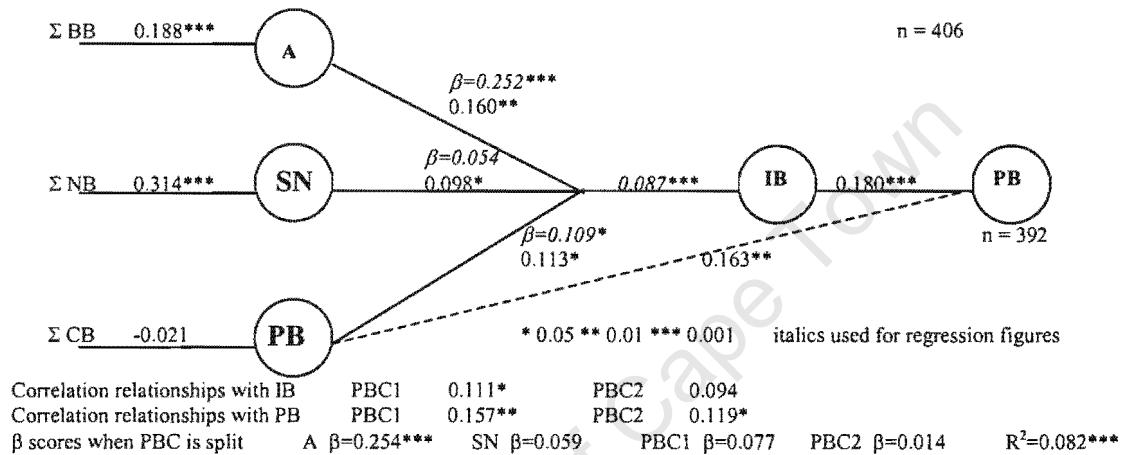


Figure 10.2: Planned behaviour model for serial monogamy



Overall, the application of the model with these data does not have high explanatory powers.

Many of the correlation factors and β scores obtained are lower than expected, given the scores found in the literature. Clearly attitude had the most important influence on IB. It was problematic that there was a comparatively low correlation between ΣBB and A. It may be that other behavioural beliefs were missed in the first stage of the research, or that these poor correlations are due to bias in the data. The addition of the perceived behaviour control variable added only 0.012 to the combined regression with IB, and produced a low β score, hence PBC does not appear to add much important information to this model. This is especially important, as the only control belief to register a significant correlation with PBC concerned "love", which was addressed in a slightly different way in the BB and NB. With these data there is very little difference between the two elements of the PBC variable. When PBC was split into PBC1 and PBC2, it reduced the combined regression score. ΣCB showed a very poor correlation with PBC, but this could be expected as control features were not important for most of the sample.

Figure 10.3: Reasoned action model for serial monogamy for males

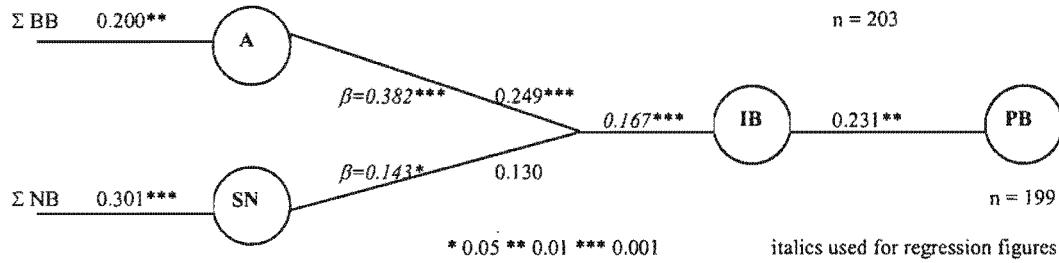


Figure 10.4: Planned behaviour model for serial monogamy for males

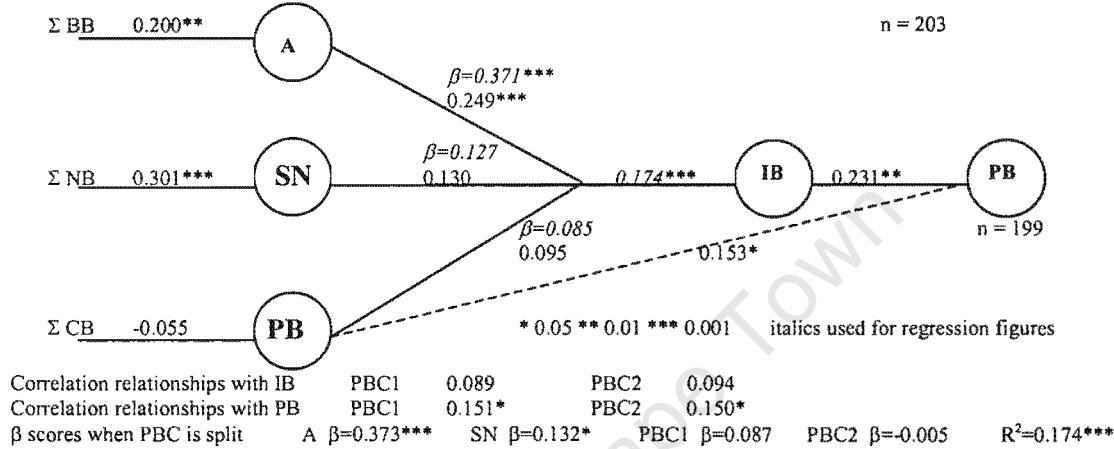


Figure 10.5: Reasoned action model for serial monogamy for females

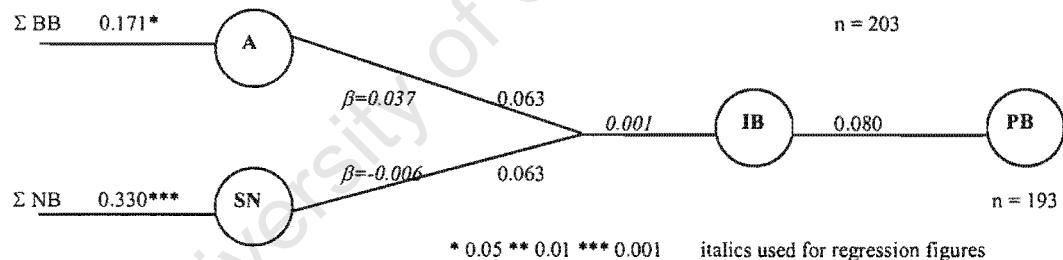
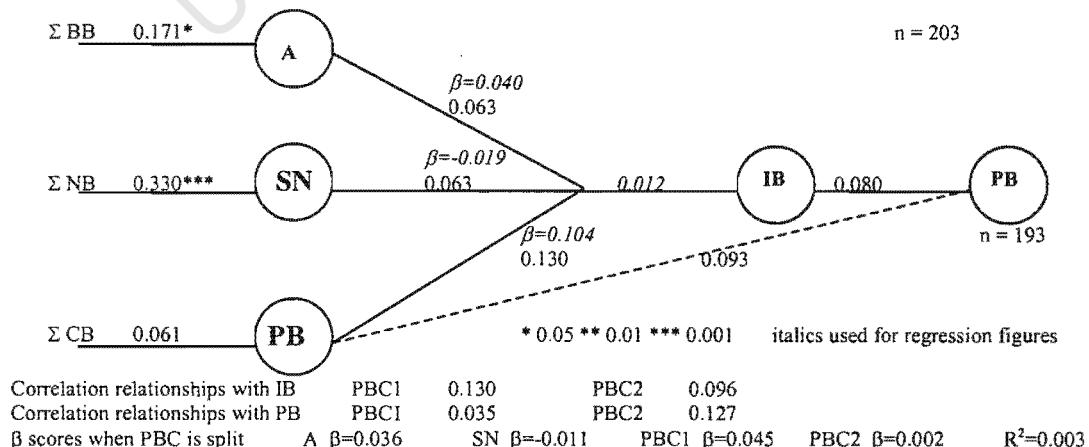


Figure 10.6: Planned behaviour model for serial monogamy for females



When the data was separated according to gender, the results for females showed almost nil explanatory powers. Even the significant correlation between ΣNB and SN was not important,

as there was none between SN and IB. The model showed that the males' responses emphasised the role of the attitude of respondents, although once again, there do appear to be gaps in the behavioural beliefs obtained. Of importance is that there is a large improvement in the explanatory power of A, SN and PBC on IB over the model for the full population, although again this was lower than expected. Control issues appeared to be of very low importance to men, but this was expected, given the male dominance in the sexual discourse.

The lower explanatory power of the model for women, as against that for men, could come from a range of bases. These include women's greater embarrassment at participating in the survey, because of the sensitive nature of the subject. In addition there may, on occasion, have been a male interviewer, and also other members of the household may have been observing the conversation. Sexuality is so male-dominated that women may have found it difficult to be clear and to talk about their beliefs in the context of the survey interview. There may have been heightened fears of exposure due to the double standard that applies to women, who are expected to service men, but are condemned as loose women or "whores" if they are seen to have sex with a man while in a relationship with another man.

Figure 10.7: Reasoned action model for serial monogamy for those with low knowledge

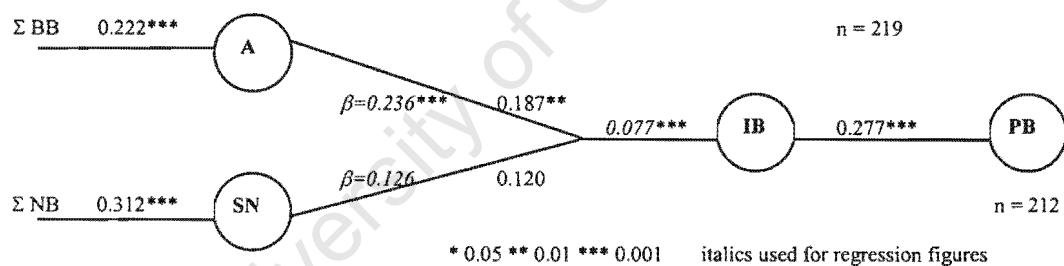


Figure 10.8: Planned behaviour model for serial monogamy for those with low knowledge

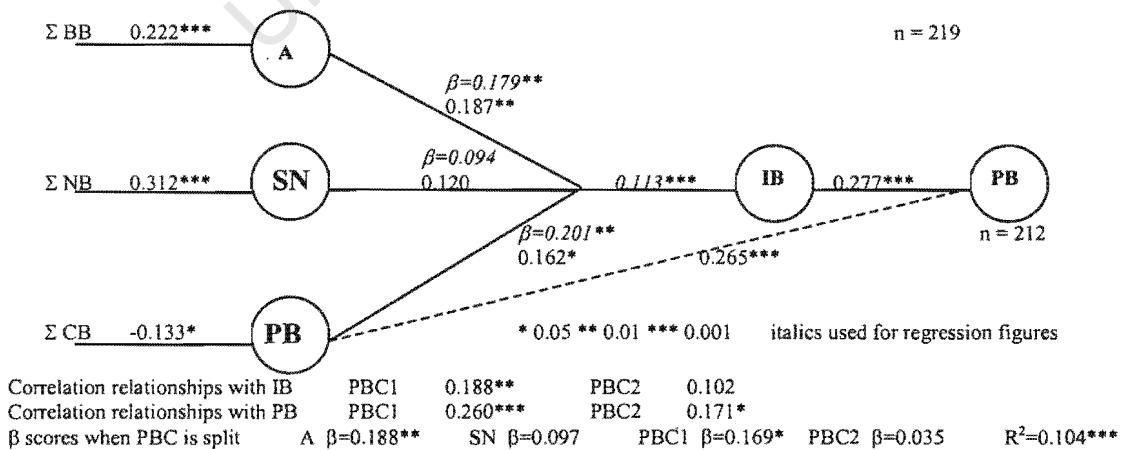


Figure 10.9: Reasoned action model for serial monogamy for those with high knowledge

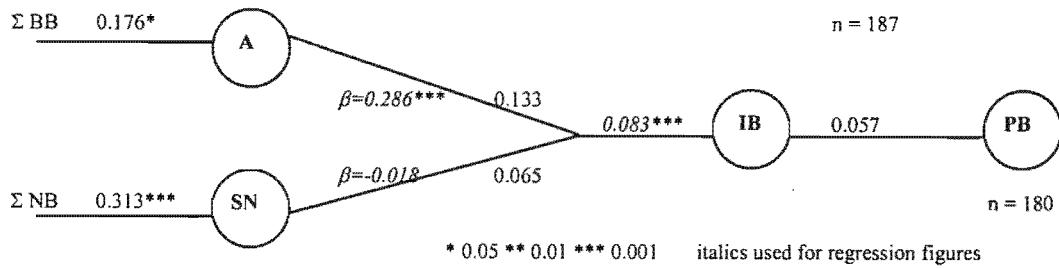
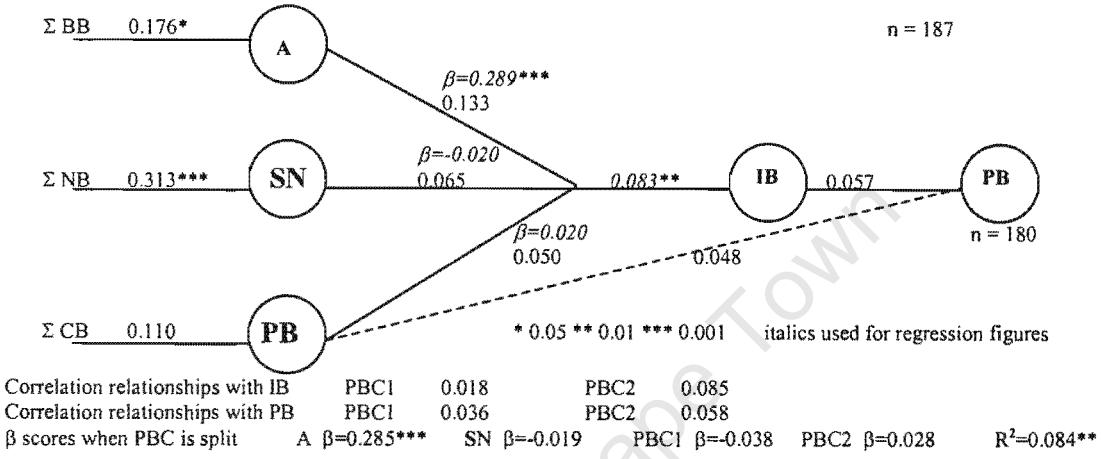


Figure 10.10: Planned behaviour model for serial monogamy for those with high knowledge



There appeared to be little additional information to be gained by the separation of the sample into those with high and low knowledge of HIV, except by using the model for Planned Behaviour for those with low knowledge. In this case, PBC gained prominence and actually has a higher β score than A. Three control beliefs also attained a significant relationship with PBC. They all revolved around love and sexual desire, an established combined theme from the other data. With control issues acquiring more meaning, a significant correlation was obtained between Σ CB and PBC. For those with low knowledge, the correlation of A with IB, plus the correlation of Σ BB to A, is also stronger. The increased role of A is further supported by virtue of raised correlation coefficients of many individual behavioural beliefs together with it. In the model for those with high knowledge, the relationship of A to IB is better, but the connection to beliefs is reduced. For this subset, a slightly different set of beliefs may have been needed.

Conclusion for the behaviour of serial monogamy

Overall, the correlations obtained were low, although significant. There was an improvement when male respondents were considered alone and a slight improvement on the PB model for those with low knowledge. The behaviours appear to be predominantly under attitudinal control. Other than for those with low knowledge, the addition of PBC added very little to the model. There appeared to be an overlap between A and PBC as indicated by the low β scores

for PBC, despite having higher correlations. Some of the problems leading to low scores may be related to the complexity of the concept of serial monogamy, which could have confused respondents. There also appeared to be confusion about permanent monogamy. This may have affected respondents and in retrospect, be in conflict with the principle of compatibility. Implicit in the principle of compatibility is the need for clarity about the behaviours in question. The problems with the data and the possible influence of social factors on the responses of women are noted in the text, and have to be born in mind in any analysis. It is assumed that the results are still sufficiently accurate to provide good information.

A number of lessons of importance did emerge. Currently, STDs are seen as more of a threat than HIV. There appears to be a reduced emphasis on male domination issues, but this may be a reflection of what is required for safer sexual practices to occur. Love and trust arose as issues of great importance. It appears that family and partner are the most important normative influences. Of concern are the poor correlations found between beliefs and A, SN and PBC. This could be due to the problems in the data, the interview techniques used or may indicate that the community of interest was too wide.

Results for condom usage among men

The behaviour of condom usage among men is addressed below.

Table 10.2: Summary of correlations of beliefs with the next stage variables for the behaviour of men using condoms

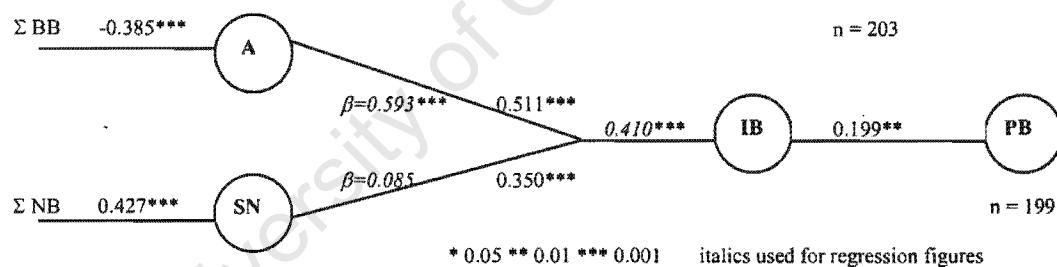
n	<u>A (full sample)</u>	<u>A (low K)</u>	<u>A (high K)</u>
Using a condom everytime I have sex:			
will prevent pregnancy	0.251***	0.336***	0.100
will protect me from diseases	0.085	0.057	0.103
will reduce my sexual pleasure	-0.313***	-0.346***	-0.262*
will mean that I do not feel my partner's body	-0.467***	-0.507***	-0.393***
will mean that I do not trust my partner	-0.246***	-0.211*	-0.276**
means that my partner will not be satisfied sexually	-0.369***	-0.400***	-0.302**
will make my partner angry	-0.296***	-0.234*	-0.347***
Girlfriend	<u>SN (full sample)</u>	<u>SN (low K)</u>	<u>SN (high K)</u>
Friends	0.324***	0.371***	0.226*
Members of family	0.300***	0.321***	0.253*
Nurses and doctors	0.390***	0.445***	0.315**
My partner will not like me to use condoms	<u>PBC (full sample)</u>	<u>PBC (low K)</u>	<u>PBC (high K)</u>
Condoms cost too much money	-0.167*	-0.117	-0.196
It is embarrassing to get condoms from the clinic	-0.073	-0.062	-0.051
I do not know how to use condoms	-0.249***	-0.245**	-0.204*
	* 0.05 ** 0.01 *** 0.001		

In this sample condom usage was not associated with HIV or disease. In the first phase, the issue of HIV was not raised often enough to become part of the questionnaire, and in the survey, prevention of disease was not a significant variable. It was significant that items dealing with sexual pleasure were negatively correlated, indicating that respondents were prepared to compromise their sexual pleasure by using condoms. Respondents also played

down the impact of condom use in their relationships. Partners, friends and families were important normative influences, especially for those with low knowledge of HIV. The presence of families as a normative influence is confusing, as from the qualitative data the youth do not inform them about their sexual practices. The normative influence must therefore operate in another manner. This may be a sense of caring from the family, which suggests to the respondent that they should protect themselves from harm. For the control beliefs, it was the two factors that achieved low importance in the first stage questionnaire, that attained the higher correlations here. These were embarrassment and knowledge of condoms, especially on the part of those with low knowledge. It was expected that the belief dealing with knowledge of how to use condoms would score highly due to the sub-sample selection criteria.

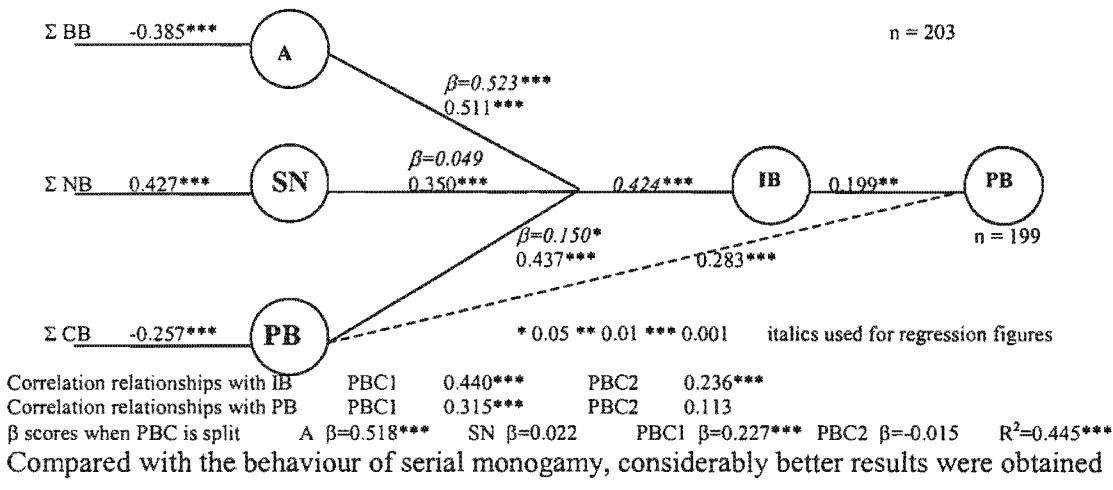
Two different measures were used to ascertain past behaviour in relation to condom usage, namely condom usage over the last four months, and proportion of partners with whom condoms were used. The responses were found to be very similar (correlation 0.995***), and consequently only the first was used in the models below, namely "how often have you used condoms in the last four months?".

Figure 10.11: Reasoned action model for men to use condoms



contributions to the combined regression of independent variables to IB (calculated from step wise regression)
 $A = 0.405^{***}$ $SN = \text{not sig.}$ total value = 0.405***

Figure 10.12: Planned behaviour model for men to use condoms



Correlation relationships with IB PBC1 0.440*** PBC2 0.236***
 Correlation relationships with PB PBC1 0.315*** PBC2 0.113

β scores when PBC is split A $\beta=0.518^{***}$ SN $\beta=0.022$ PBC1 $\beta=0.227^{***}$ PBC2 $\beta=-0.015$ $R^2=0.445^{***}$
 Compared with the behaviour of serial monogamy, considerably better results were obtained

for this data. All three of A, SN and PBC achieved a significant correlation with IB and the

overall regression score, for both the TRA and TPB models, was high. The correlations of A, SN and PBC back to beliefs were also reasonably high, although higher scores would have been expected. The negative correlation between Σ BB and A was expected, given the negative correlations between many of the individual beliefs and A, but it does mean that most of the beliefs that encourage the behaviour still have to be pin-pointed. Despite the high correlation of PBC with IB there was only an increase of 0.014 in the regression coefficient with the addition of PBC. It appears from the β weights that A was very influential and overshadowed the remainder. There were in fact high levels of multi-collinearity between A, SN and PBC, with the correlations between them being between 0.369 and 0.497. The separation of PBC into its two components showed a distinct change in pattern with the β weight for PBC1 attaining a higher level of significance. In this behaviour the "ease or difficulty" aspect of the control question is found to be a more powerful predictor than the combined score. It also produced a higher overall R^2 for the model. Σ NB produced a high correlation with SN, but SN's low explanatory contribution to IB means that it is of less importance.

Figure 10.13: Reasoned action model for men to use condoms for those with low knowledge

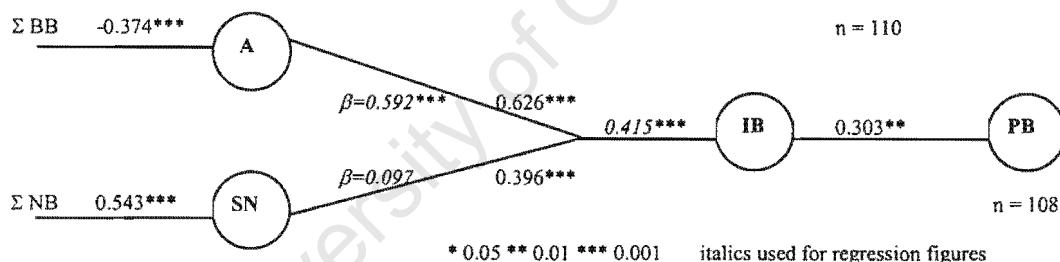


Figure 10.14: Planned behaviour model for men to use condoms for those with low knowledge

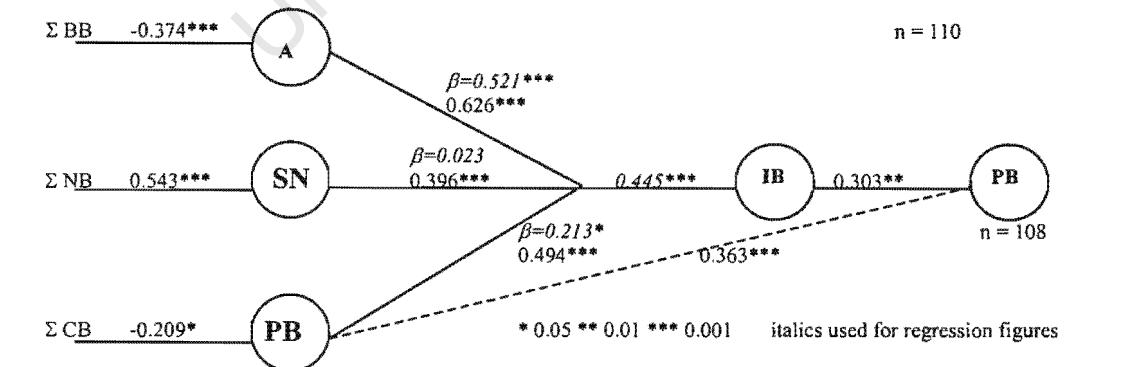
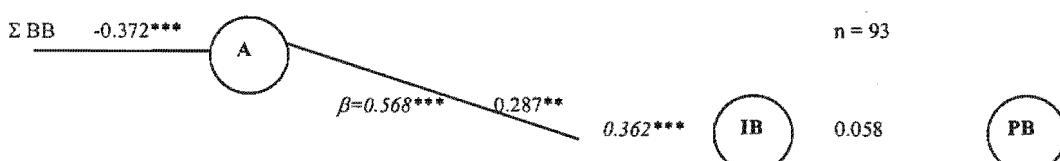


Figure 10.15: Reasoned action model for men to use condoms for those with high knowledge



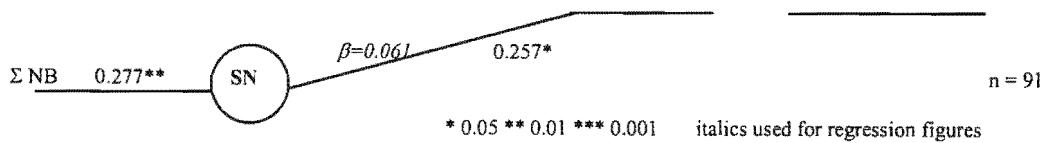
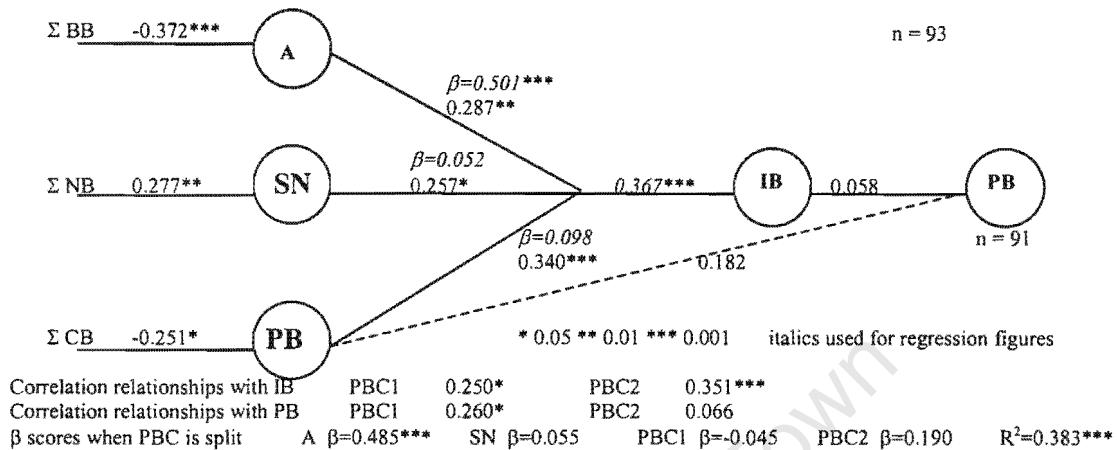


Figure 10.16: Planned behaviour model for men to use condoms for those with high knowledge



There was very little additional explanation gained from splitting the sample according to levels of knowledge. In fact, for those with high knowledge, the capacity of the model to explain the behaviour appears to be reduced. Comparing the full population and the subdivisions, there does not appear to be a large change in the β weighting of A. For those with low knowledge, the role of PBC increases again, as with serial monogamy. This may be a factor of the two control beliefs that were found to have a significant relationship to PBC, both of which have an impact on issues of difficulty rather than possibility. It is interesting to note that with the exception of the correlations of ΣNB with SN, the correlations of the summed variables with the next stage dropped when the sample was split. This could indicate that the variance was evenly distributed for CB and BB.

Conclusion for men using condoms

The correlations were improved for this behaviour over that of serial monogamy. The behaviour here was much more clearly defined, so this was expected. The behaviour appeared to be predominantly under attitudinal influence. Although the subjective norms achieve a significant correlation with IB, this does not translate into a significant β score. PBC does have a small, but significant influence. Once again, PBC and A overlap, in this case also with SN. They all seem to be picking up on a similar construct. This may to some extent be expected as many of the key beliefs for A and PBC deal with interactions with partners. The only difference appeared with PBC1, which attains a significant and influential β score, and which deals with the concept of ease and difficulty. There is little additional information

gained when the sample is split into those with high versus low knowledge. Once again, the problems with the data would have an impact on the quality of the results obtained.

Some of the key lessons for those working in an HIV context include the need to educate those who do not know about condom usage and to facilitate access to condoms. There is also a need to make the link between condoms and the prevention of STDs and HIV. With regard to condoms, there were also negative perceptions about their impact on sexual pleasure and about partners' responses to using them. The major normative influences were family, friends and partners, and here the actual role and method of influence of the family needs further investigation.

Results for women requesting partners to use condoms

The behaviour of women requesting their partners to use condoms is addressed below.

Table 10.3: Summary of correlations of beliefs with the next stage variables for the behaviour of women asking their partners to use condoms

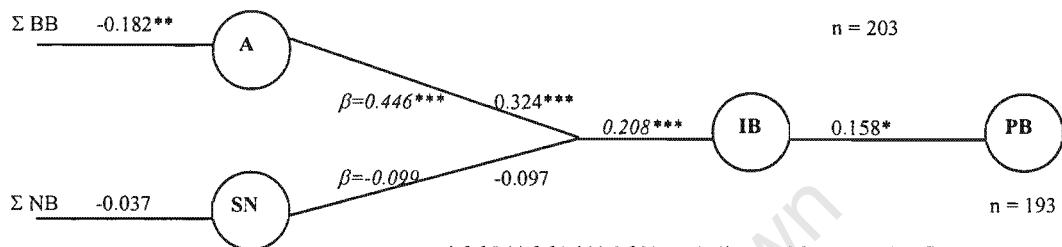
	<u>A (full sample)</u>	<u>A (low K)</u>	<u>A (high K)</u>
N	203	109	94
Asking my partner to use a condom everytime I have sex:			
will prevent pregnancy	0.037	-0.002	0.080
will protect me against disease	0.166*	0.123	0.218*
will reduce my sexual pleasure	-0.238***	-0.171	-0.298**
will mean that I do not feel my partner's body	-0.341***	-0.306**	-0.371***
shows that I do not trust him	0.036	0.262**	-0.241*
means that my partner will not be satisfied sexually	-0.191**	-0.227*	-0.094
will make him angry with me.	-0.230**	-0.290**	-0.101
Boyfriend	<u>SN (full sample)</u>	<u>SN (low K)</u>	<u>SN (high K)</u>
Friends	-0.092	-0.190*	0.048
Members of family	-0.138	-0.212*	-0.059
Nurses and doctors	-0.053	-0.061	-0.050
	0.268***	0.241*	0.306**
My partner would not like to use a condom	<u>PBC (full sample)</u>	<u>PBC (low K)</u>	<u>PBC (high K)</u>
I do not know how to use a condom	-0.215**	-0.141	-0.266**
I am scared to talk to my partner about condoms	-0.221**	-0.275**	-0.128
	-0.198**	-0.135	-0.219*
	* 0.05 ** 0.01 *** 0.001		

A very different picture appeared for the female versus the male respondents, with explanations being considerably lower. Neither fear of pregnancy nor disease featured strongly amongst the female respondents. As with the males, the most important behavioural beliefs related to sexual pleasure and potential anger on the part of their partners when asked to use a condom. Subjective norms produced surprising results in that partners, family and friends were not considered, although health professionals were seen as a positive influence in encouraging them to use condoms. The opinion of the partner and the fear of suggesting condom usage came out more strongly in the control beliefs, together with the lack of knowledge on how to use them. The correlations were generally lower than those shown by the males on the similar behaviour of condom usage. Some explanations for the reduced

power of these models for women have already been given in the discussion on serial monogamy. These are also likely to apply here.

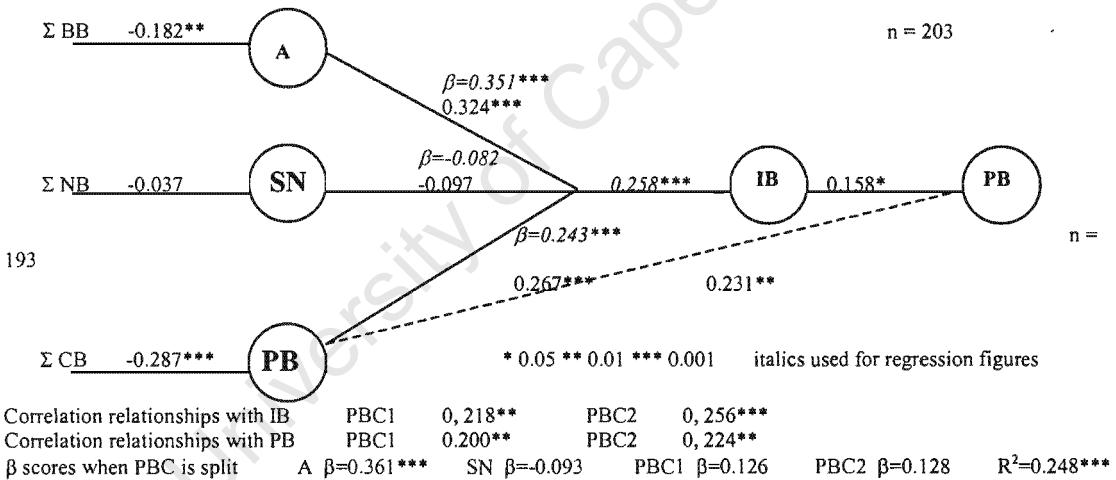
As with the male respondents, there is very little difference between the two measures of past behaviour (correlation 0.995***), so the first measure was used, namely "how often have you used condoms in the last four months?".

Figure 10.17: Reasoned action model for women asking partners to use condoms



* 0.05 ** 0.01 *** 0.001 italics used for regression figures
contributions to the combined regression of independent variables to IB (calculated from step wise regression)
 $A = 0.199^{***}$ $SN = 0.010$ total value = 0.208^{***}

Figure 10.18: Planned behaviour model for women asking partners to use condoms



Correlation relationships with IB PBC1 0, 218** PBC2 0, 256***
Correlation relationships with PB PBC1 0, 200** PBC2 0, 224**
 β scores when PBC is split A $\beta=0.361^{***}$ SN $\beta=-0.093$ PBC1 $\beta=0.126$ PBC2 $\beta=0.128$ $R^2=0.248^{***}$

The correlation levels for the female respondents were considerably lower than for their male counterparts. For the Reasoned Action and Planned Behaviour models the level of explanation, indicated by the R^2 , of IB are about half that in the case of the male respondents. Of importance here is that while A is still the most relevant of the factors feeding into IB, PBC becomes very material. Important also was the significant connection between ΣCB and PBC. It appeared that PBC existed as its own variable here with less overlap occurring with A and SN, although PBC still only added 0.05 to the R^2 score. This supports some of the data collected in the qualitative section and the literature about women feeling controlled in the arena of their sexuality. Once again, the subjective norms produced no significant results. When the results for PBC were split into their components, the significant β scores of the control factors to IB were lost. Consequently it appears that PBC operates on a different basis

for men and women. For the women the notion of impossibility appears to increase, which is supported by the other data. Again the correlation of summed beliefs to the next stage variables is low. This repetition of low correlation scores is a pattern in the data and likely to reflect the problem with the data as stated in the introduction. The problem was accentuated for women.

Figure 10.19: Reasoned action model for women asking partners to use condoms: low knowledge

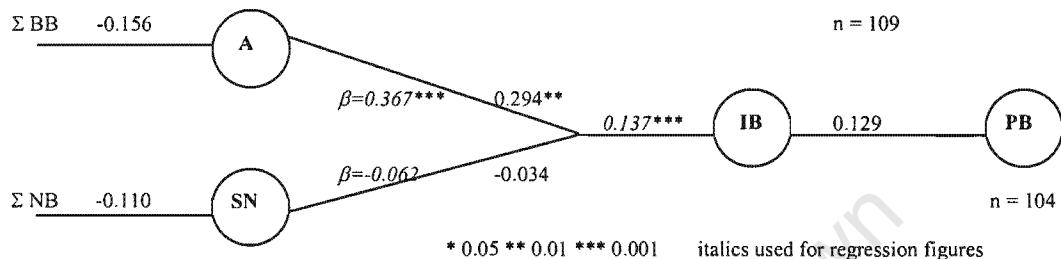


Figure 10.20: Planned behaviour model for women asking partners to use condoms: low knowledge

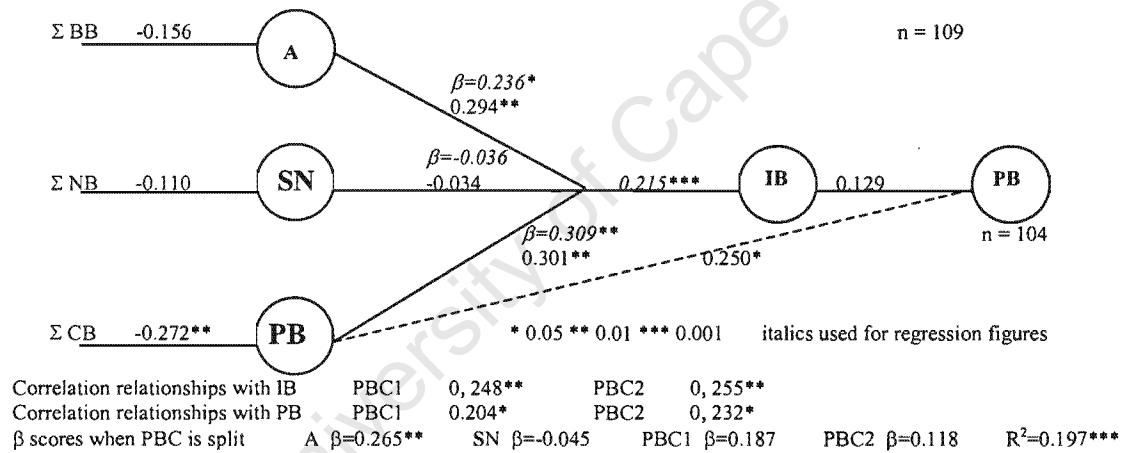


Figure 10.21: Reasoned action model for women asking partners to use condoms: high knowledge

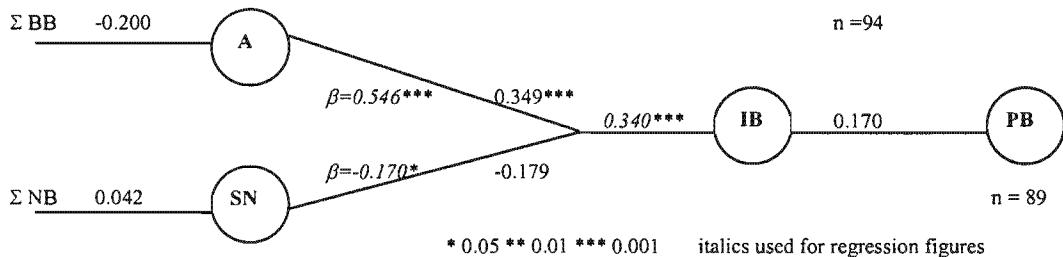
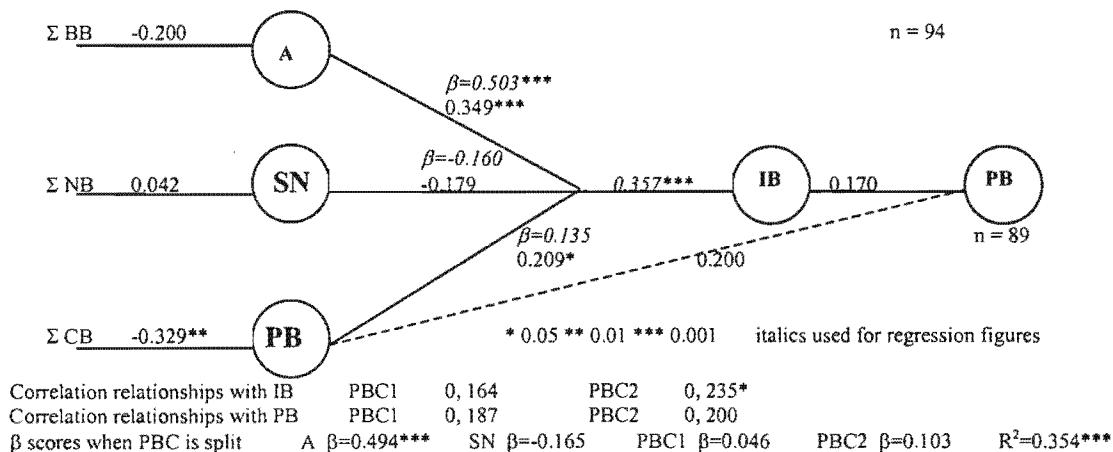


Figure 10.22: Planned behaviour model for women asking partners to use condoms: high knowledge



The sub-sample with high knowledge produced a model that dramatically increased the explanatory value over the results for the full population, with A in particular becoming much more important. For this group the PBC was also reduced. SN attains a significant relationship with IB for the sub-sample of high knowledge, but it remains weak. These women are probably better educated and have better access to resources, generally allowing them to stand up for themselves more easily. These factors, together with the better knowledge, could give them the power to stand up to male attempts at domination. The factors affecting women's responses may therefore have affected this category less. For those with low knowledge, the general explanation value of IB, as shown in the R^2 , is considerably reduced. This is the inverse of the argument discussed in the previous sentence. In the TPB model for low knowledge, PBC attains a similar significance to A. Of those variables on the left-hand side of the model, only the relationship between ΣCB and PBC became significant. This means that for women, the behavioural beliefs and normative influences were not adequately picked up for either group in the first phase.

Conclusion about women asking partners to use condoms

Correlations were generally lower for women than for men, although still higher than for the models on serial monogamy. Within this sample, there were substantial differences between those with high and low knowledge. PBC emerged as an important factor for women, especially those with low knowledge of HIV. If knowledge is related to the perception of power, then this is an important issue and should be considered for AIDS education campaigns. The value of the attitudinal information was reduced by poor correlations between EBB and A. There is some concern over the quality of the information, e.g. the results obtained on the normative influence clashed with data obtained from the qualitative section.

Generally, the poor quality of the correlations from beliefs to the next stage variable is an issue for concern for this study as whole.

There were a few lessons to be learnt from these models due to poor correlations. It is important to provide information about condoms and to improve people's access to them; The role of the dominant male ideology and the need to empower women in sexual relationships also arises. Lack of power appeared to affect women in a multitude of ways reducing even their space to think freely about their sexual practices. A culture of equality in sexual relations is integral to behaviour change. Some equality has been achieved for women who have a good education or career, or who are independently wealthy. Finally, sexual pleasure was important to the respondents. The perceived connection between safe sex and a reduction in sexual pleasure has to be circumvented.

Attending treatment for STD's

The final behaviour, concerning respondents obtaining treatment if they contract an STD, is addressed below.

Table 10.4 Summary of correlations of beliefs with the next stage variables for the behaviour of getting STDs treated

	A (full sample)	A (male)	A (female)	A (low K)	A (high K)
n	406	203	203	219	187
If I go for treatment for an STD I will get healed	0.359***	0.372***	0.347***	0.409***	0.305***
Getting treatment for an STD will prevent the disease from spreading further	0.350***	0.445***	0.234***	0.373***	0.323***
Treatment for an STD will prevent further damage	0.273***	0.333***	0.201**	0.372***	0.136
Getting treatment for an STD will be painful	-0.050	0.022	-0.126	-0.029	-0.044
Getting treatment for an STD will make me feel embarrassed in front of others	0.088	-0.076	-0.090	-0.131	-0.035
	SN (full sample)	SN (male)	SN (female)	SN (low K)	SN (high K)
Boy(girl)friend	0.212***	0.195**	0.225**	0.202**	0.223**
Friends	0.018	0.071	-0.031	-0.091	0.162*
Doctors and nurses	0.291***	0.244***	0.336***	0.265***	0.301***
Members of family	0.293***	0.314***	0.265***	0.272***	0.306***
	PBC (full)	PBC (m)	PBC (f)	PBC (l K)	PBC (h K)
I would not have money to get treatment if I had an STD	-0.145**	-0.135	-0.168*	-0.202**	-0.123
I am scared of injections and pain involved in getting an STD treated	0.090	0.191**	-0.001	-0.110	0.259***
I am embarrassed to go to get treatment for an STD	0.062	0.190**	-0.015	-0.096	0.276***
It is difficult to get to a clinic to get treatment for an STD	-0.084	0.070	-0.248***	-0.157*	-0.050

* 0.05 ** 0.01 *** 0.001

Only the first three of the behavioural beliefs attained a significant relationship with A. All of these dealt with the issue of healing. These were especially important for men and those respondents with low knowledge. Family, partners and members of the medical profession were seen as the important normative influences, but not friends. These were generally higher for women and for those with high knowledge. For males and for those with high knowledge, the control beliefs relating to fear of treatment and embarrassment attained significant

correlations with PBC. The fact that control beliefs 2 and 3 are not negative could be explained as being a rejection of the idea that these factors play a part in decision-making. This is however a contradiction of the information obtained in the qualitative section and would require further explanatory investigation.

Figure 10.23: Reasoned action model treatment of STDs

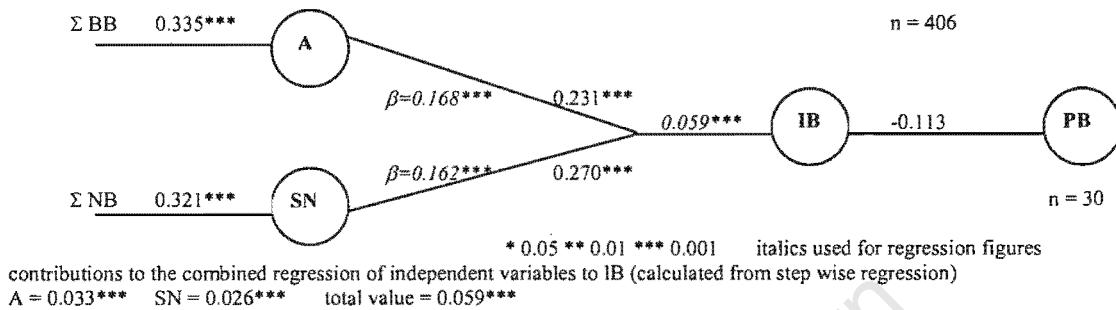
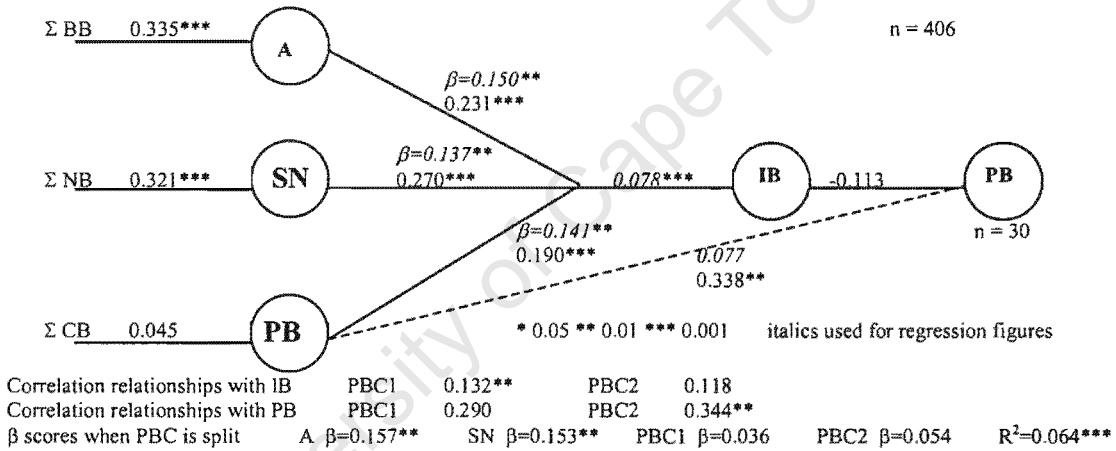


Figure 10.24: Planned behaviour model for treatment of STDs



The figures above showed very low relationships being achieved, especially in the overall R^2 for the relationship to IB. All three of A, SN and PBC reached significance in their relationship with IB, but at low levels of explanation. It is unusual in that the β scores for all three variables are fairly similar. There was no significant correlation between ΣCB and PBC, which would indicate that the beliefs collected were not a good indicator of PBC. It is possible that the respondents did not have a sufficient sense of the behaviour to be able to discriminate accurately. Only 30 out of the sample of 406 acknowledged having had an STD in the past. There is also no or very little discussion about STDs due to embarrassment, hence these diseases may also be shrouded in mystique. In addition, the split between the two possible sites of treatment at a doctor or medical service outside the community versus at the local clinic may present different issues, which this study was unable to distinguish. Information enabling separation of the sample according to where they would go for treatment is not available. These factors of ignorance and the matter of the two treatment sites

break the principles of compatibility and specificity required by the models. This would partly explain the low correlation and regression statistics. All correlations with PB should be ignored, although they are presented for interest, as the sample size of those who acknowledged previously having had an STD was too small for an adequate analysis to be done. The negative correlation between IB and B is likely to be a result of the excessive positivity of the IB variable. In Chapter Eight it was noted that not all respondents had gone for treatment. Splitting PBC into its two components actually reduced explanation on this occasion, with neither component attaining significance.

Figure 10.25: Reasoned action model treatment of STDs for males

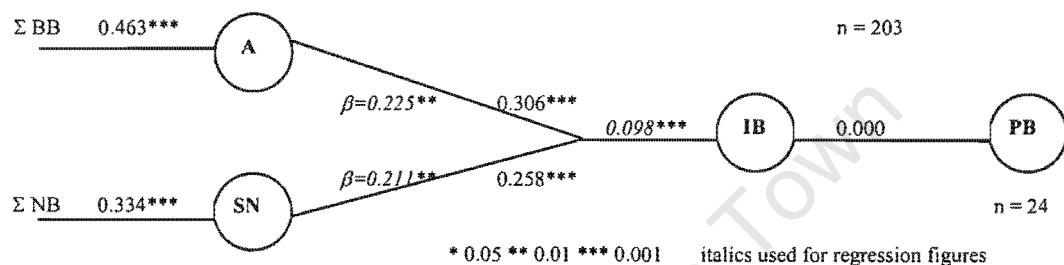


Figure 10.26: Planned behaviour model for treatment of STDs for males

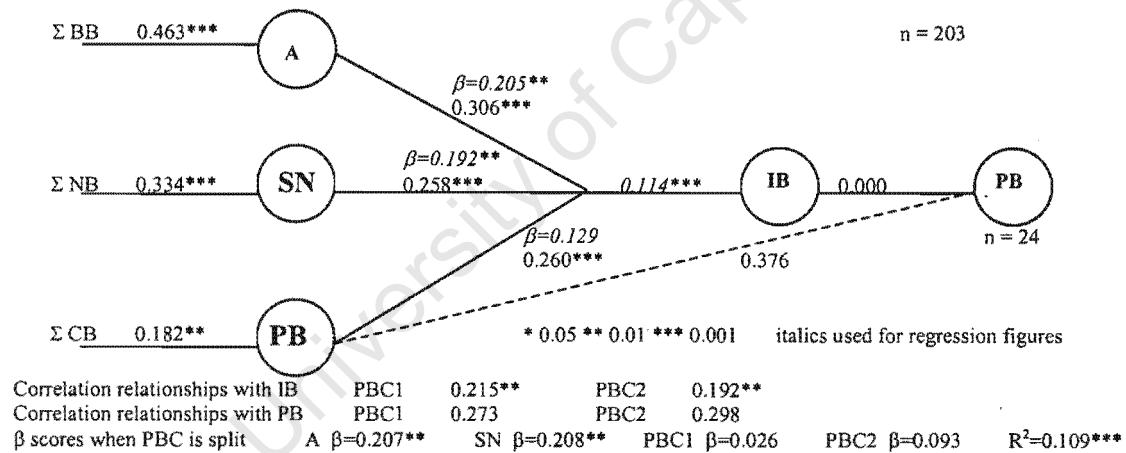


Figure 10.27: Reasoned action model treatment of STDs for females

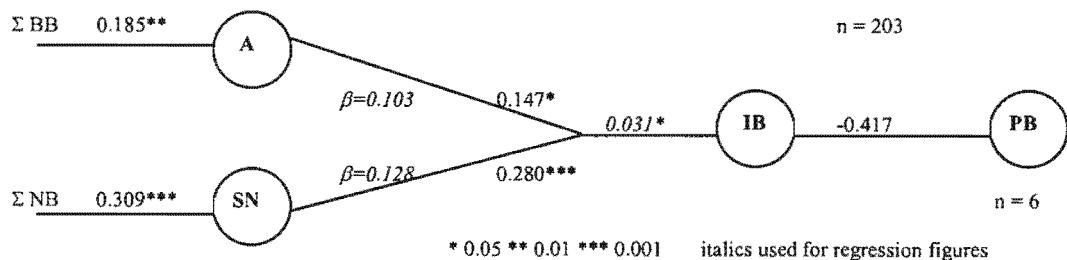
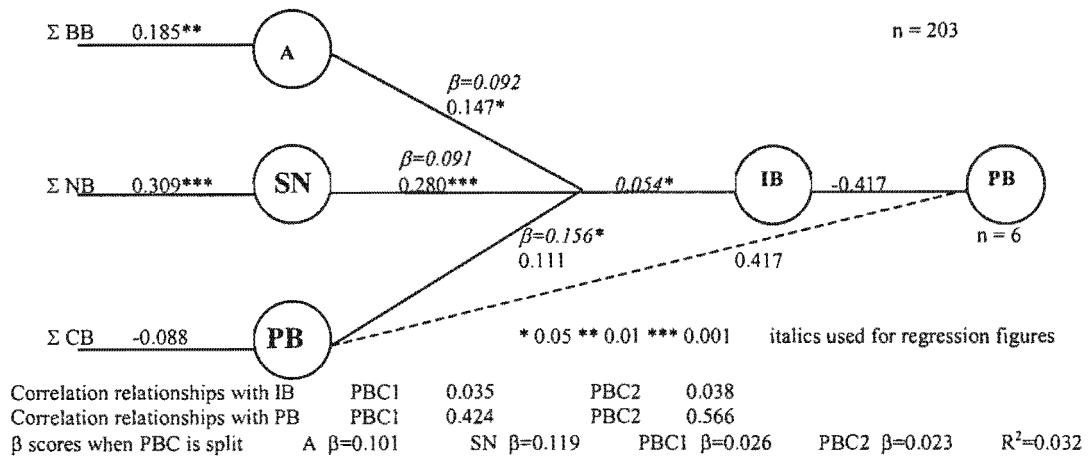


Figure 10.28: Planned behaviour model for treatment of STDs for females

With the sample being split according to gender, there was an increase in the explanatory value of the male sub-sample. There was an increase in the β weighting for the interactions between all of A, SN and PBC with IB, as well as a rise in the overall R^2 . The three variables still register fairly similar β scores although the PBC β score is no longer significant. There are strong increases in the correlation of ΣBB and ΣCB to the next stage variable for men. For the female sub-sample, there was again an overall reduction in the level of explanation provided, to the point that it becomes virtually meaningless. This is a repeat of the earlier patterns. The only factor that retained a high level of explanation was the normative influences. The high value attached to norms was expected from the qualitative results. The especially poor results could also be because of reduced exposure to the issues surrounding STDs among women, in addition to the factors addressed earlier. The sample indicated that only 6 out of 203 women acknowledged ever having had an STD. Discussion in the community about STDs is likely to be even lower among women, given its particularly negative stigma.

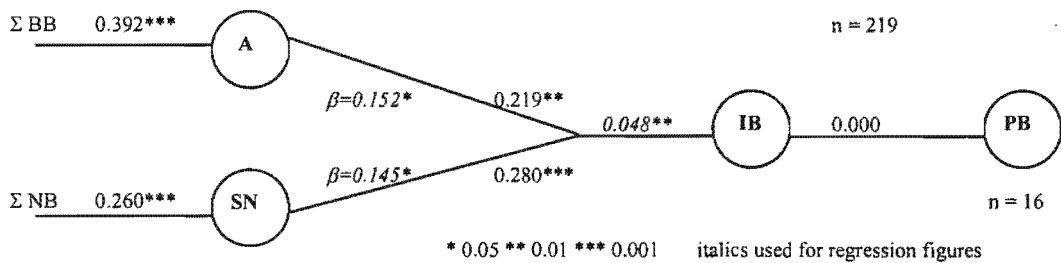
Figure 10.29: Reasoned action model treatment of STDs for those with low knowledge

Figure 10.30: Planned behaviour model for treatment of STDs for those with low knowledge

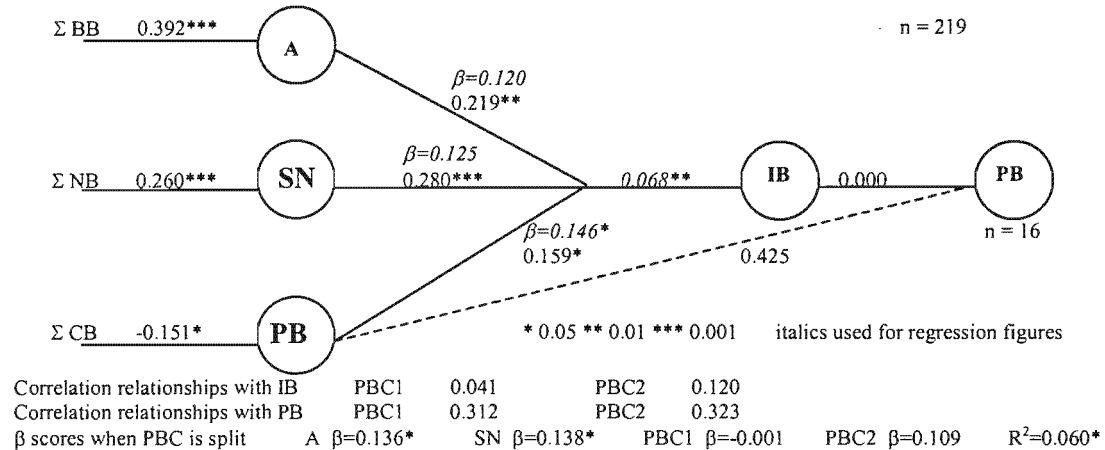


Figure 10.31: Reasoned action model treatment of STDs for those with high knowledge

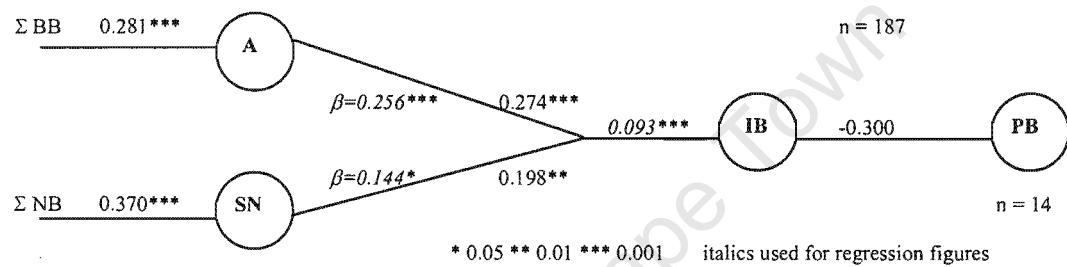
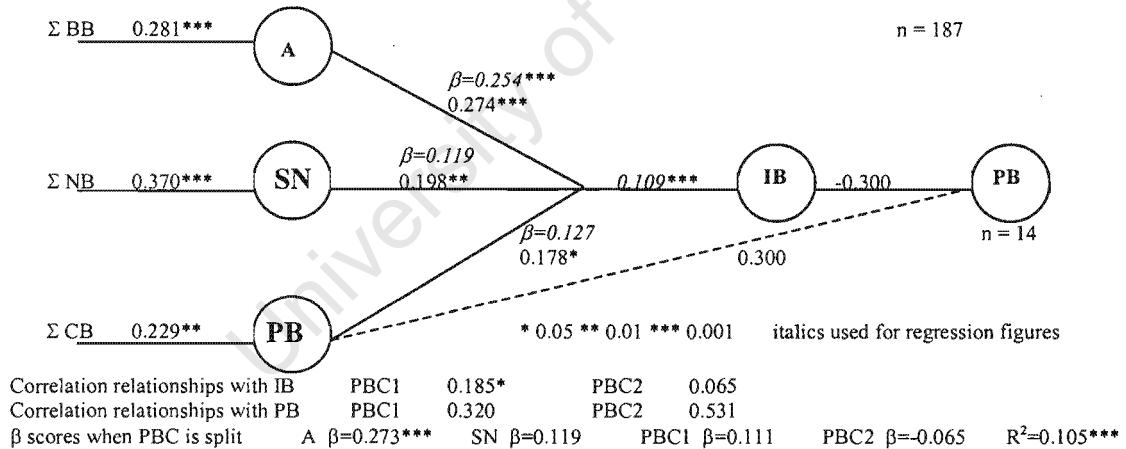


Figure 10.32: Planned behaviour model for treatment of STDs for those with high knowledge



For the sub-sample of those who have a higher knowledge about AIDS, the model produced higher regression values especially in relation to IB, with the β weighting of A increasing the most. While the correlations of SN and PBC with IB are significant, the β weights are lower than for the full population. The actual explanation potential of the low knowledge group is reduced. Most of the values in this are too low for the model to be of much practical value. PBC was the only variable to return a significant β score. In neither case did the splitting of PBC improve explanation. For those with high knowledge there is a higher and positive

correlation between Σ CB and PBC. This could indicate the value of the higher levels of knowledge.

Conclusion for the behaviour of obtaining treatment for STDs

Generally, the explanation value of these models is poor. As stated above this is likely to relate to the poor understanding of treatment for STDs and the multiple sites providing treatment, which would affect the principle of compatibility. The role of PBC for this behaviour was especially contradictory and at points defied explanation, especially if examined in relation to the qualitative data. Of interest is the relative importance of normative influences on this behaviour. It is the only time when these influences have been consistently important. Although the behaviour is secret, most people would be confident that their loved ones would want them to be healed. The lessons for activists are that education is needed about STDs and their connection to HIV. There needs to be an improvement in the facilities for treatment and access to these needs to be more private. Finally, on the positive side, is the knowledge that most people with STDs want to be healed.

Conclusion

The results show mixed levels of explanation. The highest levels of explanation were found in the behaviour of men using condoms. The models for the behaviour of women asking men to use condoms offered less explanation, but the control factor becomes more important in explaining intentional behaviour. This could be due to the relatively lower power status of women. This power differential may be the reason for the generally poorer levels of explanation for female respondents, as was mentioned earlier. The behaviours of serial monogamy and obtaining treatment for STDs showed poor results, but this could be due to the respondents having limited or confused understandings of the behaviours. This would have affected the principle of compatibility so central to TRA and TPB. A further problem noted was the poor correlations of beliefs with the next stage variables. This could be due to the possible problems with the data or to the fact that the population being investigated may have been too broad. Many of the beliefs listed could therefore have been irrelevant to sections of the respondents and confused the results. It is significant that despite the poor measures of behaviour used, there remain mostly positive correlations between both IB and PBC with PB. There is an overlap between variables, especially between PBC and A. Part of this overlap could be a problem of definition for the variable of PBC. The definition of PBC is a point of theory that needs to be examined more closely. In the final chapter, this material is re-examined in conjunction with the information elsewhere in the document to set up the final conclusions for the thesis.

Chapter 11

Discussion

This discussion will draw together all the material gathered in the thesis to attempt to provide answers, or least further direction, for the overall aims and objectives set at the beginning of the thesis. In the introductory chapter, an overall context of the need for applicable theory in psychology was sketched, and the particular context of HIV outlined. The HIV epidemic presents psychology with a unique situation, where our theory can come to the fore and make a real difference in the lives of millions of people world-wide. There are several problems in the arena of HIV that require the explanation of psychology, such as why people do not act on knowledge that should protect them; how people actually assign value to different options e.g. in the case of HIV, people may choose immediate gratification of the sexual urge, which may however cost them an early and horrible death; and why is the fear of and the discrimination against people with HIV so high, and how can it be reduced? This thesis does not attempt to resolve all these questions, but contributes to the understanding of how the theoretical approaches can be adapted and directed towards the problems at hand.

Following the introductory chapter, the context of the HIV epidemic in South Africa was described. Then potential theories for application were outlined, with a special focus on the Theories of Reasoned Action and Planned Behaviour. This laid the basis for the aims and objectives of the study to be developed and from these, the methodology could be advanced. Then the results were presented, firstly so that the qualitative data could provide a further insight into the communities. The survey data was initially presented in its basic descriptive form, before being incorporated into the models for TRA and TPB. It is primarily the results from the latter that form the basis for the discussion, which this chapter will divide into five sections. The first three deal with the core aims of the study as outlined in Chapter Five and reflect the discussion at the beginning of Chapter One. The aims were to examine the implications of this study and particularly the use of TRA and TPB: firstly for AIDS education and to provide direction for interventions; secondly, for the methodology used in the theory and how it was applied in the context of this study; and thirdly, for the structure and coherence of Theories of Reasoned Action and Planned Behaviour themselves. These are drawn together under the section entitled "Overall implications of the study" in which some broader overarching comments will be attempted. The following two sections examine the limitations of the study and look at directions for research for the future. Finally, some concluding remarks are made.

One warning that does need to remain in force when drawing conclusions from this study concerns the uncertainty in the data, which has been addressed in earlier chapters. A number of conclusions are drawn below, backed up by careful argument, but the conflict in the results between what was obtained from the qualitative interviews and the survey remains a concern. To summarise, the differences may have originated in the two methodologies picking up on different sets of intentions based on the respondents dominant view of the context during the interview. In the case of the qualitative interviews it is possible that the person was dominantly considering their social position in the community and their own sexuality. By contrast during the survey they may have dominantly been considering their context as being a person vulnerable to infection with HIV. This could have produced the very different set of responses obtained in the data. Alternatively the differences in the results could be a result of problems due to a perceived demand effect to give certain answers that supported safer sexual practices. The reasons for these problems occurring could include the sensitivity of the data, a desire to please the researcher by giving the correct answers, the difficulties that particularly women have in breaking the silence that exists in relation to sexuality, and a tendency to politeness among the respondents. Problems appeared particularly with the data from the female respondents. This showed in the low correlations obtained in the results for the Theories of Reasoned Action and Planned Behaviour, given in the previous chapter. It was suspected that this was due to the male domination in most areas of society, and the double standards that apply to women's sexuality, which may have made it more difficult for them to be honest in the interview. The first interpretation dominates in the following discussion, but the possibility that these results are a false representation of the respondents reality needs to be borne in mind.

HIV education

The epidemiological data spells out a very clear message of a fast rising epidemic. South Africa and in turn the Western Cape, have been given time and warnings to prepare ways of avoiding the coming disaster. Details are also available on how the epidemic is moving and who the most vulnerable targets are. Interventions are urgently required to halt and turn the epidemic. From this study, the Theories of Reasoned Action and Planned Behaviour produced specific information for each of the behaviours. This is outlined below.

Serial monogamy

Serial monogamy was predominantly under attitudinal influence. The correlations were generally weak for this behaviour, but the emphasis did appear to be on love in relationships. The behavioural beliefs relating to prevention of disease, sexual satisfaction and being emotionally hurt were also of importance. Both the positive and the negative elements of love

have to be addressed in relation to HIV and protective behaviours. The emphasis needs to move on to caring for one another, rather than a fear of being deserted or being made to feel bad. There is also a need to understand what love means in this context. It is not always the standard romantic love of a permanent relationship. For the respondents, love often appears to be confused with desire. Sexual satisfaction was an important part of any loving relationship.

Partners were an important normative influence, but the power differential manifests itself here. There is a need to continue to work on breaking down the power differentials in relationships. The power that men hold over women means that only half the parties concerned are making most of the decisions. The men in turn feel that to maintain power they have to insist on having multiple partners. Families are also an important normative influence, but there is a need to encourage communication on sexual issues within that context. The fear within the family of talking about sex means that the role of parents and other elders is significantly reduced, with their position being limited largely to that of disciplining, but without educating or counselling their children. Control beliefs were generally not important, with most correlations not even reaching significance. The only control belief that attained importance related to that of love facilitating monogamy.

Condom usage by men

The correlations obtained for this behaviour were generally the strongest for the study. Again, attitude was the dominant influence on intention, but control factors were also important. Sexual pleasure tended to dominate the entire picture. There was a firm belief that condoms reduce sexual pleasure. Educators need to talk about sexual pleasure in relation to condoms. Condoms have somehow to become eroticised and to be incorporated into culture. The issue of love was once again emphasised, but again there is a need to understand it more fully as in this context, love was used as a good reason to avoid using condoms. There was also the fear of making a partner angry or inviting rejection by wanting to use a condom. The links made between condoms and STDs\HIV were very low and this needs to be addressed in the future. The only role seen for condoms was their use as contraceptives.

Normative influences were low, but once again partners, family and friends are the important ones. The issue of the family is discussed later. Peer groups should be targeted so that influence of friends and lovers in the case of AIDS can be maximised. Change again requires an invocation of a culture of condom usage. Condoms need to be introduced and incorporated into the culture of the community. These adaptations to culture do happen on a continual basis as a culture is a living phenomenon. The case of condoms being introduced into the gay community is a good example.

Confidential access to and knowledge of condoms is required in order to change the blocks noted in the control beliefs. Different systems of distribution and education must be set up. It appeared that the clinics were too public and because the sisters were from the local community they would know the people who came to request condoms. These factors inhibited people and made them reluctant to attend the clinics. In addition, the nursing sisters were also seen as likely to want to embarrass clients. However, the attitude of the entire community constitutes a barrier in terms of attitudes. If the culture were to change, the problems at the clinic would also fall away. In the interim, there needs to be easy access to condoms, and a private and acceptable process of education on how to use them.

Women asking their partners to use condoms

Generally weak correlations were obtained on the behaviour of women asking their partners to use condoms. This is likely to relate to the complexity of the behaviour involving women asking men to complete a behaviour, and potentially the problems experienced by females responding to the survey as addressed above. Both attitudes and perceived behavioural controls were important in examining this behaviour. Key behavioural beliefs centred on sexual pleasure and partners' response once again. As with the men, condoms tended to mean reduced sexual pleasure. Efforts have to be made to get past this barrier, by trying to make condoms public, exciting, related to status and being the right thing to do. Also of importance for women is the perceived responsibility she has for making her partner happy. This was not something that ranked highly with the men. Beliefs also showed that there was some fear of asking men to use condoms, especially among women with a lower knowledge of AIDS. A method needs to be found to empower women in this context. Prevention of disease and pregnancy did not appear to be regarded as important.

Only health professionals were seen as being an important normative influence, but there was a strong significant connection between the subjective norms and intended behaviour. This ran counter to the other evidence, and gives the impression of being a set of responses that the interviewees felt was in accordance with the medical model. However, the high positive correlation between norms and intention suggests that this is a potentially valuable source of influence. It may be important to use educators with high medical credibility to emphasise the reality of HIV and AIDS. This may also give women a feeling of being professionally supported when approaching their partners.

Control beliefs were important, with the focus being on lack of knowledge, partners' feelings about condoms, and control over their use. Women also need to be educated about condoms

to reduce their own fear and so that they can help their partners put on the condom. Condom use may become an erotic experience on its own and this will empower the women in the sexual encounter. However, condom use remains very much under the control of the males and women fear asking their partners to use one. There was no knowledge of the female condom in the community. When it was described on occasions to women, the dominant response was to laugh dismissively; hence the female condom will need considerable educational backup when introduced.

Obtaining treatments for STDs

The overall correlations were generally low for this behaviour. Attitudes, subjective norms and perceived behavioural controls all reached significant correlations at fairly similar levels, but none was high. Respondents were likely to have problems in knowing what the implications of the behaviour are, as only 30 out of a possible 406 (less than 10%) acknowledged having had an STD in the past. Also this would have made many of the beliefs, but especially those relating to controls, difficult to take into account. This lack of experience may explain why there were few control beliefs that achieved significant relationships with PBC as well as the weak connection between the sum of the control beliefs and PBC. The behavioural beliefs connected with being healthy and limiting the spread of HIV were the key ones throughout. These should be built on as they provide a key entry point for persuading people to obtain treatment. The desire to be free of disease was uniform across both the quantitative and qualitative results. The link of STDs to HIV needs to be developed as part of the education curriculum. The motivations for treatment need to be supported and enhanced by reducing the factors that inhibit people going for treatment, i.e. the control factors. In the case of the community clinics these include lack of privacy, fear of embarrassment and pain of treatment. In private clinics there is the cost of the service and the transport to get there, as well as the pain of treatment and some embarrassment.

Again, partners and family need to discuss this. In both cases, but especially with the family, there are a number of barriers to be overcome before there can be open discussion. The normative force of the family is probably a strongly felt one, but not specifically directed as the family would not know who in that unit had an STD. Those with STDs would be aware of the desire on the part of their families that they get treated, but would prefer that the fact that they had this STD not emerge at all. Again, doctors and nurses are potentially important vehicles for education and should be used for this purpose.

Overall

The study has produced considerable information that is of potential use for AIDS activists working on the ground. Much of the contribution is not new, but it offers directed information for use in the two small communities being studied. It presents directions both for future research and for interventions. It also offers some new interpretations of the data and some of the links between beliefs and behaviour, e.g. the importance attached to feelings of embarrassment and exposure and the connections between love and certain safer sexual practices. Further investigations are required into some of the results obtained from the Reasoned Action and Planned Behaviour models, e.g. the importance of doctors, the role of love and the dynamics of power in relationships.

Comparing the results obtained here with other studies. The R^2 scores were lower than those reported from most other studies done in the Americas, Australia and the Caribbean. Bandawe and Foster (1996) also obtained higher correlation in their study in Malawi, for both condom usage and monogamy. In both the Bandawe and Foster study and this thesis, condom use was predominantly under attitudinal control, which differs from the overall findings from Australia and America, reported in this thesis. In the Malawi study HIV and STDs played a far stronger role in the decision to use condoms. HIV is likely to have been a more immediate threat in that country than in the Western Cape at the time of each study being done.

Methodological issues

One of the principal advantages of the Theories of Reasoned Action and Planned Behaviour is that there is a clearly defined methodology. This review will examine it as outlined by the theories, as well as its application within the context of the study. The advantage of the method is that it is clear and gives good direction to the researcher. It is also replicable, so the theory can be tested in different contexts. The different stages of the method allow information to be collected from the first stage, so that the beliefs used in the questionnaire are more likely to be in line with the reality of the subjects. The method also has multiple internal checks. The disadvantage of this is that the methodology becomes cumbersome and long-winded, especially if more than one behaviour is being examined. This limits the practicability of the method.

The major problem for this study lies in explaining the difference between the results for the qualitative and survey results. Given the earlier discussion it is possible that respondents answered in such a way as to give the researchers what they thought the researchers wanted to hear. This has been addressed earlier on in the text. Factors that could have reduced the bias include the following: group-based interviews as used in the Malawi study (Bandawe and

Foster, 1996); use of same-sex interviewers from outside the community; more time spent on access negotiation and becoming familiar with people; reduction in the length of the questionnaire to reduce time pressure; having access to private facilities in which to do interviews; and other specified methods for collecting sensitive data (Lee, 1993). These options do however have costs at other levels in a study. These may have limited the length of the questionnaire, made the sampling strategy too difficult to implement, and increased the cost dramatically, by e.g. bringing in interviewers from elsewhere.

A problem with the questionnaire is that it triggers certain cue items in the memory, in this case HIV related information, which may have biased the results as well. These are termed response effects (Schwarz, Groves and Schuman, 1998). It is possible that the standardised structure of the questionnaire may have produced these response sets. The repeated style of questions for each of the behaviours may also have established a response style, especially after three behaviours were tested (Schwarz, Groves and Schuman, 1998). These two considerations may have combined in prompting the respondents to answer in terms of what they felt the researcher wanted to hear. As the order of questions can affect how people respond, TRA does attempt to use the structure of the questionnaire to reduce this effect, but the repetitive structure and the framing of the whole study may have provided too many cues. There was no ethical way of hiding the reasons for the survey; given the private nature of the information sought, an accurate explanation had to be provided.

Another factor was that the questionnaire used was far too long. Even with the cuts that were introduced, the interviews took between one and three hours to complete. Some interviews actually took two visits to the respondent to complete. This would have had an impact on the results. The extended interview time would have led to exhaustion and would have cut down on the effort that the respondents put into the later sections of the questionnaire. However, it does appear that many respondents put much thought into their responses. The questionnaire took about 40 minutes to complete during pretesting test runs with colleagues. The dropping of one of the control questions specified by Ajzen was an error. It may have been better to reduce the length and repetition by excluding one of the behaviours that was used. One of two behaviours could have been excluded, either the treatment of STDs, due to the fact that so few respondents had knowingly experienced an STD; or of serial monogamy, due to problems with the definition. For the purposes of evaluating the use of the theory in this context, this may have been a better option. It would however have reduced the possible amount of information collected.

Doing the study on a community basis does present its own set of problems: In particular, the large sample size required to cover the two communities increased the complications for data gathering and analysis. Communities can also create particular meanings around a research study, which may affect how people respond to the researcher and to the questions. For example the red VW beetle that I drove became known as the AIDS car and some community members became nervous about talking to me.

Problems of memory and recall need to be taken into account. Different methods ask for information differently, so may lead to different constructions of memory, e.g. narrative form in the depth interviews and precise itemised information from the questionnaires. The additional space available in the depth interviews means that more of the respondents' own constructions of meaning are brought forward, but the time limitations mean that all the aspects of all the behaviours may not be able to be investigated. The fuller picture is available in the questionnaire, but the meaning system is already preconstructed within it. This preconstruction occurs even though the questionnaire is drawn from an earlier qualitative process. There is also more space to develop the relationship in a qualitative interview so the respondent may offer a different perspective.

Generally in an interview events from the past may be reconstructed by the situation, context and audience when the person is responding to questions. Memory tends to condense similar activities into a single global representation, omitting some of the details. This would have an impact on the process of trying to look at how attitudes are formed in relation to a particular behaviour over periods of time (Schwarz, Groves and Schuman, 1998). Thus, a wide range of factors may form a person's attitude to condoms, some of which are now beyond the individual's memory. The implications of this for the theories under discussion are that some of the important beliefs may not be immediately accessible to memory. A specific memory issue is the tendency of people to overestimate rare events and underestimate common ones (Schwarz, Groves and Schuman, 1998). This means that people might overestimate condom usage and underestimate how often they have additional lovers. Whether these actually affected the results is very difficult to say conclusively. However, their implications have to be born in mind.

In a research interview people present the sense of self that they wish to give, which will influence their structure of reality, both at a conscious and subconscious level. These are reconstructions that reality has to bend towards, so "facts" may be changed, added or left out. An important motivation that emerged for these reconstructions could include wanting to be accepted by others. Another reason is power, which is crucial to identity and since sex is so

closely related to power the pressure to present a desirable sexual image, again both consciously and unconsciously, is very powerful. One example at a simple level could be that men claim to have many partners in order to seem more powerful, while women claim fewer to seem more moral and upright, and so more powerful as well. These motivations would tie into "cultural identity" issues.

Question comprehension was a problem in the serial monogamy questions. It is not clear that the respondents fully understood the concept and that they were able to distinguish it from permanent monogamy. The concept also clashed with the formal education provided in the context of HIV and AIDS. This confusion would have reduced the accuracy of the responses. The back-and-forth translations used in the development of the questionnaire would have reduced the confusion, but it is still possible that misunderstandings occurred. Having said this, the information obtained was still useful and some was validated by information from other sources. Similarly, the behaviour of treating STDs was complicated, as less than 10% of the sample acknowledged having had an STD in the past.

What the above points also raise is the difficulty of defining a behaviour as specified by TRA. It requires good knowledge of the behaviour by respondents, which made the questions around STDs complicated, especially in defining the behaviour in terms of the four criteria. The behaviours for this study could not be defined in terms of time as they requested information far into the future. The option suggested of asking respondents about condom use on the next occasion they had sex defined the time element, but this is not a longer-term safer-sex practice. Different constructs would apply in the short versus the longer term. This is raised in more depth in the next section, but the lack of precision did present problems for all the behaviours. This is a potential shortcoming for practical applications of the models.

One key issue that arose in the statistical results was the high level of multicollinearity between variables, especially the beliefs. It may be important to look at multicollinearity, as it could provide additional valuable insights. There were very high interactions between some of the variables and many of the beliefs overlapped considerably with each other. The use of multicollinearity statistics together with factor analysis and\or multiple regression could allow for considerably more explanation. This will obviously add to the complexity of the analysis and was not attempted here, beyond some limited comments based on an analysis at face value.

Reliability was poor or improperly measured. A better method of recording reliability may have produced a more accurate understanding, but this would either have complicated the

methodology further or increased the length of the questionnaire. The qualitative data and general literature provided some validity check. This showed some problems in the survey data as discussed above.

Model

This study also raised a number of questions for the theories of Reasoned Action and Planned Behaviour. The methodological issues have been discussed above. The theory has already been tested in numerous situations so this is an examination of the finer points rather than the core base. The difference produced in the theory of Planned Behaviour by adding the perceived behavioural controls is an issue to be focussed on. One of the striking factors is the robustness of the models across a wide range of behaviours and contexts, something which was reinforced by this study. Despite numerous problems described above, the study was able to produce useful results. This reinforces the central philosophy on which the theory is based.

Bending the theory to a reality can present problems. The issue of specificity of criteria for the behaviours to be used was addressed in the previous section and found to create complications for the methodology. It is difficult to implement the four elements of compatibility when defining the behaviour: namely, action, target, context and time. Generally, only the action was listed in this study. Very different issues apply for context, target and time. Fishbein and Ajzen (1975) state that as long as the elements are consistent they do not have to be specific. Therefore, a general open time period is acceptable as long as this is consistent throughout the study. It does however reduce specificity. Given the behaviours used in this study, the time period becomes very complex. For example, condom usage should be regular, but if both parties in a relationship are faithful and free of HIV then condoms are not necessary as long as negotiation takes place around this. Similar problems were created for all the behaviours. However, to be able to put all this into a question is too complex and most people would battle to hold the information in their minds.

There is also a considerable number of hidden factors that may emerge to influence the process. It is not difficult to select a behaviour for experimentation purposes that will fit completely within the principle, but the reality often demands that more complex situations are approached, in which the behaviour can take many forms or be subject to unspecified complications. An example of this would be the range of sites at which to get treatment for STDs. Other research has supported Fishbein and Ajzen's findings that a person's attitude to a behaviour will be different depending on the context in which they find themselves (Eagly and Chaiken, 1998).

There was a need to break up the risk behaviour and the population categories in order to strengthen the model. This is a weakness of TRA and TPB, as they lose power with bigger populations and as the behaviour definition loosens. Implicit within the theory and the principle of compatibility is a required consistency among the respondents. Overall the size of the community in which the testing was done may have been too large and diverse. There were too many components to take into account concerning the respondents, such as variations in age and maturity, different levels of exposure to knowledge and skill, different genders requiring different responses to some questions, and varying meanings which may be attached to a particular behaviour.

A direct experience of the behaviour will increase the consistency of the attitude behavioural relationship and increase the temporal stability of the attitude (Eagly and Chaiken, 1998). Eagly and Chaiken's review (1998) goes on to state that an attitude that is automatically accessed without active attention or conscious thought biases perceptions of the object in the immediate situation, and behaviour simply follows from these without any necessary conscious reasoning process. This may provide some explanation of the problems found in the STD treatment model. Very few of the subjects acknowledged having had an STD, only 30 out of 406, so would not have had any direct experience on which to base their attitudes.

According to the theory, each of the main beliefs is itself informed by a complex mixture of other beliefs and values. These are the external factors in Fishbein and Ajzen's model. The concept of a blanket collection of external variables being expressed by a few beliefs may mean that many important issues are missed. Evidence for this was shown when the collection of beliefs obtained was unable to provide explanations for the attitudes, subjective norms and perceived behavioural controls, as was indicated by the poor correlation figures obtained. In addition, in order to have an educational or motivational impact on many of the beliefs, such as will induce behaviour change, an understanding of the external factors is required.

There are two issues about norms that have to be addressed. The first, also raised as a criticism in the literature, is the influence of social norms beyond the subjective normative influences of those people close to the individual. This appeared in the discussion about the position of women. Part of that influence was noted because of the reactions of partners and the increasing values for PBC, but the full extent of it could have been missed if the qualitative data had not been available. Other social norms such as the role of power in the community, the fear of disease, and the nature of loving relationships, could also have an important influence, which is difficult to pick up using the subjective norms. A second issue about SN concerns the role of the family. This was regularly given as an important normative

influence, but from the qualitative data and literature reports it is clear that the youth would keep their sexual behaviour hidden from their parents and other family members as much as possible. The normative influence therefore has to happen via indirect routes, such as a sense of caring and support or a family moral code. This bears further investigation as it may have important implications for the definition of SN. An additional complexity here, is that based on the data many parents would have severely disapproved of their young unmarried daughters in particular, participating in sexual activity under any conditions.

One of the questions raised in the literature review is the relation between control beliefs and behavioural beliefs. While there was considerable overlap between attitudes and perceived behavioural control for serial monogamy, a larger number of different results emerge supporting a separate control function for the use of condoms. In the behaviour of condom use, respondents raised control issues in the first phase, separately from the behavioural beliefs. On the basis of these points it could be argued that a separate category is required. Whether this additional information warrants the increased complexity in terms of analysis and additions to the questionnaire is a matter for debate. It may also be possible to adapt the behavioural beliefs in order to take into account more of the control aspects. What is clear however is that the control beliefs do add meaning to the results for certain behaviours. How this is to be incorporated into the methodology is up to the researchers themselves. Ajzen offers this via a new variable. The role of PBC was most clearly seen in the behaviour of women asking their partners to use condoms. This is obviously a behaviour in which control issues are likely to be important; because the woman has to ask the man to do a particular thing, the final result is partially out of her control. As was stated in the qualitative results, a number of women felt that even if they asked, their partner would not agree, and would rather leave the relationship than use a condom.

There are problems with the definition of PBC. This was difficult to interpret fully in this study as there was the problem of one question being excluded. The problems were intensified when different results were obtained on certain behaviours when the two questions used to measure PBC were split, e.g. for men using condoms. The two scales from "easy" to "difficult" and "possible" to "impossible" are different constructs. It cannot be known what the implications of the third question would have been. The problem of definition was also a focus of criticism in the literature, with its relationship to the theories of locus of control and self-efficacy being uncertain.

A number of theorists had advocated the addition of further variables, such as self-efficacy, past behaviour, etc. While each of these may add information, they detract from the

parsimony of the theory and may produce complications for the theoretical base. They also take away from the central contribution of TRA, namely its clarity and simplicity.

More recent research on attitudes has shown that the negative attitudes, which encourage avoidance, may exert stronger effects than the positive attitudes, which encourage approach. This can occur even if the negative and positive aspects are found to be virtually equivalent in psychometric terms (Eagly and Chaiken, 1998). While the quoted research focused on attitudes, similar rules could be said to apply to beliefs about the behaviour, which are in reality attitudes in their own right. These beliefs are described in terms of the cognitive aspects of the attitude structure, but also generally contain an affective component (Ajzen, 1988). The relative power of the negative aspects could have had implications for the data, especially as all the behaviours had negative material among the attitudinal beliefs. Similar problems would exist for the normative and control beliefs.

Overall implications of the study

Drawing on all three of the above sets of conclusions, it can be said that the theories of Reasoned Action and Planned Behaviour do have contributions to make and are generally applicable to the work on HIV in South Africa. Considerable information was gained, confirming other findings, generating new information, and more important, adding a depth to the understanding about HIV in South Africa and world-wide. The statistical results may have been weak, but this is likely to have been largely a result of the methodological problems. It is partly due to the robustness of the model that some good results were obtained at all. The methodology was functional although there are problems with implementation that will require resolution, especially in relation to sensitive topics like HIV. These are examined below. It is noted that the theory also operated as intended to produce the information required.

However, some problems were certainly found and noted in this thesis. Difficulties that arose from the principle of compatibility for the definition of behaviour, and the size of the population that may ideally be researched, were addressed earlier. A single major criticism for the practical application of TRA or TPB in underdeveloped countries is the cost in terms of time and infrastructure. The method takes a long time to implement, as it has to go through a first phase, followed by the development of the questionnaire, and finally the full survey. There are further complications due to the length of the questionnaire needed to satisfy theory requirements and the lack of familiarity of respondents with the methods such as Likert scales. Even following the complex statistical procedures required is sometimes a difficult issue, as equipment and expertise may not always be available. South Africa has better access

to resources than most third world countries, but the methodology still presented problems. Adaptations to deal with these need to be made.

The implementation of the methodology could be improved with the assistance of a clear manual for operation, plus support for sampling and interviewing skills. Some guidance and ideas have been forwarded here. This needs to be drawn together into a document so that a researcher or activist attempting to use these theories to develop a campaign has the experience of others to work with. Continual reference needs to be made back to the basic theories.

There is also some information that was gained from the qualitative data and which may have been difficult to detect or was not picked up in the TRA results. This is a strong motivation for having different methodologies and theories commenting on one another. The single biggest obstruction to safer sexual practice appeared to be male dominance. This factor came through in both the qualitative and quantitative data. Women's sexuality seemed to be strongly influenced by men in most cases. This was described in depth in the qualitative results chapter, but was also reflected in the responses to the survey, and repeatedly in other studies reported in the literature review. The other major discourses were on love, rejection and the importance of sexual pleasure and freedom. These discourses were used to maintain the power differential. They drew on social representations of gender, power and sexuality. They also manifested themselves in lay theories such as, there being more women than men in the two communities, ideas about how STDs are transmitted, reasons for multiple partners and the impact of condoms on sex. There was also considerable romanticisation of African sexuality. A strongly dominant discourse, especially amongst the men, but also shared by a majority of women, created a distinction between African sexuality and that of other cultures. On the positive side, they spoke of open love, pleasure, ease of sharing, high sexual needs and a very high virility. On the negative side was acknowledged exploitation, fears of rejection, feeling bound in fixed behaviour patterns and the risks of infection.

General lessons

This section covers information and findings obtained by combining inputs from the qualitative data, TRA and TPB results, and the literature. It is already commonly accepted in the literature that knowledge is not enough to bring about behaviour change. This assertion has also been supported by the results of this thesis. However, what appears to emerge is that a depth of knowledge is required, otherwise contrasting information could put limits on the behaviour change. For example, questions such as, "Why bother to change your sexual behaviour if you can contract HIV through casual contact?" Or, "Why should I use condoms

or stick to one partner when a “better” prevention strategy is to identify people with HIV and expel them from the community?”, can immediately undermine new HIV knowledge.

Superficial knowledge and understanding can have detrimental effects, especially when combined with existing beliefs, theories and understandings of sexuality and HIV. Very often the medical facts run at odds with cultural or religious beliefs, and in these cases the existing cultural or religious beliefs will dominate or reinterpret the new knowledge. One example could be: good people who are moral do not get AIDS so, firstly, if you get HIV you are immoral and evil; and secondly, to protect yourself you should select only “good” people to have sex with, and then you will be safe. Then there is the clash of knowledge with ideology, such as the right to male domination and the attachments to power, such as the right to multiple partners.

Education cannot be applied only in an overall general fashion. For it to be successful, there needs to be both general and very specifically directed messages to subsections of the population. For example, in shebeens, there needs to be a supply of condoms and education about how to use them. The interaction between alcohol and dangerous sex must be examined as well. Other groups that could benefit from specifically directed education include political and other leadership figures, sangomas, and school pupils. Educators must recognise the differences in the community, for example between hostel dwellers and those in informal housing, or between those that have been urbanised for less than a year versus those who have lived in the area for more than 20 years. These groups have different experiences of medicine and life, access to resources, and knowledge and familiarity with key information important to understanding HIV. Essential knowledge about how to use condoms, how to identify STDs, and a few other gaps need to be filled. Explicit precise messages are of importance here. There are specific areas where clear factual knowledge is required. These include use of condoms, STD identification and treatment, clarity on how HIV is not transmitted and acceptance of PWAs. These are obvious factual programmes that can be implemented. Sources of education are also important, and people who are respected and known to the community should be used to provide this. It would therefore be important for different reasons to use peers and doctors to do medical education. Community leadership should support the education without adding their usual qualifications about it. Families also need to be involved, which would mean breaking the silence that surrounds the subject. Churches are not universally trusted according to the qualitative data, but remain vitally important. There is a strong necessity to try using community leadership from the political parties, as well as from sports, schools and community organisations and churches, but this would mean that the leadership would have to change and develop which, based on information from the qualitative data, is something they are not ready for. As an activist working in the area, I

found that interventions constantly ran up against a resistance that took a number of different faces, such as the following: other issues are more important; sex cannot be spoken about to children or youth as it may encourage them to have sex; a general fear of talking about sex publicly; a lack of resources; and conflict among HIV activists.

An additional factor that requires consideration, is as stated earlier, the legacy of apartheid. This system led to intense dehumanisation, broke up families, and separated people from the resources necessary to survive. The legacy of it remains in the poverty, the highly-skewed distribution of wealth, racism, social separation of races and classes, crime, and mistrust. All these factors have to be addressed in any intervention that may take place. As in many other areas of life in South Africa, effective intervention against HIV requires changes beyond those immediately demanded by the syndrome. Employment, adequate housing, general education, protection of women and other oppressed groups, reduction in crime, and improvement in services generally, are all important. Adequate nutrition and control of other diseases, not just AIDS, is essential. All these factors increase the rates of transmission of HIV, so require intervention.

All the protection behaviours for HIV present problems. Monogamy for life was not a feasible option, and this was therefore dropped as a potential safe behaviour for this study. Even serial monogamy was not generally acceptable and as such, offers only partial protection. The option of using condoms was soundly rejected for reasons ranging from loss of sexual pleasure to this not being part of their culture. The female condom was virtually unknown. Obtaining treatment for STDs did find more acceptance, but the link between STDs and HIV was very seldom made. There needs to be concerted effort put into changing these attitudes and finding ways of making the behaviours acceptable, e.g. eroticising condoms, and making STD treatment safe and accessible. Powerful social representations and lay theories have developed against the use of safer sexual practices. These are backed up by perceptions about AIDS. Ultimately, one is left with the sense that from the qualitative data that AIDS is something to be feared intensely, but which cannot be combated. It can only be kept away by wishful thinking and the rejection of PWAs or anything else associated with HIV.

Sex is not an isolated activity, but is fully connected with all other areas of behaviour. Likewise, HIV prevention is linked to similar areas in people's lives. This was shown in the literature, qualitative findings and TRA\TPB research findings. There are a number of direct connections that can be drawn from this study. This includes the focus on sex in peer relations and the abuse of the notion of "culture" in arguing for unsafe sexual behaviours. These are not new discoveries, but mostly build on what is already known. Sexual decisions are influenced

by identity issues and how people perceive themselves (Campbell, 1997). Sexuality is key to how people define themselves, e.g. most of the political leaders were very proud of their sexual conquests, and so were the playboys. The entire issue of identity does require further research in relation to the issues of HIV. It is also possible that people may operate under a number of identities with respect to HIV. Perceptions of ideal behaviour differ from behaviour in reality. Respondents appear almost to live in two worlds, one of which is the ideal behaviour that they know they should practice in relation to HIV. This is presented to the researcher or medical professional to maintain their narcissistic image of being clean and respectful. The second is the social world where they may practice a very different behaviour. This is shown to their peers to maintain their participation in the group in which their sexual prowess may be exaggerated. All these images are crucial as to how their identity is defined and lends more support to the idea of doing research on identity in relation to HIV. This is one explanation of the phenomenon, but more work on identity issues is likely to deepen the insight. As one respondent from the qualitative data section put it, when you "have this girl" all thoughts of condoms and safer sex disappear. This refers to the discussion of on-line and off-line beliefs that were raised in Chapter Four.

A key aspect of both the qualitative and quantitative data was a sense of low vulnerability to HIV. Many of the respondents did not believe that HIV or AIDS could affect them. This, balanced against heightened fear, gives the basis for the strong development of denial as a defence mechanism, and does not bode well for behaviour change. The psychological theory expects fear to lead to denial, which was supported in the data. People distanced themselves from AIDS by personal choices, such as, "I only sleep with clean people", or by physical distance, "AIDS is only in Johannesburg". Alternatively, AIDS is minimised by the belief that cures are available from sangomas; that contracting HIV is a matter of fate "If I get it, I get it"; or by making its avoidance less important than sex. Even alternatives like suicide are contemplated, rather than facing the disease. All these perceptions and ideas reduce the motivation to change behaviour patterns. Silence was also an overarching problem. HIV, AIDS, STDs and sex cannot be spoken about openly, other than in a joking way within select groups. There appears to be a universal acceptance that this is not a subject for open discussion. Within the family nobody talks about sex, parents will not allow it to be taught at schools, the churches preach rather than assist, and other organisations argue that they have higher priorities. The community leadership is afraid to stand up and talk about these subjects, other than in very general terms. This silence must be broken, but those in the powerful positions know that to open such discussion is to invite change and potentially loss of their own power and position. There is a perception that HIV is a nuisance and that it gets in the

way of one's life. Also there is, especially for men, spontaneity in sexual relations which most do not want to lose.

A block exists against people using condoms. This seems to centre on the simple desire not to use them, as well as doubts about their usefulness. From the qualitative interviews, this block seemed almost to override the motivations for using condoms. To refuse condoms was the first response, then the motivations would arise, mostly in the areas of pleasure and control.

Care needs to be taken in focusing on "marginalised" groups, as this leads to stereotyping and further marginalisation (Crewe, 1997). Identification of people with HIV makes them more vulnerable to discrimination and isolation. This was borne out by the recent murder of an AIDS activist who went public with her illness. Even after her death the prejudice lived on as the police dragged their heels in the investigation. South Africa already has high levels of xenophobia (Skinner, 1998), and this discrimination is being extended to those with HIV, with their being labelled as part of the "out" group and being blamed for the disease. In the qualitative data it became clear that to be associated in any way with HIV, even by wanting to use a condom or being friendly with someone who is HIV-positive, is enough for someone to be rejected by their community. As the epidemic increases, so will this labelling. Already there were rejecting comments being made about a particular person because they were from another community. In the long term, this can only be detrimental. The high levels of fear that maintain this behaviour need to be addressed. TRA, together with theories such as social representations and identity theory can make an important contribution to this endeavour.

In Chapter One, two discourses were raised in relation to HIV, namely the medical discourse and stigmatisation. Both are prevalent in this data, but remain distinct and disjointed in relation to one another. However they link into the other discourses, especially around male dominance and differences in power between the genders. If a person is diseased and infectious, and either has or is perceived to have HIV, they fall to the bottom of the power continuum, as they are socially unwanted.

All of this reinforces the importance of the use of theory, in working with the HIV epidemic. The Theories of Reasoned Action and Planned Behaviour, as well as other social psychology theories, would be valuable. Practical theories that have clear goals and limitations are extremely useful and important. What has also been highlighted is the importance of the full application of a theory rather than drawing piecemeal on different theoretical approaches. The danger of the latter is that the underlying philosophical base of the theory is undermined and its potential to operate adequately in a particular situation thereby reduced. It is best therefore

to have a central theory, plus additional contributions to assist the interpretation, ensure validity and fill gaps. The explication of the male dominance ideology is a useful example. The HIV syndrome is enormously complex, so multiple considerations and theoretical inputs are required. The multiple theoretical input is useful to make up for the gaps in the central theory.

TRA does work well with other theories. This was shown in the literature (Fishbein, Guenther-Grey, Johnson, et al, 1996) and also in this study, where the different approaches serve to explicate each other and provide validity checks. Social representations and lay theories co-operated well in the study to add explanation and strength to each other. The analysis is deepened and more information is used, so this collaboration can grow stronger.

With regard to the discipline of psychology, based on experience gained in this thesis, I would like to make a comment on the problems of definition. The pursuit of ever-higher predictions is considered desirable, but the models end up being so complex that they are virtually inapplicable outside a psychology laboratory. Definitions are also extended until they become so wide that their meaning is actually reduced. An example of this is the attempt to include everything, i.e. thoughts, emotions and behaviour as being a part of attitude. These models and definitions are formidable in that few gaps are left, but they create problems in the applied situation. Psychology needs to become more lateral to encourage the development of thinking and it also needs to take a more practical approach. There appears to be a desperate search for a single test of meaning, almost paralleling the alchemist's search for gold, which I believe is a false search. This meaning should be found rather in the co-operation between theories which look at a situation simultaneously from different vantage points. This was shown here in the manner in which lay theory and social representations were able to comment on the results of TRA and TPB to provide additional meaning. Within this process the emphasis needs to remain predominantly constructive.

Limitations of the study

The major problem with the data was the difference between the qualitative information and the results from the survey. A number of attempts have been made to explain it including that the different methodologies drew on different intentions, methodological issues and the sensitivity of the information, but it has put serious limitations on the interpretation of the data. This has been discussed above and some solutions offered, but uncertainty must remain over how best to use the results found here. The conflict between the quantitative and qualitative data is considerable. There was no follow-up intervention research project as

previously planned, so that the application and usefulness of the theory could not really be tested.

A second problem was that the study did compromise the method in some respects. All the questions on perceived behavioural controls should have been included. It may also have been possible to define the behaviours more tightly in terms of the four criteria. It was decided not to follow up on actual behaviour, due to its private and intimate nature and the difficulty that people had in talking about their own sexual behaviour. Having no good measure of behaviour did compromise the study and meant that the connection between intentions and behaviour was rendered largely meaningless. For the rest, the methodology attempted to keep as close to the original as possible. Considerable care went into the sampling, training of fieldworkers and questionnaire development. A warning for future research is close attention should be paid to the methodology. Poor or lazy research or the taking of short cuts to reduce costs can easily undermine even the more robust theories.

The study tried to do too much. Too many safer sex behaviours were focused upon, which meant that the questionnaire was too long. This in turn compromised the study on other levels. The full gamut of behaviours formed part of the negotiations for access to the communities, which made it difficult suddenly to drop some of them from the study. Therefore, right at the beginning, a lower-key approach was required. The behaviour of relating to people with HIV was dropped due to time and thesis-length considerations. This is a pity as it is potentially a vital way of getting HIV into the open, which was a crucial step for behaviour change, as has been noted in other sites internationally.

The rigour of this study was not sufficient to answer some crucial questions completely, especially the debate between the Theories of Reasoned Action and Planned Behaviour. It was also not possible to examine new concepts that emerged, e.g. the different normative role of the family and the different meanings attached to the two PBC scales. The thesis did not set itself up to tackle technical theoretical issues as its major component. The focus was on the potential for the application of theory.

Directions for future research and work

In the directions for future research there are two focus areas. The first covers the direct work needed to develop the material gathered here. The second will look at the research requirements for the further development and extension of the theories of Reasoned Action and Planned Behaviour. There is a need to monitor changes in these belief structures over time, especially with the advent of democratic rule and self-government. The advent of

democracy may have significant effects on people's self image and methods of relating. In addition, as the HIV epidemic advances, so the number of cases and extent of education increases, and this will have an impact on beliefs, attitudes, subjective norms and perceived behavioural controls. Information is needed on what lies behind beliefs and what they mean, in order to be able to intervene. A purely cognitive intervention may miss the mark. The qualitative data gives some indicators, but further interviews, questionnaires, and most importantly intervention studies, are required. Research still needs to be done on the implementation of findings for the theories of Reasoned Action and Planned Behaviour.

Some questions continue to exist around Reasoned Action and Planned Behaviour, although this study did make some contribution to finding answers. Although control beliefs were important for some behaviours, they were not as relevant for others. While this may be expected from the theory, given that they should only come into play where behaviours are not under pure voluntary control, some questions still need to be resolved if this cannot be incorporated into the original theory in another way. An additional contrasting query must also be raised as to whether the facilitatory control beliefs do not have a role for voluntary behaviours as well, by encouraging such behaviour to happen. Both of these need tightly directed research to find answers. Some questions were also raised around normative beliefs and the principle of compatibility needs further testing.

There is a need to follow what is happening in attitude research generally, including in measurement and methodological issues. For example, the idea that negative beliefs exert a stronger force than positive beliefs also requires investigation as this could have implications for the basic structure and communication between variables.

In this study a number of new research questions arose that bear further investigation in relation to HIV behaviour and for theoretical development. These include the role of identity in interpersonal connections during sexual negotiation, and how this identity differs from that used in other, different situations. Also important are the role and structure of the male dominance ideology, especially pertaining to sexuality and the negotiation of safer sexual practices. The relationship of power to sexuality, although not a new area, does bear further research in this context.

Theories evolve over time as new information emerges and contexts change. Further research needs to be done on both TRA and TPB, bearing in mind two provisos: firstly, acknowledgement and preferably maintenance of the philosophical base of the theory; here I would suggest that parsimony and simplicity are important points to emphasise. Too often the

contribution of the original theory is reduced or destroyed by lumping theories together, or by arbitrarily adding new components. Secondly, care must be taken not to make theory too complex or too restrictive, as it is then no longer useful or practical.

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Appendix 1
First phase questionnaire

University of Cape Town

University of Cape Town

Free Association On Beliefs Questionnaire

I am doing some research on AIDS among young people. So as a young person living in this community I am going to ask you what you believe and know about some of the behaviours that are important in relation to AIDS. Everything that you tell me will be totally confidential. Your name does not even appear on the questionnaire. The interview will take about half an hour. First I do need some basic details about you.

Brief details on person.

Age Sex Housing type Community

Organisations

Employment status

For the rest of the questions I want you to just say the first things you think of in response to what I ask you. It is important that you just give me these first ideas and do not try to think about your answers too much or tell me what you think I want to hear. I will first go through an example of what these questions will look like.

For example:

What do you see as being the advantages of playing sport at least twice a week?

What do you see as being the disadvantages of playing sport at least twice a week?

Is there anything else that you associate with playing sport at least twice a week?

The answers may be

- keeping fit
- meeting friends
- can get injured
- boring
- *uses a lot of time

Free Association On Beliefs Questionnaire

I am doing some research on AIDS among young people. So as a young person living in this community I am going to ask you what you believe and know about some of the behaviours that are important in relation to AIDS. Everything that you tell me will be totally confidential. Your name does not even appear on the questionnaire. The interview will take about half an hour. First I do need some basic details about you.

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For example:

What do you see as being the advantages of playing sport at least twice a week?

What do you see as being the disadvantages of playing sport at least twice a week?

Is there anything else that you associate with playing sport at least twice a week?

The answers may be

- keeping fit
- meeting friends
- can get injured
- boring
- *uses a lot of time

Finally I want to know if you feel that anybody or anything is controlling your decisions. The questions are:
Is there anything that would make it difficult or prevent you from drinking this weekend?
Is there anything that would make it easier or force you to drink this weekend?
Are there any factors beyond your control that come to mind when you think of drinking alcohol this weekend?

Single partners:

Now I would like to start looking at the behaviours related to AIDS. I will begin with the behavior of having sex with only one boy (girl)friend and not having sex with anybody else until that relationship ends and you start a new relationship in which you only have sex with that new boy (girl)friend. Do you understand what I mean by that behavior?

For the first question I am again interested in what you believe about the behavior.

What do you see as being the advantages of only having sex with the one boy(girl)friend you are involved with at the time?

What do you see as being the disadvantages of only having sex with the one boy(girl)friend you are involved with at the time?

Is there anything else that you associate with only having sex with the one boy(girl)friend you are involved with at the time?

In the next questions I want to know who has an influence over your decisions. The questions are:

Are there any groups or people who would approve of you only having sex with the one boy(girl)friend you are involved with at the time?

Are there any groups or people who would disapprove of you only having sex with the one boy(girl)friend you are involved with at the time?

Are there any other groups or people who come to mind when you think about only having sex with the one boy(girl)friend you are involved with at the time?

Again I want to know if you feel that anybody or anything is controlling your decisions. The questions are:

Is there anything that would make it difficult or prevent you only having sex with the one boy(girl)friend you are involved with at the time?

Is there anything that would make it easier or force you to only have sex with the one boy(girl)friend you are involved with at the time?

Are there any factors beyond your control that come to mind when you think of only having sex with the one boy(girl)friend you are involved with at the time?

Condoms:

The next set of behaviours concern condom usage.

Men

What do you see as being the advantages of using condoms every time you have sex?

What do you see as being the disadvantages of using condoms every time you have sex?

Is there anything else that you associate with using condoms every time you have sex?

Are there any groups or people who would approve of your using condoms every time you have sex?

Are there any groups or people who would disapprove of your using condoms every time you have sex?

Are there any other groups or people who come to mind when you think about using condoms every time you have sex?

Is there anything that would make it difficult or prevent you from using a condom every time you have sex?

Is there anything that would make it easier or force you to use a condom every time you have sex?

Are there any factors beyond your control that come to mind when you think of using a condom every time you have sex?

Women

What do you see as being the advantages of asking your lover to use a condom every time you have sex?

What do you see as being the disadvantages of asking your lover to use a condom every time you have sex?

Is there anything else that you associate with asking your lover to use a condom every time you have sex?

Are there any groups or people who would approve of your asking your lover to use a condom every time you have sex?
Are there any groups or people who would disapprove of your asking your lover to use a condom every time you have sex?
Are there any other groups or people who come to mind when you think about asking your lover to use a condom every time you have sex?

Is there anything that would make it difficult or prevent you from asking your lover to use a condom every time you have sex?

Is there anything that would make it easier or force you to ask your lover to use a condom every time you have sex?
Are there any factors beyond your control that come to mind when you think of asking your lover to use a condom every time you have sex?

STD's:

These questions concern the treatment of sexually transmitted diseases.

What do you see as being the advantages of going to get treatment for an STD?

What do you see as being the disadvantages of going to get treatment for an STD?

Is there anything else that you associate with going to get treatment for an STD?

Are there any groups or people who would approve of your going to get treatment for an STD?

Are there any groups or people who would disapprove of your going to get treatment for an STD?

Are there any other groups or people who come to mind when you think about going to get treatment for an STD?

Is there anything that would make it difficult or prevent you from going to get treatment for an STD?
Is there anything that would make it easier or force you to go to get treatment for an STD?
Are there any factors beyond your control that come to mind when you think of going to get treatment for an STD?

PWA's:

These questions cover how you feel about people who have AIDS.

What do you see as being the advantages of sitting next to a person with AIDS in a taxi?
What do you see as being the disadvantages of sitting next to a person with AIDS in a taxi?
Is there anything else that you associate with sitting next to a person with AIDS in a taxi?

Are there any groups or people who would approve of your sitting next to a person with AIDS in a taxi?

Are there any groups or people who would disapprove of your sitting next to a person with AIDS in a taxi?

Are there any other groups or people who come to mind when you think about sitting next to a person with AIDS in a taxi?

Is there anything that would make it difficult or prevent you from sitting next to a person with AIDS in a taxi?

Is there anything that would make it easier or force you to sitting next to a person with AIDS in a taxi?

Are there any factors beyond your control that come to mind when you think of sitting next to a person with AIDS in a taxi?

Single partners:

I want to ask you more questions about keeping to one sexual partner. This time I want to ask you about sticking to one partner for life.

What do you see as being the advantages of having one sexual partner for life?

What do you see as being the disadvantages of having one sexual partner for life?

Is there anything else that you associate with having one sexual partner for life?

Are there any groups or people who would approve of you having one sexual partner for life?

Are there any groups or people who would disapprove of you having one sexual partner for life?

Are there any other groups or people who come to mind when you think about having one sexual partner for life?

Is there anything that would make it difficult or prevent you having one sexual partner for life?

Is there anything that would make it easier or force you to have one sexual partner for life?

Are there any factors beyond your control that come to mind when you think of having one sexual partner for life?

What words do you use when you describe something that you really like or that you really dislike?

eg Soccer is great

Soccer is terrible

What is the opposite of each word.

eg if you gave me the word good the opposite is bad

Appendix 2
Survey questionnaire

University of Cape Town

University of Cape Town

QUESTIONNAIRE ON HIV FOR KAYAMANDI AND MBEKWENI

questionnaire no

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3
DEMOGRAPHICS

Put a tick in the correct box

.. Age last birthday Date of birth

5

1. Sex

male female

6

3. a.What is the highest standard that you have passed at school.

1. Did not attend school

8. Std 5

2. Sub A

3. Sub B - -

4. Std 1

5. Std 2

6. Std 3

7. Std 4

9. Std 6/Form 1

10. Std 7/Form 2

11. Std 8/Form 3

12. Std 9/Form 4

13. Std 10/Form 5

8

b. Do you have other training or education?

Yes

No

9

Specify

11

4. Do you work for money at all (do you have paid employment)?

Yes

No

12

(i) If YES,

Describe the work you do:

(eg. shopkeeper, painter, taxi or busdriver,
salesman, etc.)

14

(ii) If NO,

Are you a: homemaker

student

unemployed: unfit for work

unemployed: fit for work

prefer not to work

--

other

--

specify.....

15
16

If unemployed, for how long have you been unemployed?

Time period:

- - - years

months

18

Describe your last job:

20

5. How long have you been living in Kayamandi/Mbekweni?

..... years

22

KNOWLEDGE

1. Do you think that the HIV virus can be passed on in the following ways?
(use AIDS germ if respondent does not understand HIV virus)

a) By drinking from an unwashed cup used by a person with the HIV virus?

Yes No Don't know

23

b) Through kissing a person with the HIV virus

Yes No Don't know

24

c) By a mother who has the HIV virus to her unborn baby during pregnancy

Yes No Don't know

25

d) From touching a person who has the HIV virus?

Yes No Don't know

26

e) By sexual intercourse with someone who has the AIDS germ?

Yes No Don't know

27

Do you think that someone who looks healthy but has the HIV virus can pass it on to other people?

Yes No Don't know

28

Do you think that AIDS can be cured?

Yes No Don't know

29

Of the people who get AIDS, how many of them do you think will die of it?

None of them will die of AIDS

A few of them will die of AIDS

Many of them will die of AIDS

Most of them will die of AIDS

All of them will die of AIDS

Don't know

30

What can you do to protect yourself from getting AIDS? just tick the answers given, do not prompt, but encourage.

Use condoms when you have sex

31

Stick to one sexual partner for life

33

Reducing the number of sexual partners

34

Treating STD's as soon as they arise

35

Going to see a doctor

36

Go and see a traditional healer

37

Being tested for HIV or AIDS

38

Other

40

Do you know what a condom is?

Yes No Don't know

41

INTENDED BEHAVIOUR

In all of the following questions I want you to carefully note the statement that is being given and then to state how you feel about that statement by selecting an option on a scale of 1 to 7. Each number represents a different value that you can give to the statement. You select an option by circling the correct number that corresponds to the view you selected. If you feel the statement is very important and you agree with it strongly, you will select the option "extremely good", if you disagree but not strongly, you will select "bad". For example, if you thought that the following statement was a good idea, but did not feel strongly about it you would circle the option good;

Doing some exercise everyday is good for you

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7
extremely good	very good	good	not sure	bad	very bad	extremely bad

Serial Monogamy

For these questions I am asking about the behavior of having sex with only one boy(girl)friend and not having sex with anybody else until that relationship ends and you start a new relationship in which you only have sex with that new boy(girl)friend. Check that the person answering the questions fully understands this concept before you continue.

1. I intend to only have sex with the one boy(girl)friend I am involved with at the time?

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7
extremely true	very true	true	not sure	false	very false	extremely false

42

2. Men
I intend to use a condom every time I have sex

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7
extremely true	very true	true	not sure	false	very false	extremely false

43

Women

I intend to ask my partner to use a condom every time I have sex

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

44

Both men and women

3. If I get an STD I intend to have it treated.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

45

ATTITUDES

1. For me to only have sex with the one boy(girl)friend I am involved with at the time is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad

46

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very dirty not sure clean very extremely
 dirty dirty clean clean

47

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very great not sure awful very extremely
 great great awful awful

48

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very ugly not sure beautiful very extremely
 ugly ugly beautiful beautiful

49

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very valuable not sure not very extremely
 important important important not not
 important important

50

2. Men

Using a condom every time I have sex is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good very good good not sure bad very bad extremely bad bad

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely dirty very dirty dirty not sure clean very clean extremely clean {clean

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely great very great great not sure awful very awful extremely awful awful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely ugly very ugly ugly not sure beautiful very beautiful extremely beautiful beautiful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely important valuable very important not sure not important very important not not important extremely important important

Women

My asking my partner to use a condom every time we have sexual intercourse is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good very good good not sure bad very bad extremely bad bad

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely dirty very dirty dirty not sure clean very clean extremely clean clean

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely great very great great not sure awful very awful extremely awful awful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely ugly very ugly ugly not sure beautiful very beautiful extremely beautiful beautiful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely important valuable very important not sure not important very important not not important extremely important important

Both men and women

3. Treating sexually transmitted diseases is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad

61

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very dirty not sure clean very extremely
 dirty dirty clean clean

62

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very great not sure awful very extremely
 great great awful awful

63

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very ugly not sure beautiful very extremely
 ugly ugly beautiful beautiful

64

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very valuable not sure not very extremely
 important important important not not important
 important important

65

questionnaire no

3

OUTCOME EVALUATION

1. Protecting myself from sexually transmitted diseases, eg "the drop", is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad

4

2. Protecting myself from getting AIDS or HIV is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very bad not sure good very extremely
 bad bad good good

5

3. My sexual partner becoming spoiled and disrespectful is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad

6

4. Showing that I truly love my partner is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very bad not sure good very extremely
 bad bad good good

7

5. Protecting myself against being hurt if my partner should leave me is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely bad very bad not sure good very good extremely good good

8

6. Getting the maximum sexual pleasure from sex is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good good very good not sure bad very bad extremely bad bad

9

7. The masculine "right" to have many sexual partners is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good good very good not sure bad very bad extremely bad bad

10

8 To satisfy my-partner when we have sex is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good good very good not sure bad very bad extremely bad bad

11

9 Avoiding pregnancy is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good good very good not sure bad very bad extremely bad bad

12

10 Feeling my partners body without a condom between us is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely bad bad very bad not sure good very good extremely good good

13

11 Showing that I trust my partner is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely bad bad very bad not sure good very good extremely good good

14

12 Having my partner get angry with me is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely bad bad very bad not sure good very good extremely good good

15

13 Getting healed of sexually transmitted diseases is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely good good very good not sure bad very bad extremely bad bad

16

- 14 Preventing the spread of sexually transmitted diseases is
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very bad not sure good very extremely
 bad bad good good
- 15 Being embarrassed because of being known to have a
 sexually transmitted disease is
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad
- 16 Injections and pains resulting from treatment for
 sexually transmitted diseases is
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very bad not sure good very extremely
 bad bad good good
- 17 Preventing further damage by a sexually transmitted
 disease is
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very bad not sure good very extremely
 bad bad good good
- BEHAVIOURAL BELIEFS**
- Serial Monogamy**
 For these questions I am asking about the behavior of having sex with only one boy(girl)friend and not having sex with anybody else until that relationship ends and you start a new relationship in which you only have sex with that new boy(girl)friend. Check that the person answering the questions fully understands this concept before you continue.
- 1 Having sex with only that person will protect me from
 sexually transmitted diseases.
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false
- 2 Having sex with only that person will protect me from
 getting AIDS
 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

3 If I have sex with only that person he or she will become spoiled and disrespectful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

23

4 Having sex with only that person will show that I love him/her

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

24

5 If I have sex with only that person I may be hurt if that person leaves me or is unfaithful to me

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

25

6 I will get enough sexual satisfaction if I have sex with only that person

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

26

7 Having sex with only that person will undermine the masculine "right" of men to have many sexual partners

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

27

Condoms

Men

1 Using a condom everytime I have sex will prevent pregnancy

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

28

2 Using a condom everytime I have sex will protect me from diseases

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 29
extremely true	very true	true	not sure	false	very false	extremely false	

3 Using a condom everytime I have sex will reduce my sexual pleasure

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 30
extremely true	very true	true	not sure	false	very false	extremely false	

4 Using a condom everytime I have sex will mean that I do not feel my partners body

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 31
extremely true	very true	true	not sure	false	very false	extremely false	

5 Using a condom everytime I have sex shows that I do not trust my partner

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 32
extremely true	very true	true	not sure	false	very false	extremely false	

6 Using a condom everytime I have sex means that my partner will not be satisfied sexually

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 33
extremely true	very true	true	not sure	false	very false	extremely false	

7 Using a condom everytime I have sex will make my partner angry

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 34
extremely true	very true	true	not sure	false	very false	extremely false	

Condoms**Women**

1 Asking my partner to use a condom everytime I have sex will prevent pregnancy

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

35

2 Asking my partner to use a condom everytime I have sex will protect me against diseases.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

36

3 Asking my partner to use a condom everytime I have sex will reduce my sexual pleasure

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

37

4 Asking my partner to use a condom everytime I have sex will mean that I do not feel my partners body

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

38

5 Asking my partner to use a condom everytime I have sex shows that I do not trust my partner

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

39

6 Asking my partner to use a condom everytime I have sex means that my partner will not be satisfied sexually

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

40

7 Asking my partner to use a condom everytime I have sex will make my partner angry with me

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

41

Sexually Transmitted Diseases

1 If I go for treatment for a sexually transmitted disease I will get healed

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

42

2 Getting treatment for a sexually transmitted disease will limit the disease from spreading further

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

43

3 Getting treatment for a sexually transmitted disease will prevent further damage by the sexually transmitted disease

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

44

4 Getting treatment for a sexually transmitted disease will be painful

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

45

5 Getting treatment for a sexually transmitted disease will make me feel embarrassed in front of others

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

46

SUBJECTIVE NORMS

1. Most people who are important to me think that I should only have sex with the one boy(girl)friend I am involved with at the time.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

47

2. Men

Most people who are important to me think that I should use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

48

Women

Most people who are important to me think that I should ask my partner to use a condom everytime we have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

49

Both men and women

3. Most people who are important to me think that if I get a sexually transmitted disease I should get it treated

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----
extremely true	very true	true	not sure	false	very false	extremely false

50

NORMATIVE BELIEFS

Ask the respondent what they think these groups, namely {their boy(girl)friend, friends, members of their family, doctors and nurses and members of their church, would think of them doing the behaviour. The reason we are asking this is to find out how important the influence of each one of these groups is in relation to the others.

If they do not have a sexual partner then ask them to reflect on their last sexual partner or if they not in a church at the moment then the general importance of the church to them.

Serial Monogamy

As described above I am asking about the behavior of having sex with only one boy(girl)friend and not having sex with anybody else until that relationship ends and you start a new relationship in which you only have sex with that new boy(girl)friend. Check that the person fully understands this concept before you continue.

1. My boyfriend / girlfriend thinks that I should only have sex with him / her

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----
extremely true	very true	true	not sure	false	very false	extremely false

51

2. My friends think that I should only have sex with that person

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----
extremely true	very true	true	not sure	false	very false	extremely false

52

3. Most members of my family think that I should only have sex with that person

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

53

4. The people in my church think that I should only have sex with that person

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

54

Condoms

Men

1. My girlfriend thinks that I should use a condom everytime we have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false , very extremely
 true true false false

55

2. My friends think that I should use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

56

3. Most members of my family think that I should use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

57

4. The nurses and doctors think that I should use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

58

Women

1. My boyfriend thinks that I should ask him to use a condom everytime we have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

59

2. My friends think that I should ask my boyfriend to use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false

60

3. Most members of my family think that I should ask my boyfriend to use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very - true - not sure false very extremely
 true true false false

61

4. The nurses and doctors think that I should ask my boyfriend to use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

62

Both men and women**Sexually transmitted diseases**

1 My boy(girl)friend thinks that if I get a sexually transmitted disease I should get it treated

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

63

2 My friends think that if I get a sexually transmitted disease I should get it treated

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

64

3 The doctors and nurses think that if I get a sexually transmitted disease I should get it treated

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

65

4 Most members of my family think that if I get a sexually transmitted disease I should get it treated

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true - false false

66

MOTIVATION TO COMPLY

1. Generally speaking I want to do what my boy(girl)friend thinks I should do.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

67

2. Generally speaking I want to do what my friends think I should do.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

68

3. Generally speaking I want to do what the doctors and nurses think I should do.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

69

4. Generally speaking I want to do what the people in my church think I should do.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

70

5. Generally speaking I want to do what most members of my family think I should do.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

71

PERCEIVED BEHAVIOURAL CONTROLS

1. It is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very easy not sure difficult very extremely
 easy easy - - - difficult difficult

72

to only have sex with the one boy(girl)friend I am involved with at the time.

2. If I wanted to I could only have sex with the one boy(girl)friend I am involved with at the time.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

73

Men

3. It is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very easy not sure difficult very extremely
 easy easy - - - difficult difficult

74

to use a condom everytime I have sex.

4. If I wanted to I could use a condom everytime I have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

75

Women

3. It is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very easy not sure difficult very extremely
 easy easy difficult difficult difficult

76

to ask my partner to use a condom everytime we have sex

4. If I wanted to I could ask my partner to use a condom
everytime we have sex.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

77

Both men and women

5. It is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very easy not sure difficult very extremely
 easy easy difficult difficult difficult

78

get an STD treated.

6. If I wanted to I could get an STD treated.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

79

questionnaire no

3

CONTROL BELIEFS**Serial monogamy**

1. My desire makes me want to have sex with many men / women

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

4

2 My lack of trust in my boy(girl)friend makes it easy for me to have many sexual partners

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

5

3 My love for my boy(girl)friend makes it easy to only have sex with him / her

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

6

4 It is easy to find other men/women to have sex with

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

7

5 I need to have sex with other men/women while my boy(girl)friend is unavailable.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

8

Condoms

Men

1 My partner will not like me to use condoms

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

9

2 Condoms cost too much money

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false false false

10

3 It is embarrassing to get condoms from the clinic

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 11
extremely true	very true	true	not sure	false	very false	extremely false	

4 I do not know how to use condoms

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 12
extremely true	very true	true	not sure	false	very false	extremely false	

Condoms

Women

1 My partner would not like to use a condom

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 13
extremely true	very true	true	not sure	false	very false	extremely false	

2 I do not know how to use a condom

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 14
extremely true	very true	true	not sure	false	very false	extremely false	

3 I am scared to talk to my partner about condoms

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 15
extremely true	very true	true	not sure	false	very false	extremely false	

Both men and women

Sexually transmitted diseases

1 I would not have the money to get treatment if I had a sexually transmitted disease

1 -----	2 -----	3 -----	4 -----	5 -----	6 -----	7 -----	<input type="checkbox"/> 16
extremely true	very true	true	not sure	false	very false	extremely false	

2 I am scared of the injections and the pain involved in
getting a sexually transmitted disease treated

17

3 I am embarrassed about what the nurses will say if I go to get treatment for a sexually transmitted disease

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
extremely very true not sure false very extremely
true true false false false

18

4 It is difficult to get to a clinic to get treatment for a sexually transmitted disease

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
extremely very true not sure false very extremely
true true false false false

PAST BEHAVIOUR

1. Have you ever had sex?

Yes

1

No

1

Rather not say

20

If NO then go onto question nine.

2. How regularly have you had sex in the last four months?

more than once a week

1

about once a week

1

once or twice a month

1

less than once a month

1

3. How many different partners have you had sex with over the last six months?

21

22

4. How often have you used condoms over the last four months?

all the time

more than half the time

less than half the time

never

23

5. With whom have you used condoms?

with all partners

only with some partners

never

24

Why?

27

6. Have you ever had a sexually transmitted disease?

Yes

No

Rather not say

28

If YES, when?

30

If NO, then go onto question 8,

7. Was it treated?

Yes

No

Rather not say

31

If YES, how?

34

8. Have you done anything to protect yourself from getting AIDS?

Yes

No

Rather not say

35

If YES, what

38

9. Do you know anybody who is HIV positive or had AIDS?

Yes - No

Rather not say

39

If YES, how did you feel towards them and what did you say and do?

42

GENERAL ATTITUDES

1 Showing people with AIDS that I accept them is

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very good not sure bad very extremely
 good good bad bad

2 Most people who are important to me think that I should sit next to a person with AIDS in a taxi.

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

3 I will fight against anyone who tries to make me sit next to a person with AIDS in a taxi

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

4 There is a chance that I will be infected with HIV

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

5 I am worried about AIDS

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 extremely very true not sure false very extremely
 true true false false

Appendix 3

Answers to the knowledge questions

The answers defined as correct in the survey are listed below. An abbreviated form of the question is provided in the left column and the correct answer in the right column.

<u>questions</u>	<u>correct answer</u>
Can the HIV virus be passed on in the following ways?	
drinking from a cup used by a person with AIDS	no
kissing a person with HIV	no
mother-to-child transmission	yes
touching a person with the virus	no
sexual intercourse with a person with HIV	yes
Do you think that someone can have virus but look healthy?	yes
Do you think that AIDS can be cured?	no
Of the people who get AIDS, how many of them do you think will die of it?	all or most
What can you do to protect yourself from getting AIDS?	
using condoms during sex	yes
stick to one sexual partner for life	yes
reducing the numbers of sexual partners	yes
treating STDs rapidly	yes
going to see a doctor	no
seeing a traditional healer	no
being tested for HIV or AIDS	no

Appendix 4

Vusi	Kayamandi, male, 25, NGO worker, Std 9, ANC Youth League
Fatyela	Mbekweni, male, 23, university student, ANC Youth League
Hombile	Mbekweni, female, 30, university education, teacher
Pumla	Kayamandi, female, 20, student in Std 9
Jikela	Kayamandi, male, 17, student in Std 7
Madoda	Kayamandi, male, 18, student in Std 8
Phindile	Kayamandi, female, 24, completed two years at university, unemployed
Mvuyi	Mbekweni, male, 18, student in Std 9
Kholeka	Kayamandi, female, 16, student in Std 8
Popololo	Mbekweni, female, 27, works for a union
Thandeka	Mbekweni, female, 17, student in Std 7
Mniniawa	Mbekweni, male, 19, student in Std 9, PASO organiser
Molefi	Mbekweni, male, 22, student in Std 10, COSAS organiser
Nomsa	Mbekweni, female, 16, student in Std 7, school beauty queen
Rev Sisulu	Mbekweni, male, 67, Zionist minister and herbalist, civic executive
Andile	Mbekweni, male, 58, employed by civic, civic leadership
Ayanda	Mbekweni, male, 37, university education, headmaster, ANC chair
Cebo	Kayamandi, male, 46, Std 10, mayor
Themba	Kayamandi, male, 43, college ed., teacher, Civic and ANC executive
Jikani	Kayamandi, male, 47, works for NGO, senior activist in the ANC
Bongani	Kayamandi, male, 51, university education, headmaster
Fezile	Mbekweni, female, 57, Std 10, union organiser, ANC Woman's League
Sipho	Mbekweni, male, 48, spaza shop owner
Normfuzo	Kayamandi, female, 52, teacher

The following interviews had more than one respondent each, but were not group interviews in structure.

Jongile and Lucas Kayamandi, males, both around 20, work for NGOs.

Kayamandi, female nurses at the local clinic, both in early 30s

The fieldworkers interviews were as follows

Kholisile	Kayamandi, male, 16, student in Std 4
Lindiwe	Mbekweni, female, 24, Std 10, spaza shop assistant
Xoliswa	Mbekweni, female, 17, student in Std 6
Nombulelo	Mbekweni, female, 22, unemployed
Nkululeko	Mbekweni, male, 16, student in Std 7
Pakama	Kayamandi, female, 21, Std 2, unemployed
Nomfundo	Kayamandi, female, 24, Std 8, unemployed
Golomi	Mbekweni, female, 15, student in Std 6
Hombakazi	Kayamandi, female, 30, no education, unemployed, runs a shebeen
Philani	Kayamandi, male, 28, labourer
Inutu	Kayamandi, female, 25, clerk
Lulama	Kayamandi, female, 14, student in Std 4
Oriba	Mbekweni, female, 17, student in Std 8
Meshack	Kayamandi, male, 16, student in Std 4
Qondiwe	Mbekweni, female, 44, runs a shebeen
Funeke	Mbekweni, female, 64, Sangoma

The two focus groups were run with

Twenty Std 7 and 8 school pupils, both males and females, from the Mbekweni high school
Seven traditional healers, either sangomas or herbalists, practicing in Mbekweni