

# UNIVERSITY OF CAPE TOWN



DEPARTMENT OF SOCIAL DEVELOPMENT

## Predictors of Condom Use Behaviour and Intentions of African Migrant Youth in South Africa

A dissertation to be submitted to the Department of Social  
Development, University of Cape Town in partial fulfillment  
of the requirements for the award of  
Degree of

MASTERS IN SOCIAL WORK

BY

KWANELE SHISHANE (SHSKWA001)

Supervisor: Dr. Johannes John-Langba  
June, 2016

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FACULTY OF HUMANITIES

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**COMPULSORY DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: .....

Date: .....

## **DEDICATION**

I can do anything through Christ who strengthens me (Philippians 4 verse 13). If not for God, I would have not been where I am today so all glory and honor goes to Him. The dissertation is also dedicated to my parents Mr and Mrs Shishane and my family, whose unconditional love, teachings and support has played a huge role in my life. I have committed and will continue to commit myself to my studies because I see myself as honouring my family and living up to the standards they see in me, so to my parents and family this one goes to you!

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## **ABSTRACT**

Although the prognosticators of condom use among youth in South Africa have been extensively studied, very little is known about the attitudes and subjective norms influencing sexual behaviours that could influence safe sex intentions among the population of migrant youth in South Africa.

This study aims to investigate the predictors of condom use behaviour and intentions among migrant youth in South Africa and examines the influences of acculturation on the relationship between condom use intention and behaviour among this population. This was done through the exploration of the nature and extent of condom use; condom use behaviour; acculturation and condom use behaviour; association between acculturation and intentions to use condom use; association between intention and condom use behaviour; and perceived behavioural control and condom use behaviour among African migrant youth. Ajzen's theory of planned behaviour (TPB) and Berry's model of acculturation provided the theoretical framework for the empirical investigation of the study. The current study utilized a sexually active sample (N=91) of youth African migrants residing in Cape Town, with ages ranging 18-35 years. Age proportion by percentage was 18-25 at 46.2%, 26-3 at 30.8% and 32-35 years at 20.8%. A cross sectional quantitative research design was utilized and a time location non-probability sampling procedure was assumed in this study. Participants were recruited through a non-profit organisations working with African migrants in Cape Town. The instrument used was an anonymous semi-structured questionnaire consisting of five measures that assess the central study variables and a demographic section.

Results indicate that attitudes had an insignificant relationship with condom use behaviour. Referent group norms had a .378 correlation (significant at 0.01 level) which indicate that peer norms had an influence on condom use behavior. Hierarchical multiple analyses were conducted, attitudes and subjective norms were entered in the first step

explaining 15% of the variance on condom use behaviour. After entry of perceived behavioral control and intentions at step 2 the total variance explained by the model as whole was 22.7%. The two control measures explained an additional 7.7%, this means that perceived behavioral control and intentions explain an additional 7.7% ( $.077 \times 100$ ) of the variance in condom use behaviour of variance on condom use behaviour, even when the effects of attitudes and subjective norms are statistically controlled for. With respect to gender differences, females reported less condom use compared to males.

This study concludes that, the central study variables did not have a highly significant correlation with condom use behaviour, with attitudes having the least significance. This study identified barriers to condom use such as culture and religion emphasize the need for future interventions to target popular opinion leaders (POL's) so as to influence cultural and religious beliefs that might have an impact on condom use.

## CHAPTER ONE: INTRODUCTION

This chapter consists of five sections; it will present a contextual understanding to the background of the problem under study; the rationale and significance of the study.

Following this will be the definitions of all significant concepts. Furthermore, it will state the research questions and research objectives.

### **Background and context**

Although predictors of condom utilisation among youth in South Africa have been extensively studied (Hendriksen, Pettifor, Lee, Coates, & Rees, 2007; MacPhail & Campbell, 2001), very little is known about the socio-cultural effects on sexual behaviours that may affect safer sex intentions of the population of migrant youth in South Africa that might inform HIV/AIDS prevention efforts targeted at this population (Hendriksen, Pettifor, Lee, Coates, & Rees, 2007; MacPhail & Campbell, 2001). The level of understanding about HIV/AIDS is allegedly high among South African youth but observed susceptibility and stated levels of condom use among this population are low (UNAIDS, 2011) and may be even lower among migrant youths who stand the chance of being left out on the national sexual behavioural surveys due to their immigration status (John-Langba, 2007).

Usually regarded as hard-to-reach populations, migrant youth are at a very high-risk of contracting HIV/AIDS due to a history of displacement, sexual and gender-based violence, economic disruption, psychological stresses and forced migration from a continent that continues to dwarf the rest of the world on the HIV/AIDS balance sheet (Zwi & Cabral, 1997). Youth migrants are persons between the ages of 13-19 years that have crossed international borders running away from war and/or maltreatment on the grounds of race, religion, nationality, economic hardship, or being a member of a certain social and political group (Tantho, 2014). Although the relationship of acculturation and HIV-related risk

behaviours has been studied extensively among other migrant populations (Marks, Cantero, & Simont, 1998) however, there is paucity in research to examine this relationship among African migrants as well as migrant youth specifically.

Additionally, existing research has not examined in depth the particular mix of demographical and life experiences that may lead to HIV-related risk behaviours among this population. Research has confirmed that correct and consistent condom use considerably reduces HIV transmission (Shaw & Rienzo, 1995). Therefore, a greater comprehension of the determinants of condom use behaviour and intentions of migrant youth is crucial for the development of evidence-based programmes and policies targeted at migrant youth populations in South Africa.

African migrants are not seen in a positive light in South Africa (Crush, 2007). As a result, the issue of xenophobia which is described as the fear 'phobos' or hatred of foreign 'xenos' people came about (Crush, 2007). The attributed causes of xenophobia are linked to historical, social and economic factors. One of the most commonly quoted or attributed cause of the xenophobia incidence in South Africa is apartheid-the discriminatory attitudes learned during apartheid are still existent in many South Africans (Khan, 2007). Xenophobia in South Africa has also been clarified in terms of socio-economic inequality in the country, as there is the notion or perception that foreign people have come to steal the already limited citizen's employment opportunities. There is also the notion that they come to steal their woman in order to get citizenship and this is linked to the countries 'poor' immigration policies.

Crush (2007) wrote an article on immigration, xenophobia and human rights in South Africa. One of the main themes in this paper was exploring the citizen's views of immigration and the presence of non-citizens in the country. In this study it was evident that South Africans are prejudiced towards foreigners and especially to African immigrants, with

whites being more hostile than blacks (Crush, 2007). The writer posits that these feelings are prevalent and cut across indicators of age, education, gender, economic status and race. Furthermore, the writer states that migrants know that South African nationals do not have favourable attitudes towards them (Crush, 2007). A large number of South Africans hold a strong belief about immigration and migration having a negative impact on the country (almost 60% people believing that migrants “weaken” society and the economy, and above 60% people believing that migrants lay a strain on South African resources). Crush (2007) argues that fear of crime, diseases and intimidations around getting employment and the economy, are the leading justifications given for hostility towards migrants in South Africa (Crush, 2007).

### **Statement of the research problem**

African migrants in general are often a marginalised group in a foreign society whose voices remain unheard (Khan, 2007). There is limited research on the intentions of migrants as a result little is known about them. Some migrants are institutionalised and separated from the rest of the society (Khan, 2007). This can afford migrants the ability to continue speaking their native language and continue with their practices even in a foreign country. However, on the other hand, the harsh reality of limited funding and lack of resources can affect the effectiveness and proper implementation of programmes and social safety nets that could afford migrants the kind of care they need, thus making it seem as though they are discarded people whom the society has no interest in their well-being (Khan, 2007).

Furthermore, the impact of poverty, unemployment, HIV/AIDS has a devastating impact on the lives of many migrants in South Africa. The Center for Women’s Global Leadership, 2010 argues that poverty eat away at the spirit just as malnutrition eat away at the body; it decreases self-esteem and particularly makes some women blame themselves for

being poor. The blame is at times internalized, and may turn into self-abuse, increasing self-destructive coping mechanisms like abusing drugs and substances. Chitranshi (2009) further argues that poor people have a high risk of depression, stress, vulnerability to mental illness and poor health; vulnerability to violence and abuse and having difficulty leaving abusive relationships (Cohen, 1994); living on the streets and homelessness (Chitranshi, 2009; Rurevo & Bourdillon, 2003); prostitution (Center for Women's Global Leadership, 2010); social exclusion (Chitranshi, 2009; Jean, 2006) and emigration (Mbirimtengerenji, 2007; Skalli, 2001). This may cause a significant strain financially on caregivers, especially the parents who rely solely on government aids as their main source of food and income. This makes them highly vulnerable and therefore knowing their intentions towards condom use would be of significance especially when it comes to influencing education on healthy and safe sex practices.

African migrant youth are predominantly at a high-risk for HIV/AIDS due to a history of displacement, sexual and gender-based violence, economic disruption, psychological stresses and forced migration from a continent that continues to dwarf the rest of the world on the HIV/AIDS balance sheet (Zwi & Cabral, 1997). The level of information given out and understanding about HIV/AIDS is reportedly high among South African youth however perceived vulnerability and reported condom use among this population is small (UNAIDS 2011) Despite HIV/AIDS prevention efforts (education, free condoms, and promotion of condom use), the rate of HIV continues to rise among young adults. Thus, increasing knowledge about transmission and risk of HIV infection, and promoting condom use among young adults are not sufficient solutions to controlling the spread of this disease (Neff, 2012). This therefore calls for further research, to investigate why young adults persist on engaging in high-risk sexual behaviors albeit the level of education they have about HIV/AIDS transmission and the protective role of condoms. Which therefore makes this study

significant because despite HIV/AIDS prevention efforts (education, free condoms, and promotion of condom use), the rate of HIV continues to rise among young adults, including those in college (Duncan, Harrison, Toldson, Malaka, & Sithole, 2005).

Thus, increasing knowledge about transmission and risk of HIV infection, and promoting condom use among young adults are not sufficient solutions to controlling the spread of this disease. Changing young adult engagement in risk behaviour is the most effective way of curtailing the HIV epidemic (Catania, Kegeles, & Coates, 1990). Thus, researchers need to develop a better understanding as to why young adults carry on to engage in high-risk sexual behaviours even though they are educated about HIV/AIDS transmission and the protective role of condoms. This study is fitting because in essence it aims to explore the predictors of condom use behaviour and intentions of African migrant youth in South Africa and examine the influences of acculturation on condom use behaviour and condom use intention.

### **Aims and objectives of the study**

This study aims to investigate the predictors of condom use behaviour and intentions among migrant youth in South Africa and examines the influences of acculturation on the relationship between condom use intention and condom use behaviour among this population.

The specific objectives of the study include to:

- Determine the predictors (attitude, subjective norm and behavioural control) of condom use behaviour among African migrant youth in South Africa.
- Examine the relationship between acculturation and condom use behaviour among African migrant youth in South Africa.

-Examine the relationship between acculturation and the intention to use condoms among African migrant youth in South Africa.

-Assess the associations between intentions and condom use behaviour among African migrant youth in South Africa.

-Examine the relationship between perceived behavioural control and condom use behaviour of African migrant youth in South Africa.

### **Research questions**

The research questions that this study attempted to answer include:

1. What is the nature and extent of condom use among migrant youth in South Africa?
2. Do attitudes, subjective norms, and perceived behavioural control predict the male condom use intentions of migrant youths in South Africa?
3. What is the relationship between level of acculturation and condom use behaviour among migrant youth?
4. What is the relationship between acculturation and condom use intention among migrant youth?
5. Is the decision to use condoms under the volition of migrant youth?

### **Rationale and significance of the study**

There is limited research done on African migrants, as a result very little is known about their intentions and experiences in life. This therefore limits the extent to which there could be a broader understanding of their perceptions or intention on condom use which is reflective of the migrant population in South Africa. Migrants are hardly fully incorporated into relevant spheres of action (Crush, 2007). Migrant people in South Africa find themselves having limited opportunities where they can exert their freedom due to the explicit existence

of inequalities in terms of their position and their rights and due to public policies continually failing to take their needs into account (Khan, 2007).

In addition, limited research has been done to examine the particular mix of demographical and life experiences that may lead to HIV-related risk behaviours among this population. Evidence is now conclusive that proper and consistent condom use substantially reduces HIV transmission (Shaw & Rienzo, 1995). Therefore, a greater understanding of the determinants of condom use behaviour and intentions of migrant youth is crucial for the development of evidence-based programmes and policies targeted at migrant youth populations in South Africa. The aim of this study was to explore the predictors of condom use intentions among African migrant youth in South Africa, and the influence of acculturation on condom use intention and behaviour. The Theory of Planned Behaviour (Ajzen, 1985) and Berry's Model of Acculturation (Berry, 1980) informed the theoretical underpinning or line of inquiry of this study. Consistent with the application of the theory of planned behaviour, the primary focus of the study was to determine the extent to which migrant youths' attitudes, subjective norms, and perceived behavioural control predict their condom use intentions and behaviour.

Analysis of migrants in South Africa should not ignore the historical inequalities and limited access to education which manifest through the increased levels of unemployment and underdevelopment in all the regions of the country (Sally & Crush, 2007). Therefore, any evaluation of how migrants live in South Africa must take into consideration the historical divisions that prevailed in the past, which enabled some South Africans, compared to people in other African countries to enjoy a better standard of living whilst some people in other countries were less privileged or could not access those benefits. In turn this influences migrant's personal outlook and quality of life.

Current statistics reflect an increase of migrants in South Africa (Crush, 2007). This research study therefore took place in order provide a platform for migrants living in South Africa a chance to ascertain their subjective perceptions, intentions and experiences. It was done to help bring about awareness on the subjective norms and intentions of migrants in SA in particular. The voices of the voiceless and marginalised are at the core of this study.

The national burden of HIV/AIDS in South Africa provides impetus for this study of the factors that influence sexual behaviours and in particular those related to the use of safer sex practices as methods of prevention of the spread of the disease. Notwithstanding this, HIV/AIDS continues to pose a challenge for health educators and policy makers who develop targeted AIDS prevention programs for various population sub-groups in South Africa.

Youth in South Africa are often treated as a homogenous group, making it difficult to assess preventive and risk behaviours for the various migrant subgroups. The implication is that there is paucity in health education and research programs on HIV/AIDS prevention addressing the specific needs of the different African subgroups such as African migrant youths who are particularly at high risk due to a history of displacement, sexual and gender-based violence, economic disruption, psychological stresses and forced migration.

To be successful at encouraging consistent condom use, comprehensive understanding of all aspects of sexual behaviour including cultural patterns of sexual behaviour is needed.

### **Significance of the study to social work practice**

This research relates to social work because essentially social work involves working with human beings (Dunk 2007). Social workers traditionally focus on broader systems that inform and shape lived experiences of individuals and communities (Dunk, 2007). Sexuality is an important aspect of being human throughout life, and social workers acknowledge people's sexualities' to wider systems of influence. Knowledge about everyday sexuality is

vital to social workers as social workers deal with a variety of clients faced with increasing complexities brought about by modernity (Dunk, 2007). Additionally, knowledge gathered from this study is congruent with the ethical and political dimensions of the profession in terms of developing frameworks for social work education in this area. This study is an attempt at such a comprehensive examination among migrant youth. It will provide social work researchers and HIV/AIDS practitioners with evidence on the sexual reproductive health behaviour of African migrant youth in South Africa. This will allow for a better understanding of the variables and barriers involved in safer sexual behaviour, and increase the likelihood of encouraging condom use not only among this population but other populations considered to be most-at -risk for HIV as they are quite often the clients of social workers.

Additionally, the results of this study will inform social work practitioners of prevention efforts to identify the most, relevant to psychosocial determinants of condom use among migrant youth in South Africa.

According to UNAIDS (2011), heterosexual intercourse remains to be the predominant mode of transmission of HIV in South Africa and like in most other generalized HIV epidemics in other regions of the world most infected persons contract HIV during their youth years. Thus, a study of sexual behaviours and determinants of intentions to use condoms to prevent HIV infection among this population is crucial for providing significant information for targeted HIV prevention interventions and service delivery.

The implications of the study findings will offer insight which will lead to further clarifications on the intentions of African migrant youth in South Africa. The researcher hopes that this study will contribute in the development of policy, contribute to social work practice and research in terms of replication of the study, inform therapeutic counselling, programme formulation and implementation, education around condom use, HIV as well as

sexually transmitted infections and bring about awareness on the needs of migrants and influence policy making procedures in government.

Migrant assistance agencies that are involved in youth reproductive health issues would find this research useful as well. Therefore, findings gathered from this study are made available to both ARESTA as well as the Department of Social Development.

Additionally, Tlou (2009) states that present South African experimental research consists of a wide range of diverse topics, which makes it difficult to generalise. Therefore, testing existing theories and making them specific to African contexts seems to be a need (Tlou. 2009). Molla, Nordrehaug, Astrom and Brehane (2007) observed that research underpinned by the theory of planned behaviour in Africa has concentrated on condom use intentions, and have assessed behaviour retrospectively rather than prospectively. Therefore, supplementary studies must be conducted in efforts to examine the effectiveness of these theories in predicting preventative behaviours in an African context.

### **Definition of key terms**

*Attitude.* Is an orientation that locates objects of thought on dimensions of judgements (Weiten, 2010). Additionally, Jung's definition of attitude is a "readiness of the psyche to act or react in a certain way" (1921: 687 as cited in Weiten, 2010). Furthermore, Jung posits that attitudes very often come in pairs, one conscious and the other unconscious. Furthermore, Baron and Byrne (1987) describe attitudes as a long-term, overall assessment of individuals, objects, or issues. He further affirmed that attitude is lasting, and prevails through time, whereas temporal feeling cannot be regarded as an attitude.

*Acculturation.* A process in which members of one cultural group adopt the beliefs and behaviours of another group (Hazuda, Stern & Haffner, 1988). Although acculturation is usually in the direction of a minority group adopting habits and language patterns of the

dominant group, acculturation can be reciprocal, this means that the dominant group can also adopts patterns typical known to belong to the minority group (Hazuda, Stern & Haffner, 1988). Assimilation of one cultural group into another may be evidenced by changes in language preference, adoption of common attitudes and values, membership in common social groups and institutions, and loss of separate political or ethnic identification (Hazuda, Stern & Haffner, 1988)

*Youth.* The South African definition for a youth is any individual between the ages of 10-24 (Republic of South Africa, 2000). Of interest to this study youth is defined as persons within the ages of 18-35 years' cohort.

*Migrant.* According to The United Nations, a migrant is an individual who has resides in a foreign country above a year regardless of the motives, voluntary or involuntary, and regardless of the regular or irregular nature of the means used to migrate. There are different kinds of migrants, they include; economic migrants, irregular migrants, skilled migrant and illegal migrants amongst others. This study focuses on youth's who were born in their home countries and moved to South Africa to either join their loved ones or to pursue their own development.

*Migrant youth.* This study defines youth migrants as those refugees, immigrants, labour migrants and undocumented persons currently residing in South Africa and are between the ages 18-35 years.

*Cross boarder migrants.* Cross-border migration can be understood as the movement for labour purposes from the South to the North. According to the IOM (2010) labour migration is described as a cross-border movement for purposes of occupation overseas.

*Condom.* Is a thin rubber sheath worn by both man and women during sexual intercourse as a contraceptive or as a protection from infection. Condoms are designed respectfully for both male and female genitalia.

*Condom self-efficacy.* Refers to a person's judgement of how well they can perform certain behaviours under numerous circumstances (Bandura as cited in Montano & Kaspyzyk, 2002).

*Condom use behaviour.* Contraception use is a multifaceted aspect in decision making and is subjected to individual's beliefs concerning the effectiveness of contraception and its side effects (Gilliam, Warden, Goldstein, & Tapia, 2004 as cited in Tantoh, 2014), beliefs about ethics and social acceptance (Leonard, Chavira, Coonrod, Hart, & Bay, 2006 as cited in Tantoh, 2014), awareness about procedures (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006 as cited in Tantoh, 2014), and the duration of the assumed relationship (Harvey, Henderson, & Casillas, 2006 as cited in Tantoh, 2014).

*Perceived behavioural control.* Behavioural performance is determined by motivation (intention) and ability (behavioural control) (Ajzen, 1985). Perceived behavioural control refers to people's perceptions of their ability to perform a given behaviour (Ajzen, 1985). It consists of two facets: these are efficacy expectancies and outcome expectancies. The first one refers to an individual's control over the behaviour and the level of confidence an individual has towards his/her ability to perform or not perform the behaviour (Ajzen, 1991). On the other hand, outcome expectancies refer to a person's perception that the performance of a behaviour will result into a favourable outcome. Therefore, people will be hesitant to perform behaviour if they believe that the performance will not result in a desired outcome (Ajzen, 1991).

*Subjective norm.* This refers to the perceived social pressure to engage or not to engage in certain behaviour in question (Ajzen, 1991). It is defined as an individual's perception of how people significant to them perceive and influence their performed behaviour. In establishing subjective norms, individuals take normative expectations of significant others in their environment into account. In other words, individuals consider if

significant others think they should or should not perform a certain behaviour, and then use this information to work out their subjective norm (Ajzen & Fishbein, 1980).

## **CHAPTER TWO: LITERATURE REVIEW**

There is a dearth of literature on the actual intentions of African migrant youth in South Africa. The researcher has consulted a range of literature pertinent to the research study. This chapter will present a brief history of migration in South Africa, literature on policy and legislation pertinent to the study; the nature and extent of condom use among African migrant youth; condom use behaviour among African migrant youth, acculturation and condom use behaviour; association between acculturation and the intention to use condoms; association between intention and condom use behaviour as well as perceived behavioural control and condom use behaviour. The sources utilised for this literature review, includes online journal articles, scholarly articles, and legislative documents.

### **History of migration in South Africa**

Migration history in South Africa has continued to grow over the years. Migration in South Africa can be traced prior to the arrival of the first white migrants under the leadership of Jan van Riebeck in 1642 (as cited in Tantho, 2014). The recorded movement of black Africans took place previous to and after the arrival of white settlers (Timaeus & Graham, 1989).

During the 1880s and early 1890s the increase in the mining industry was identified and from there has attracted migrants (Harries, 1982). In post-apartheid South Africa, the expectation was that circular or temporary internal labour migration would have been replaced by the permanent settlement of Africans at places of employment (Posel, 2004). However, evidence suggests that temporary internal labour migration in the country has not declined; rather it appears to have increased, particularly because of the rise in female labour migration. Africans continue to migrate, mostly from households in rural areas, to work or to

look for work and they continue to maintain ties with, and membership in, their country of origin (Posel, 2004).

According to a survey by the Southern African Migration Project (SAMP), 81% of Lesotho's adult population has been to South Africa (Crush, 2007). As many as 83% of Lesotho's citizens have parents and 51% have grandparents who have worked in South Africa. The comparable figures for Mozambique are 29%, 53%, and 32%, while for Zimbabwe the corresponding figures are 23%, and 24% (Crush, 2007). The year 2000 latest date for which figures are available, showed that migrant stock included 687,678 migrants from other Southern African developing countries (SADC) countries and 228,318 from Europe. Other source areas of growing importance included the rest of Africa (41,817) and Asia (40,889) (Crush, 2007). In all, immigrants made up 2.3 percent of South Africa's total population in 2001. Statistics South Africa (2010) has alleged that the number of undocumented migrants is approximately within the 500,000-to-1-million range and the numbers continue to grow.

In the middle of 1994 and 2004 an estimated 150,000 claims/applications for asylum were acknowledged by the Department of Home Affairs, of which 26,900 asylum seekers were approved refugee status. In 2006, 53,363 asylum claims were projected and this was the highest recorded number. At the end of 2007, the number of lawfully recognized refugees was projected at 36 800, asylum seeker applications amounted to 89,000 and new asylum applications were estimated at 45,673 (of which only 5,879 were decided, adding to the backlog). In 2006/7 the number of economic migrants issued with individual work permits (not including corporate permits) was 19 601 (Department of Home Affairs, 2008 as cited in Tantho, 2014). From the 2006 claims, 78% (41,437) were from men; while women comprised of 20% (10,769) and 2% (1,155) were children. This therefore makes the study of

migrant's intentions in South Africa significant because they already compose a large number of the population in South Africa.

### **Relevant policies and legislation**

The Refugees act and the South African Constitution enshrines a Bill of rights that affords, migrants entitlement to all human rights however due to discrimination, in reality they continue to face challenges in terms of the violation of their rights albeit the current policies and legislations.

According to the Immigration Act of 2002, immigrants who are able to add to the increase of South Africa's economic base are permitted to apply for residence (Khan, 2007). Likewise, applications by skilled workers in occupations for which there is a shortage in the country are encouraged but then again applications by entrepreneurs who wish to relocate their existing businesses or establish new businesses in South Africa are also accepted (Khan, 2007). Any person who would like to retire in South Africa may do so if they can provide the Minister of home affairs with proof that they have the financial means to do so (Khan, 2007).

The Refugees Act of 1998 which was implemented in 2000, states that the established South African government intended to develop a law that will advocate that refugees be treated as human beings that have rights instead of just providing them with housing to ensure physical protection (Khan, 2007). Chapter 5 of the Refugees Act expand on the rights and obligations of refugees, specifically the protection and general rights of refugees.

According to (section 27), a refugee should; (b) enjoy full legal protection, which includes the rights set out in Chapter 2 of the Constitution, the bill of rights. The constitution served as a foundation for the transformation agenda of the new democracy to protect the human rights of all persons living in South Africa and to rid itself of all forms of racial discrimination and

inequality that had been instituted against them by the Apartheid government (Lombard & Kruger, 2009).

The South African Constitution, 1996 (Act No 108 of 1996: 2) enshrines a Bill of Human Rights which forbids unfair discrimination against anyone on the basis of age, race, ethnicity and physical disability. It preserves and affirms the democratic values of human dignity, equality and freedom as well as the right to remain in the nation (Khan, 2007). To further support this, the International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), which are both endorsed by a majority of SADC member states, ban discrimination based on sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Wachira, 2008).

The South African Constitution and the Refugee Act (The Republic of South Africa 1998), also affords particular rights through protective legislation to refugees and asylum seekers. These rights include the right to employment and basic primary education which the populations of the republic also receive (Khan, 2007). More recent legislation has confirmed that this includes access to free basic social and healthcare services and free ART for both refugees and asylum seekers - with or without a permit (NDOH, 2007). In term of the protection and promotion of the rights of refugees, South Africa has legislated and done so in a progressive manner however there is still room for improvement (Khan, 2007).

In South Africa favourable policy development around immigration has been held back by the country's unpleasant immigration history, ambiguity with regards to the compatibility between immigration and post-apartheid transformation, and a community that shows no desire of any kind for immigration (Sally & Crush, 2007). The immigration policy was an exposed tool of racial domination before 1994. Up until 1991, the official definition

of an immigrant was that an individual had to be able to assimilate into the white population (Sally & Crush, 2007). By definition, Africans were not thought of as migrants (Sally & Crush, 2007). Rather, migrants came to South Africa as temporary contract migrants under bilateral agreements between the apartheid government and neighbours including Lesotho, Mozambique, and Malawi (Sally & Crush, 2007).

The bilateral agreement gave rise to the South African migrant labour system, a system still that is still in place today (Khan, 2007). After 1994, the South African government had a hard time in formulating a policy appropriate to the country's new role in a changing regional, continental, and global migration regime (Khan 2007). Defining a post-apartheid migration policy that will be responsive to South Africa's changing role in Africa was the core struggle, as well as the complex relationship between migration and development, and the problem of rampant xenophobia, was witnessed most graphically in May 2008 (Khan, 2007).

Xenophobia is said to be a profound and pervasive phenomenon that the government has not yet fully acknowledged, much less addressed, beyond favourable efforts (Khan, 2007). It is said to be the greatest problem facing migrants in South Africa as it hinders them acknowledgment, from enjoying all fundamental political, economic, social, cultural, civic and other human rights and freedoms equivalent to South African nationals (Crush, 2007). In late 2002, a new Immigration Act was signed into law after nearly eight years of negotiations. The act laid out a more immigration-friendly framework focused on attracting skilled migrants. Additionally, the act committed the government to seeking way of doing away with xenophobia in society (Khan, 2007). The preamble to the 2002 Immigration Act maintained that xenophobia needed to be contested. However, the act failed to lay out specific measures that will help achieve this, and there is also no evidence that the act itself has made any difference to South African attitudes (Khan, 2007). As many South Africans are still in

disagreement. Approximately 40% of people are opposed to Africans from elsewhere enjoying the same access to health and educational services as South Africans (Crush, 2007).

In 2004, the then ANC Minister of Home Affairs acknowledged the act's failings and vowed to set in motion a policy review process that would lead to a new policy framework and legislation (Khan, 2007). Many years later, the need for a review has become even more urgent (Khan, 2007). However, it cannot be disputed that recent efforts have shown a little improvement in terms of tolerance amongst citizens in this area.

Vearey (2011) argues that little research has been undertaken to explore forced migrants' access to psychosocial and mental health services. There is an argument that some forced migrants experience mental health problems, linked to violence experienced in their country of origin, on their journey to South Africa, and/or within South Africa itself (Bandeira, Higson-Smith et al. 2010). In response to this, a research study was undertaken to explore the psychosocial and health rights of South African citizens and forced migrants in Johannesburg who currently receive trauma counselling and support from the Trauma Clinic of the Centre for the Study of Violence and Reconciliation (CSV), a non-governmental organisation (NGO) located in the inner-city (Vearey, 2011). Findings from this study revealed that South Africa has a progressive, integrative, urban refugee policy that encourages forced migrants-refugees and asylum seekers – to self-settle and integrate (Vearey, 2011).

Different from other countries in the region, South Africa does not have refugee camps and many refugees and asylum seekers find themselves in complex urban environments such as Johannesburg (Vearey, 2011). These migrants are assured a range of rights, including those to protect their health and psychosocial wellbeing. However, it cannot be denied that these rights are not always protected (Vearey, 2011).

Vearey (2011) further states that refugees and asylum seekers living in South African cities are expected to become self-sufficient by earning a living and integrating within the host community. Over the last four years, the Consortium for Refugees and Migrants in South Africa (CoRMSA) has provided evidence-based updates on the challenges faced by migrants when attempting to access public healthcare services in South Africa. These challenges include language problems, access not being granted on the grounds of lack of documentation or for “being foreign”, as well as the problematic interactions with frontline healthcare providers.

Furthermore, Wachira (2008) states that there are several global and local human rights promises pertinent to migrants’ right to health. Of considerable significance, is that the government should take the necessary precautions to ensure the protection of peoples’ health and to ensure that they receive medical attention when they are ill (Wachira, 2008).

Constitutionally, migrants have all these rights however due to discrimination, in reality they continue to face challenges when attempting access to healthcare, and other services, they continue to be the most marginalised, isolated and poor (Crush, 2007), which results into them being in immensely untenable positions (Vearey, 2011). In addition to these problems migrants experience demographic challenges, relocation/moving challenges, racial prejudice which interferes with their ability to build social relationships in interracial institutions. Additionally, health care services in South Africa for migrants are not prioritised with regards to the allocation of funds towards health care services and training of health care workers which will be made easily available to them (Vearey, 2011).

Crush (2000) states that albeit South Africa priding itself on having one of the most progressive constitutions in the world, and a Bill of Rights that guarantees a host of basic political, cultural and socio-economic rights to all who are resident in the country, there’s

been continuous statements regarding South African nationals being intolerant of foreign nationals, and this has extremely escalated since 1994.

Research has depicted that intolerance is tremendously pervasive and rising in intensity and seriousness (Crush, 2007). There is lack of support for migrants' rights, therefore the ill-treatment of migrants and refugees perseveres (Crush, 2000). Additionally, the abuse of rights is condoned by current legislation that allows for unjust sentences for wrongful doings (Klaaren & Ramji, 2001).

In summary of policy and legislation, despite the formation of a national coordination initiative, migration policing has been a disjointed effort. This indicates that protective policies have not been well executed in practice (Vearey, 2011) as the growing effects of this are the continuous violation of human rights which can be seen in the abusive attacks and the violent arrests of undocumented migrants (Klaaren & Ramji, 2001). These rights violations have led to the embarrassing attention of domestic and foreign human rights organizations (Klaaren & Ramji, 2001).

### **How policy and legislation relates to social work practice**

Essentially social workers by very definition are human rights workers (Dunk, 2007). They have, for a long time been involved in advocacy and campaigning for social justice. They are ideally placed in places where they lobby for better evaluation and evidence led policy to ensure that communities realise and claim their collective rights and that those rights and responsibilities are met (Dunk, 2007). The social policy implications of this study point to the need to develop or incorporate policies that would allow targeted HIV/AIDS education messages at the stage of the resettlement process based on empirical findings on the culturally specific determinants of condom use intentions among African migrants. In addition, the effect of level of acculturation on attitudes and subjective norms of African

migrants' intentions to use condom would assist policy makers in developing effective national policies that take acculturation into account. Additionally, assist social workers to develop community support for such vulnerable communities in ways which are empowering, based on partnership and recognising culture to move forward. Social service delivery systems in the area of HIV/AIDS prevention and education will also find this research invaluable to the development and implementation of culturally relevant programmes for at-risk ethnic minority youth aside from the dominant culture approaches.

### **Nature and extent of condom use among migrant youth**

Sexual behaviour is influenced by a variety of factors. Early sexual debut, premarital sex, the keeping of multiple partners as well as the prevalence of HIV transmission as a result of high risk sexual behaviour e.g. lack of condom use, are common sexual behaviours among migrant youth.

Eaton, Flisher and Aaro (2003) posit that a great amount of research evidence points to the complexity of sexual behaviour. HIV risk behaviour is influenced by factors at three levels: within the person, within the proximal context (interpersonal relationships, physical and organisational environment) and within the distal context (culture and structural factors). Eaton, Flisher and Aaro (2003) present a paper on a research review on aspects that promote and exacerbate dangerous sexual behaviour among South African youth.

Eaton, Flisher and Aaro (2003) did a review on the sexual behaviour of youth between the ages of 14 and 35 years in 1990 and 2000. The review concluded that 50% of young people are sexually active by the age of 16 years. A large number of the students who were sexually active reported having one partner in the previous year, with a minority of 1% and 5% of females and 10–25% of males having more than four partners per year; and

between 50% and 60% of sexually active youth reported never using condoms (Eaton, Flisher & Aaro, 2003).

Varga (1997) did a study with the aim of exploring barriers to condom use among commercial sex workers in Durban, South Africa. Findings from this study indicated that there were numerous hindrances to consistent condom use. Amongst these obstacles were: the threat of being physically violated by clients, having an appealing and trustworthy appearance to prospective clients, and financial incentives for unprotected sex. In this study monetary difficulties were deemed to be the major cause for putting the condom use rule aside. Sex workers would calculate their daily proceeds against their finances e.g. food, rent or transportation which were all dependent upon making a certain quota each evening. In the event that a sex worker has not reached a certain quota on that night's work, the probability to accept additional payment for unprotected sex until that financial quota is attained was high. Varga (1997) further stated that a number of sex workers also described fixed clients with whom they were not strict on using condoms with in fear of losing the regular income. Finally, several women acknowledged high alcohol consumption and frequent use of dagga (marijuana) or mandrax as major obstructions in making an informed decision and being able to implement condom use with clients (Varga, 1997).

Mberu (2008) posits that premarital sexual relationships have become more and more common in Nigeria. Young people in Nigeria are said to have high risk sexual behaviours such as casual sex and keeping of multiple partners, including commercial sex workers (Isiugo-Abanihe, 2003). Substantial immigration of young, unmarried adults from conservative rural environments to more sexually permissive African cities in recent years has been linked to a large amount of AIDS sero-prevalence levels (UN, 1994).

Furthermore, transmission of HIV dynamics turns out to be more multifaceted as frequent movements between cities, and home villages remain the norm for many urban migrants in sub-Saharan Africa (Andersson, 2001). The long distance movement between diverse socio-cultural environments, with ambiguous movement difficulties and social support networks at destinations defines migrants, to some extent as risk-takers (Peterson, 1958). Consequently, migrants may be predisposed to higher risk-taking behaviour; this may involve riskier sexual behaviour in the new social setting, due to personal values established before migration (Brockhoff & Biddlecom, 1999).

Neff (2012) posits that they are psychological barriers (e.g. perceived risk) as well as behavioural barriers (e.g., knowledge and social factors) that impact on an individual's use of or the intention to use condoms. Cates and Stone (1992) as with other researcher's state that currently the most effective way to prevent sexually active people from contracting and transmitting HIV/AIDS is through correct and consistent condom use.

Notwithstanding the legitimacy of individualistic models in Western societies where they have been predominantly adopted, their key limitation is the inadequate focus on broader environmental and economic factors that may influence individual health-related behaviour, protective sexual behaviour in particular (Mberu, 2008). Moreover, evaluations of interventions based on the Health Belief Model, have shown unsatisfactory effects on risky behaviour (Auerbach, Wypijewska & Brodie 1994).

Fishbein and Ajzen (2005) recognised the importance of testing the applicability of socio-cognitive models in the fight against HIV/AIDS. At the core the objective of their research was to investigate the application of the theory of reasoned action (Fishbein & Ajzen, 1980) and the theory of planned behaviour (Ajzen, 1991) in the development of a HIV/AIDS health promotion programme in the workplace. When answering the question

“How do you feel about always using a condom during sexual intercourse” participants elaborated on the benefits and shortcomings of using a condom. On the advantages of condom usage, respondents (87%) indicated that they recognise value in using condoms for preventing sexually transmitted infections, as well as in preventing pregnancy (76%). The prevention of infection and prevention of pregnancy themes were reported more by females (96% and 89% respectively) than by males (73% and 53% respectively). Seemingly, women were more concerned with the practical utility of condoms whereas males responded with vague statements such as safer sex (40%) and rational issues such as healthy life style and sound values (40%) (Fishbein & Ajzen, 1980).

### **Condom use behaviour among migrant youth**

Condom use behaviour among migrants has been studied extensively. Research has highlighted that condom use or the lack thereof is sometimes not within the female’s volition as they fear their partners and due to fear of rejection. It is also noted that there are some myths around HIV transmission that dwarf the use of condoms.

Crosby and Yarber (2001) state that previous research has indicated that young adults have multiple reasons and misperceptions for not using condoms including the belief that birth control pill and oral sex lower the risk of contracting HIV, having sex with only one partner prevents them from being at risk of contracting HIV, the withdrawal method prevents HIV transmission, misconceptions regarding emergency contraception, and false beliefs that their partners are disease free and also have the false belief that their peers do not use condoms and do not get infected and as a result, they do not need to use condoms either and have no risk of contracting HIV/AIDS (Carey, Bosari, Carey, & Maisto, 2006). Since beliefs and attitudes work interchangeably it can be deduced from this that a person’s attitude and belief towards something influences their behaviour towards it.

Hendriksen, Pettifor, Lee, Coates, and Rees (2007) posit that young adults are currently the main group at higher risk for HIV infection. For example, Ferguson, Quinn, Eng, and Sandelowski (2006) compared African American gender differences in a qualitative study. Findings highlighted female students as the ones not using condoms for the subsequent reasons: they were in long-term relationships, they were emotionally attached, they feared rejection from that partner, lack of communication skills regarding condom use, and the mutual fear was that their male partners might think they were adulterous if they began this new behavior if initiating condom use.

Adih and Alexander (1999) did a study to explore the determinants of condom use to prevent HIV infection among youth in Ghana, results from this study indicated that older respondents were more likely to have used a condom before. Other scholars have found the opposite to be true; they have found young people to be more unlikely to report frequent condom use during intercourse. In Ghana, contraceptive services are normally catered to adults; this explains why young people find it more challenging to obtain condoms since they may not have adequate financial resources to consume condoms (Adih & Alexander, 1999). Additionally, albeit the availability of financial means, they feel embarrassed to go to the store or family planning centre to buy them. However, participants with higher levels of self-efficacy were reported to be more likely to have used a condom (Adih & Alexander, 1999).

Musariri (2012) did a study that looked at the determinants of condom use among migrant farm workers in two South African provinces. The results in this study revealed that access to free condoms, having sex while drunk, financial stability and living arrangements with spouse are the factors linked to condom use among migrant farm workers in Limpopo and Mpumalanga.

Among migrant men financial stability was significant while among women, marital status, having sex while drunk and living arrangements with spouse are the significant factors

associated with condom use (Musariri, 2012). Socioeconomic factors such as transactional sex, forced sex and demographic factors such as age, proved to be insignificantly associated with condom use (Musariri, 2012). Furthermore, a number of surveys undertaken in South Africa found that the rate of HIV infection is high while condom use is relatively low in the districts situated around migrant and on truck routes (IOM, 2010). As such, migrants have been identified in the National Strategic Plan (2012-2016) as one of the key populations at risk of HIV infection and should be targeted with prevention, care and treatment interventions specific to them (Musariri, 2012).

Additionally, the use of condoms is one of the major strategies for combating sexually transmitted infections as well as HIV (Bond & Dover, 1997). In Africa condom use has been massively debated over the past years, facing opposition from many perspectives (Bond & Dover, 1997). Whilst both men and women have negative attitudes towards condoms, because of their economic and social dependence on men, women are in a weaker position to negotiate condom use; this is further exacerbated if the women are migrants (Zuma, Gouws, Williams, Lurie, 2003). Several socioeconomic, cultural and religious factors have been identified as barriers to condom use, and these vary in influence between men and women (Lurie, Williams, Mkayi-Mwamburi, Garnett, Sweat, Gittelsohn, & Karim, 2003).

Mberu (2008) posits that young people who live away from home, away from parents and relatives are more likely to use condoms at sexual debut. This finding points out the hindering roles of parents and relatives in accessing and utilizing sexual-related information and services even when they are available (Mberu, 2008). Sex remains part of the sacred norms in many African cultures and that young people who live with their parents or relatives may be discouraged from accessing sex-related services such as condoms for fear of being identified as sexually promiscuous or being reprimanded if discovered (Mberu, 2008). It's for comparable reasons that health care providers are identified as unwelcoming to young people,

consequently hindering them from seeking sexual and reproductive health information and services in the area (Mberu, 2008).

### **Acculturation and condom use behaviour among migrant youth**

The relationship between acculturation and condom use behaviour has been studied extensively in Western countries, however in South Africa there is limited research done to explore this relationship.

Culture has been defined in the literature as “the way of life among members of a group, including the values, beliefs, norms, and traditions that might influence some people to put themselves at risk for HIV transmission” (Wilson & Miller, 2003:185). Within racial/ethnic groups, a cultural process related to health risk behaviours is referred to as acculturation.

Culture is conserved but can adjust as individuals interact and communicate within their ecological system. For instance, a person might be a part of more than one culture/system, such as at church or at home. Acculturation is a process of culture learning that changes the nature of beliefs and values that an individual embrace (Marin & Gamba, 1996). Since culture plays a significant role in health behaviour (Landrine & Klonoff, 2001), and acculturation levels assist researchers in understanding what values and beliefs individuals subscribe to (country of origin or host culture), acculturation was measured in the current study.

Acculturation is a process of culture learning that changes the nature of beliefs and values that an individual holds (Marin & Gamba, 1996). Acculturation has been identified as a variable relating to sexual risk behaviour for HIV infection. Hou (2009) did a study that compared White students from traditionally White universities with African American students (from traditionally African American Universities), and established that African

American students reported higher perceived risk and riskier sexual peer norms than the White sample.

Other research has revealed the reverse relationship between risky sexual peer norms and perceived risk; the more one's peer group participates in risky sexual behavior, (i.e., less condom use, multiple sexual partners), the less perceived risky behavior they portray (Carey, Bosari, Carey, & Maisto, 2006; Selvan, Ross, Kapadia, Mathai, & Hira, 2009). The rationale supporting this belief is that individuals observe their allies partaking in certain ways and (seemingly) not being infected with HIV/AIDS and this influences how the individual behaves.

According to Okonkwo Fatusi and Ilika, (2005) the social environment plays an important role in the health-related behaviour of young people, and this includes friends and peers, sexual partners, family members as well as the community, school and other youth serving institutions. The impact of peers on reproductive and sexual behaviour of young people has particularly been strong (Diclemente, 1991 as cited in Mberu, 2008)

Gilbert and Cervantes (1986) posit that the social norms and attitudes in the USA are less restrictive than traditional Latino norms with respect to substance use and sexuality for Latino women. For example, women in Mexico generally abstain from or drink low quantities of alcohol, whereas non-Latino white women in the USA drink alcohol more frequently and consume a greater volume when they drink (Gilbert & Cervantes, 1986). As Mexican, Puerto Rican and Cuban women acculturate to the USA, their use of alcohol (Black & Markides, 1993) and their use of marijuana and cocaine increases (Amaro, Whitaker, Coffman, & Heeren, 1990).

Further, national surveys and surveys conducted in Northern California have found that acculturated Latino women are more likely than their less acculturated counterparts to

have multiple sex partners, and to use alcohol before having sex (Marin & Flores, 1994).

However, acculturated women are not necessarily more likely than less acculturated women to engage in unprotected sexual intercourse (Marin & Flores, 1994).

Gilbert and Cervantes, (1986) state that studies of acculturation and risk behaviours of Latino men have produced mixed findings. Amaro, Whiteker, Coffman, and Heeren, (1990) state that Mexican men drink less frequently than non-Latino white men, but they drink more heavily when they drink. Marks, Garcia, and Solis (1990) state that as Mexican, Puerto Rican and Cuban men acculturate to the USA, their use of marijuana and hard drugs increases but not their use of alcohol. With respect to sexual risk behaviours, some national and state surveys have found that highly acculturated Latino men are more likely than less acculturated men to have multiple sexual partners (Sabogal, Perez-Stable, Otero-Sabogal & Hiatt, 1995); contrariwise other investigations have found the opposite effect or have found no differences in number of partners (Ford & Norris, 1994). Though these mixed results may indicate that the social norms and attitudes governing the sexual behaviours of Latino men do not differ substantially from the social norms and attitudes governing the sexual behaviours of non-Latino white men, additional studies of the role of acculturation in sexual risk are required to investigate the issue further Gilbert and Cervantes, 1986).

Hendriksen, Pettifor, Lee, Coates, and Rees (2007) state that condoms continue to be the effective protection against HIV and other sexually transmitted infections (STIs) for sexually active young grownups. These researchers further contend that in South Africa a lot of young people are aware that condoms help alleviate the chances of contracting HIV, STIs, and unwanted pregnancies and that correct and consistent condom use is essential every time they engage in sexual activities. Additionally, condoms are provided free of charge by the government in South Africa and are available to everyone through a number of venues,

including public-sector clinics, youth centres, schools, university campuses and public toilets (Hendriksen, Pettifor, Lee, Coates, & Rees, 2007).

87% of South African youths report that it would be "very easy" to obtain condoms if the need arose (Hendriksen, Pettifor, Lee, Coates, & Rees, 2007). However, even with such access, the prevalence of HIV infected individuals in South Africa continues to be on the rise.

Baron and Kenny (1986) contend that acculturation may have an influence on the use of substance prior to a sexual encounter which, in turn, may promote unsafe sex. In other words, substance use may mediate association between acculturation and unsafe sex (Baron & Kenny, 1986). This brings the need to find significant relations among acculturation, substance use before sex, and risky sexual behaviour. Thereafter, the relationship between acculturation and risky sex might lessen after controlling for the assumed mediator (Baron & Kenny, 1986).

The aforementioned studies illustrate how acculturation impacts cultural groups, but also how different messages are received by different groups and within the same groups. Meaning, how one individual become more acculturated and engage in less risky behaviours whereas another individual becomes more acculturated and engages in riskier behaviours. The acculturation measure utilized in the current study allows the researcher to understand how individuals see themselves in terms of cultural influences and how these influences impact condom use.

Brewster, Cooksey, Guilkey, and Rindfuss (1998) posit that the link between religious affiliation and contraceptive use at first sex are mixed. Brewster et al, (1998) discovered that strong religious beliefs among teenagers make them less likely to use a contraceptive method when having sex for the first time, but also found changes on the influence of religion over time. In a similar study of adolescent males, fundamentalist affiliation was found to be

associated with increased levels of sexual risk behaviour (Ku, Sonenstein, & Pleck, 1992). On the contrary, alternative research has found no relationship between religion and contraceptive use (Nonnemaker, McNeely & Blum, 2003). In Africa, knowledge on the relationship between religion and condom use is little and researchers are only commencing to point out the prominence of religion in reproductive behaviour of African youth (Mberu, 2008).

### **Association between acculturation and the intention to use condoms**

Likewise, the relationship between acculturation and condom use behaviour has been studied extensively in Western countries, and in South Africa there is limited research done around this area. However, research has pointed out that, traditional African cultures are normally patriarchal and oppressive towards women (Airhihenbuwa, 1995).

HIV/AIDS prevention researchers in Africa have highlighted that pervasive, culturally entrenched gender discrimination increases the risk of HIV infection among African women (Ng'weshemi, Boerma, Bennett, & Schapink, 1997). Additionally, in Southern Africa, as in other parts of the world, condom use has been responded to, with resistance especially from traditionalists, cultural and religion moralists. Therefore, even at the availability of condoms, social, cultural and practical factors hinder people from using them (Avert, 2012). Burgoyne and Drummond (2008) stated that seemingly in Africa condoms are perceived to have a range of negative attributes, these include low sexual pleasure, promiscuity in men and women, being unsafe to use and being an indicator of lack of trust in relationships. In a study done in Zimbabwe, results indicated that condom use was linked to prostitution and therefore equally men and women were reluctant to utilise them in their marital relationship (Duffy, 2005).

Afable-Munsuz and Brindis (2006) did research on acculturation and the sexual and reproductive health of Latino youth in the United States. Their literature review included a

range of studies, these studies commented on theories that might explain how acculturation influences sexual and reproductive health. Thereafter, two general theories were employed. One, was labelled "stress theory," it emphasizes the stress that migrant teenagers face in adapting to a different culture. According to this theory, teenagers who are faced with negotiating competing values and norms of different cultures may experience stress and be vulnerable to high-risk or maladaptive behaviours, such as early sexual initiation (Afable-Munsuz & Brindis, 2006). Consequently, the more acculturated a teenager is, the more stress he or she encounters and the more likely he or she is to engage in risky behaviours.

The second theory was, "cultural norms theory," describes acculturation as a process of change in values and norms regarding gender, sexual activity and family formation. For example, the less acculturated Latinas are, the more value they may place on virginity, family responsibility and obedience to men, a concept known as *marianismo* (Afable-Munsuz & Brindis, 2006). Therefore, bigger acculturation levels may lead to more awareness of alternative roles for women and alleviate the probability teenage pregnancy. Furthermore, Afable-Munsuz and Brindis (2006) posit that acculturation can also be observed in terms of losing or retaining traditional norms that shape family relationships. For example, more acculturation may lead to a loss of traditional norms such as *simpatia*, which emphasizes maintenance of harmonious relations; which emphasizes avoidance of conflict and respect for authority within the family; and *familism*, which stresses the importance of family life and interdependent relations among the individual, family and community (Afable-Munsuz & Brindis, 2006). Thus, teenagers who are not very acculturated would tend to circumvent getting involved in behaviours that infringe these norms; and greater acculturation might lead to more sexual risk-taking (Afable-Munsuz & Brindis, 2006).

Unger (2000) did a study on acculturation and attitudes about contraceptive use among Latina women in the US. In this study it is stated that the male-dominated Latino

culture may make it difficult for Latina women to insist on using contraceptives if their partners do not wish to do so (Ortiz & Casas, 1990). This is because the traditional Latino culture places a strong emphasis on family and motherhood (Giachello, 1994), and because Latino men may view multiparity as an expression of their virility (Wiest, 1993), therefore Latina women may be reluctant to use contraceptives or to ask their partners to do so. It is stated that women might also be unwilling to use contraception for religious reasons or because they believe that their friends would not approve of them using contraception (Gibson & Lanz, 1991). Additionally, it is possible that a lot of Latina women in the United States lack adequate access to contraceptives or information about how to use contraceptives effectively (Russell, Williams, Farr, Schwab, & Plattsmier, 1993).

Ford and Norris (1994), conducted research in the United States on a sample of urban Hispanic adolescents and young adults. Their findings indicated that females with high acculturation levels were more likely to have had at least one sexual partner in the last year, more likely to have had non-Hispanic partners, and to have had oral and/or anal sex. Further findings indicated that the more acculturated Hispanic adolescents and young adults were, the more likely they used condoms (Ford & Norris, 1994), and express less negative beliefs about condoms (Ford & Norris, 1994), than their less acculturated counterparts. This indicates that even though acculturation might lead to increased rates of sexual behaviours, it may also lead to greater acceptance of preventive behaviours that can minimize the risk associated with sexual behaviour (Unger 2000).

### **Associations between intentions and condom use behaviour**

The intention to use a condom is influenced by a variety of factors and it should be noted that intent does not necessarily transcend into action.

The anticipation that a person can effectively complete a certain behaviour, such as using a condom, is theorised to be a noteworthy predictor of whether one attempts the

behaviour (Ajzen, 1985). Potard, Courtois, Samedy, Mestre, Barakat and Réveillère (2011) did a study with the aim of testing the application of Ajzen's Theory of Planned Behaviour to risky sexual behaviour. These researchers studied factors that predicted the intention to use a condom among a sample of French adolescents, and looked at the effect of gender. Participants consisted of 230 French high-school students from five different schools in France. Conclusions from this study suggested that the decision of whether or not to use a condom during sexual encounters was strongly linked to 'perceived control' and 'personal attitudes'. This thus indicates that these determining factors are important in adolescents' intention to use a condom. According to these researchers the greatest predictors of the intention to use condoms for girls are perceived control and individual attitudes, while individual attitudes is a better predictor than perceived control for boys. For example, (Carey, Bosari, Carey, & Maisto, 2006) state that if students have the false belief that their peers do not use condoms and do not get infected, they also do not need to use condoms either and they are not at risk of contracting HIV/AIDS (peer influence). This is in agreement with what Gerrard, Gibbons and Bushman (1996) reports that "decisions regarding sexual risk taking are highly vulnerable to emotional interference, and, therefore, may not be as rational as decisions involving precautionary measures that are less emotion laden, such as wearing a seat belt or getting a flu shot" (p.401).

Factors such as optimistic bias, condom self-efficacy, communication ability, in combination with risk assessment might also influence the decision and enactment process. For example, optimistic bias is said to be a factor involving labeling one's behavior as risky, therefore the more optimistic bias, the less perceived risk (Gerrard, Gibbons & Bushman 1996). Neff (2012) also confirmed this on her study and states, that general peer influences (e.g., peer norms, subjective norms, and peer pressure) are all contextual antecedents that can contribute to the perception of one's risk in terms of health behaviours.

Furthermore, Potard, Courtois, Samedy, Mestre, Barakat & Reveillere (2011) contend that adolescents with a positive attitude towards condoms, who reported confidence in their ability to use condoms, reported more intention to use condoms than their peers with less positive attitudes. Thus, the intention to use a condom is influenced by personal, intimate factors (self-efficacy) for adolescent girls, while for boys the most decisive factors appeared to be social and individual attitudes. These researchers argued that no significant relationship between condom use intention and actual behaviour was found in their study. They say this is explained by the fact that condom use does not just involve one person (like smoking, drinking, eating, etc.), but involves interaction and negotiation with another individual (Potard et al., 2011)

However, results from this study confirmed results from previous studies showing that there is a relationship between perceived control and the intention to use a condom (Potard et al., 2011). With regard to use (actual behaviour), this study also demonstrates that perceived control is an essential factor. These researchers found that the overall perception and ability to overcome obstacles specifically linked to ‘condom use’ seems to be another essential determinant of the intention to use them (Potard et al., 2011). They argue that the more a young woman feels at ease with using condoms (self-efficacy), the more she is likely to use one during her sexual encounters (Potard et al., 2011). And argue that this analysis applies mainly to girls, because the ‘perceived control’ variable is not significantly associated with ‘intention to use a condom’ for boys.

Abraham, Sheeran, Normsan, Conner, De Vries, and Otten (1999) did a study that aimed to enhance behavioural prediction by identifying post-decisional cognitive processes capable of differentiating between intenders who acted in accordance with their intentions and those who did not. These authors wanted to study the cognitive correlates of condom use by understanding the post-intention cognitive processes that differentiate between intenders

who act and those who do not act. The findings from the Abraham et al. (1999) study suggested that measures of condom use intention and general condom use self-efficacy distinguished between participants who used a condom in their last sexual encounter and those who did not. The majority of those who used condoms intended to use them (Abraham et al., 1999). The majority of those who reported not using condoms had also intended to use them. A discriminant analysis comparing users and non-users of condoms at their last sexual encounter showed that the comparative significance of condom use was strongly related to condom use, while negotiation planning, general self-efficacy, negotiation self-efficacy and having a condom available showed moderate correlations (Abraham et al., 1999). Findings from this study demonstrate the effectiveness of interventions to focus on planning, enhancing confidence in relation to condom use negotiation and encouraging people to carry condoms. Such interventions seem to have an influence on whether people use condoms or not (Abraham et al., 1999).

In the Theory of Planned Behaviour and the Theory of Reasoned Action, intentions are postulated to be the major determinants of health-related behaviour. Research in Western contexts bears this out to some extent. For example, intentions to use condoms have a moderate to strong correlation of 0.44 with self-reported condom use (Sherran & Orbell, 1994), although such correlational research does not prove that intentions cause behaviour. In South Africa the intention to abstain altogether from sex until marriage is expressed by a small minority, mostly women from conservative Christian backgrounds, and almost never by young men. The intention to be monogamous is expressed by many women (but by no means all). With young men, however, the picture is not the same as a lot of them consider monogamy to be just as undesirable as abstinence (Sherran & Orbell, 1994). When people were asked how they intend to change their behaviour to reduce their risk of HIV infection,

the intention to be faithful or to reduce the number of partners was reported more often than the intention to use condoms (Blecher, Steinberg, Pick, Hennick, & Durcan, 1995).

Furthermore, Two South African studies with young adults suggest that self-efficacy for condom use is indeed linked to higher self-reported condom use (Peltzer, 1999), although the direction of causality is not proved by the correlational methods used (Eaton, Flisher & Aaro, 2003).

South African research has discovered that low self-esteem is associated to early sexual debut and having multiple sexual partners (Perkel, Strebel, & Joubert, 1991). It has been hypothesised that a person with a poor sexual self-concept may rely on others for affirmation (Perkel, Strebel, & Joubert, 1991). This may lead him or her to search for external affirmation in multiple sexual encounters. South African research also indicates that young people with low self-esteem are more concerned with what their partners think of them and with avoiding displeasure or rejection from partners, than people with more positive self-esteem (Perkel, Strebel, & Joubert, 1991). A person with low self-esteem is therefore more likely to think that condoms are offensive to their partner, to think that using condoms may make their partner think they are dirty, to be embarrassed about using condoms and to have a negative attitude towards condoms (Perkel, Strebel, & Joubert, 1991).

Bryan, Kagee and Broaddus (2006) formulated and tested models of intentions and behaviour among adolescents from Cape Town, South Africa. Results suggested that 50% of young people are sexually active by age 16, boys debut prior than girls, and most young people use condoms inconsistently, if at all (Bryan, Kagee & Broaddus, 2006). While most young people are cognisant of the consequences of AIDS, there were disparities in knowledge about exactly how HIV is transmitted, and how it is related to AIDS, as well as misapprehension of the effectiveness and practical use of condoms (Bryan, Kagee & Broaddus, 2006).

Jemmott, Heeren, Ngwane, Hewitt, Jemmott, Shell, and O’Leary (2007) did a study that was underpinned by the theory of planned behaviour. The aim of the study was to examine the modifiable determinants of the intention to use condoms among Xhosa-speaking South African adolescents. Participants in the study were 390 Xhosa-speaking 6th grade students (mean age 12.1 years) in public schools in the township of Mdantsane, in Eastern cape. Findings from their study indicated that attitude and perceived behavioural control predicted the intention to use condoms, whereas subjective norm did not. These researchers argue that adolescents with positive attitudes toward condoms, who perceived they could effectively utilise condoms had firm intentions to use condoms than did their peers, however normative beliefs did not (Jemmott et al, 2007). These researchers point out a very interesting dynamic in their study and state in African societies where emphasis on communism and interdependence as opposed to the individualistic approach frequently emphasized in Western societies, it was interesting and unanticipated for them that subjective norms rather than attitude and perceived behavioural control would be important as indicators (Jemmott et al., 2007).

Additionally, Madu and Petlzer (2003) formulated a measure concerning condom use based on focus groups conducted with South African university students. Factor analysis of the measure generated five components related to lack of condom use: poor relationship (condoms imply mistrust or unfaithfulness), misleading beliefs or myths (condoms don’t work, only foreigners get AIDS), inconvenience of condom use, socially negative attitudes (shame surrounding having condoms), and non-availability (Madu & Petlzer, 2003). Some of these components reflect attitudes (poor relationship, social attitudes), while others are described as issues around self-efficacy (inconvenience and non-availability) and information (misleading beliefs) (Madu & Petlzer, 2003).

In conclusion, Brown, DiClemente and Reynolds (1991) argue that social networks and cultural norms can have an impact on labelling behaviour as high risk through disapproval, peer pressure, and social stigmatization. Developmentally, late adolescents depend on peer groups to provide a structure for making decisions, therefore indicating a need to focus on peer group norms in intervention strategies (Ratliff-Crain, Donald, & Dalton, 1999), because literature shows that people assume that others who appear similar to them share their same attitudes and behaviours. This concept is called self-positivity bias or optimistic bias (Weinstein, 1989) and this attitude can be very harmful in the context of high-risk sexual behaviours and is sometimes referred to as “unrealistic optimism” (Raghubir & Menon, 1998).

### **Perceived behavioural control and condom use behaviour of migrant youth**

Perceived behavioural control is said to have an impact on whether or not individuals use condoms. Individuals with high self-esteem/self-efficacy are said to execute condom use behaviour successfully. However, studies on the sexuality of young people have highlighted gender inequalities that inhibit vulnerable groups from negotiating safe sexual encounters which minimizes condom use behavior.

Conner and Norman (1995) state that perceived self-efficacy characterises the belief that an individual can alter risk health behaviours through personal action, for example, by employing one's skills to resist temptation. Behaviour modification is perceived as dependent on a person's perceived capability to cope with stress and boredom and to mobilize resources and courses of action required to meet the situational demands (Conner & Norman, 1995).

Additionally, they state that efficacy beliefs have an impact on the intention to modify dangerous behaviour, and the level of effort used to attain this goal, and the persistence to continue striving in spite of barriers and setbacks that may undermine motivation. And that

perceived self-efficacy has come to be a widely applied theoretical concept in models of addiction and relapse (Conner & Norman, 1995). These authors contend this suggests that success in coping with high-risk situations depends partly on people's beliefs that they operate as active agents of their own actions and that they possess the necessary skills to reinstate control should a slip occur (Conner & Norman, 1995). For example, Levinson, 1982 (as cited in Conner & Norman, 1995) state that teenage girls with a high rate of unprotected intercourse have been found to use contraceptives more effectively if they believed they could exercise control over their sexual activities.

Furthermore, studies on the sexuality of young people have highlighted gender inequalities that inhibit young women from negotiating safe sexual encounters (Holland, Ramazanoglu, Sharpe & Thomson, 1992). Wilton & Aggleton, (1991) argue that social constructions of masculinity that encourage the idea of men 'needing' sex continue to limit women's potential in negotiating safe sex and limit opportunities for women to either refuse sex or negotiate safe sex. Furthermore, Richter and Swart-Kruger (1995) indicate that for individuals such as children living in the street there are limited opportunities for them to exert control over their sexual encounters. Additionally, another widespread risk factor is substance abuse, sexual intercourse while under the influence of glue, marijuana or alcohol reduces condom use (Kruger & Richter, 1996). Therefore, this emphasizes the importance of social and economic contexts in which street children negotiate their sexuality to be taken into account (Kruger & Richter, 1996).

Migrants find themselves in vulnerable situations that make it tough for them to use condoms (IOM, 2010). Siziya, Rusakaniko, Tshimanga & Marufu (1999) state that migration has been reported to escalate individuals' vulnerability when they are in situations where negotiating safe sex is difficult. Previous research has shown that the problem of risky sexual behaviour and abuse is typical of many migrant communities and particularly those on

commercial farms (Siziya et al., 1999). A study done in Zambia at Chiawa farm revealed that women are at times tempted or coerced into sex in exchange for employment, favourable tasks or extra wages, and in such compromised circumstances, condoms are rarely used (Bond & Dover, 1997).

Kowalewski, Longshore, and Anglin (1994) examined psychosocial factors involved in acquiring safer sex behaviours in a sample of 161 injection drug users who reported having multiple sexual partners in the past year. They tested the first two stages of the ARRM (AIDS Risk Reduction Model) using a measure of perceived risk (stage one) and intention to use condoms during vaginal or anal intercourse in the next year (stage two). They analysed differences in the predictive value of the ARRM between condom users and non-users. Individuals in the two groups who held the belief that they were susceptible to AIDS also saw themselves to be at risk of infection. The more educated condom users were, the more they perceived themselves to be at risk of infection (Kowalewski, Longshore & Anglin, 1994). In the two groups, beliefs regarding condom self-efficacy and having more peers who used condoms, predicted intentions to use condoms in the future, also prior condom use was positively related to future condom use (Kowalewski, Longshore & Anglin, 1994). They also found that greater perceptions of HIV risk infection predicted perceptions that condoms are pleasurable for both groups. The authors also indicated that self-efficacy is related to one's ability to negotiate using condoms with a partner, thus self-efficacy is socially defined and reinforced through social network and partner (Kowalewski, Longshore & Anglin, 1994). One important insinuation is that for both condom users and non-condom users, an intention to use condoms in the future is strongly influenced by peer condom use (Kowalewski, Longshore & Anglin, 1994).

Lurie, William, Mkayi-Mwamburi, Garnett, Sweat, Gittlelsohn and Karim (2003) did a study to measure HIV-1 discordance among migrant and non-migrant men and their rural

partners, and to estimate the relative risk of infection from inside versus outside primary relationships. Result findings indicated that a total of 70% of couples were negatively concordant for HIV, 9% were positively concordant and 21% (35 of 168) were discordant (Lurie et al., 2003). Migrant couples were more likely than non-migrant couples to have one or both partners infected and to be HIV-1 discordant (Lurie et al., 2003). Among the discordant couples, the males were infected; migration status made no difference on this (Lurie et al, 2003). In the mathematical model, infections from outside regular relationships than from inside were calculated to be 26 times more likely among migrant men, non-migrant men were 10 times more likely to be infected from outside their regular relationships than inside (Lurie et al, 2003). What was evident in this study is that migration continues to play an important role in the spread of HIV-1 in South Africa (Lurie et al, 2003). The direction of spread of the epidemic is not only from returning migrant men to their rural partners, but also from women to their migrant partners (Lurie et al., 2003).

Chireshe (2010) did a study on the impact of poverty on women's psychosocial well-being: narratives from Zimbabwean migrant women in South Africa. In this study it is evident that poverty is one of the major issues that put migrant woman at high vulnerability to HIV infection and little to control when it comes to the initiation of condom use in their sexual behaviours. Responses from the respondents in the study were that some drivers demand sex as payment for assistance they render to illegally cross into South Africa. The woman reported that the money they get at work is too little, they feel exploited, and budgeting for it is very stressful. Some reported to be homeless and stay under very inhuman and shameful conditions. When the problem of money persists, then they engage in commercial sex to supplement, one would rather die of HIV/AIDS than hunger (Chireshe, 2010).

William, Adih, and Alexander (1999) conducted research with the purpose of identifying the psychosocial and behavioural aspects that impact condom use, in efforts to diminish the risk of HIV infection among young men in Ghana. Their findings showed that 65% of the sexually active male respondents had used condoms at least once, and only 25% had used condoms at last intercourse (William et al, 1999). Findings from the study further indicated that perceived susceptibility to HIV infection, perceived self-efficacy to use condoms, perceived barriers to condom use, and perceived social support were significant predictors of condom use (William et al, 1999). The most significant result was that perceived barriers significantly interacted with perceived susceptibility and self-efficacy (William et al, 1999). Respondents who perceived a high level of susceptibility to HIV infection and little problems in accessing condom were almost six times as likely to have used condoms at last intercourse, compared to others (William et al, 1999). In the same way, young men who perceived a high level of self-efficacy to use condoms and little barriers to using condom were almost three times more likely to have used condoms the last time they had sexual intercourse compared to others (William et al, 1999).

Stigma is also said to lead to problems with safer sex practices (Clark, Lindner, Armistead & Austin, 2003). Eisenmen, Cunningham, Zieler, Nakazono, and Shapiro (2003) say people who fear being stigmatized will avoid using condoms and being tested for HIV and thus could infect others without knowing. Rosenheck, Ngilangwa, Manongi and Kapiga (2010) surveyed 1,629 women and found that participants who believed they might have HIV/AIDS also had high stigma towards HIV/AIDS and thus avoided being tested for HIV/AIDS. Individuals, who feared they may have HIV but have not been tested, also due to fear of being stigmatized, were likely to be unable to negotiate condom use because they are afraid their partner might ask about their STD status. This therefore suggests that HIV/AIDS stigma can impact important variables, such as, perceived risk, intention to engage in safer

sexual behaviours, HIV/AIDS knowledge, condom self-efficacy (Burkholder, Harlow & Washkwich, 1999). Additionally, previous research has demonstrated the damaging effects of the relationship between stigmatization of people and sexual risk behaviour and that the impact of stigma may be different in separate populations and cultures.

In Fishbein and Ajzen's, (1980) study, when asked "How easy or difficult will it be for you to always use a condom during sexual intercourse", 74% of participants had confidence in their ability to use condoms; 42% reported that they would find it easy, while 32% indicated that they would find it very easy (Fishbein & Azjen, 1980). A large sum of males (86%) indicated that they would find it easy to use a condom, 14% of them indicated that they would find it difficult (Fishbein & Azjen, 1980). Conversely, females (65%) indicated they would find it easy, while 30% reported that they would find it difficult to use a condom (Fishbein & Azjen, 1980). Gender inequities in condom use decision-making were indicated; additionally, this study suggests that males are the ones in control when deciding whether to use a condom or not, and that any interventions to increase condom use should target males, especially since most available condoms are male condoms (Fishbein & Azjen, 1980).

In closing of this section, having knowledge of the above mentioned can influence the planning and shaping of health care provision and safe sex education. The migrant's perception or intention towards condom use could offer insight that would enhance the quality of safe sex education they receive.

In conclusion of this chapter, policy and legislation pertaining to the study is there, it is well documented, and at the core advocates for the protection and promotion of all human rights, however there is still room for a lot of improvement in the implementation of them in terms of protecting and promoting the rights of African Migrants in SA. Literature around the

topic exists as well and offered good insights pertaining to the study and allowed for good argument for this study, however improvement in terms of making it specific to Africa is still needed as most of the studies reviewed were conducted in the United States, and the relevance of their findings for understanding condom use in the African context is still speculative. Additionally, some of the findings are based on studies that focus primarily on female youths and their relevance for male youths are not obvious.

### CHAPTER THREE: THERORETICAL FRAMEWORKS

In discussing the literature, various theoretical models relevant to the research are presented in this chapter, allowing for a better comprehension of migrant's youths intentions. The sources utilised for discussing these theoretical frameworks, includes books, online journal articles, and scholarly articles.

Ajzen's (1985) theory of planned behaviour (TPB) and Berry's (1980) model of acculturation provided the theoretical framework for the empirical investigation of the predictors of condom use among migrant youth in South Africa. This study utilized the theory of planned behaviour (Ajzen, 1985) as the foundation conceptual framework to explore the predictors of condom use intentions of African migrant youths. The researcher is aware that this theory has been used over the years and has been updated. The central theoretical concepts of interest to this investigation were attitudes, subjective norms, perceived behavioural control, and intentions to use a condom. Therefore, this particular version was used because it is the one applied extensively to examine predictors of condom use behaviour in particular.

The strength of the theory of planned behaviour to the problem area of condom use is based on its ability to predict volitional behaviour in a systematic and scientific manner. Various studies that used the Theory of Planned Behaviour have shown how volitional behaviour can be explained by limited concepts. According to Abraham and Sherran (1994), because HIV is largely transmitted through sexual behaviour it could be prevented through appropriate behavioural changes in attitudes, subjective norms, and perceived behavioural control as they relate to sexual behaviour. From a macro theoretical perspective, Berry (1980) has proposed a framework for the study of acculturation that takes into account the multidimensionality of acculturation and the link between the individual and group

acculturation. The framework describes acculturation within the context of the minority group and the dominant society. This group-level framework was utilized to investigate the effect of acculturation on the predictor-intention relationship of condom use by a group of African migrant youths. At the group level, social, cultural and psychological changes may occur for both the dominant and the non-dominant groups; however, it is the latter category that experiences the greatest pressure to change (Berry & Kim, 1988).

### **The Theory of Planned behaviour**

The Theory of Planned Behaviour (TPB) is an adaptation of the Theory of Reasoned Action developed in 1980 to predict an individual's intention to engage in a behaviour at a specific time and place. Ajzen (1980) posits that the theory of reasoned action is a replica for the prediction of behavioural intention, spanning predictions of attitude and predictions of behaviour. The theory was proposed to explain all behaviours over which people have the ability to exert self-control. The theorist posits that the key component to this model is behavioural intent; behavioural intentions are influenced by the attitude about the likelihood that the behaviour will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome (Ajzen, 1980).

The theory of planned behaviour states that variables important in determining an attempt to perform behaviour include beliefs about the likely consequences of success and failure, the perceived probabilities of success or failure, normative beliefs regarding important referents and motivation to comply with these referents (Ajzen, 1985). This generally means that individuals will try to perform behaviour if they believe the benefits of success are out-weighed by the consequences of failure and if they feel significant others (with whom they want to comply) believe they should attempt to perform the behaviour (Ajzen, 1985). Successful execution of the behaviour will be the end result if the individual

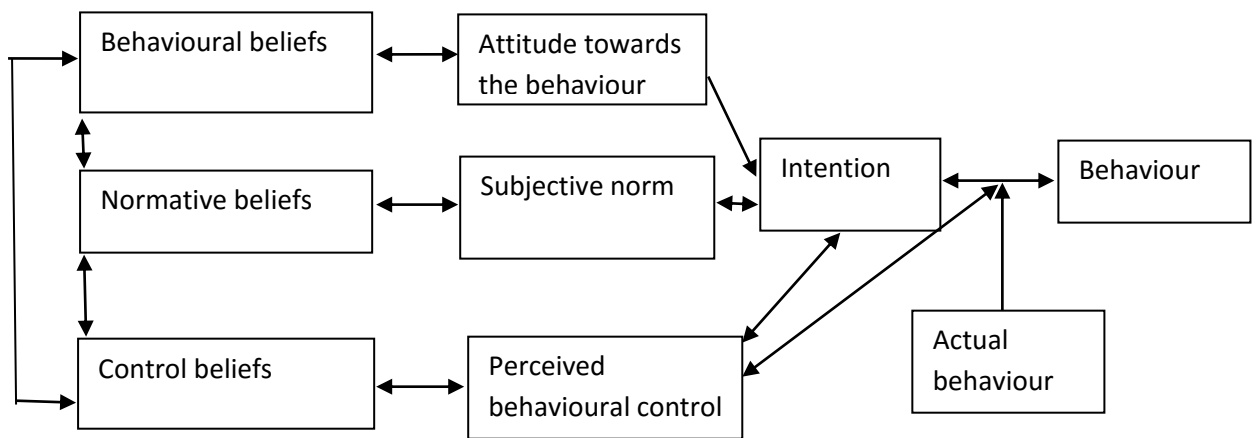
has sufficient control over the internal and external factors that influence the execution of a behaviour (Ajzen, 1985).

According to Sable and Libbus (1998), Theory of Planned Behaviour is grounded on three independent constructs: attitudes, subjective norms, and perceived behavioural control. Attitudes regarding a specific behaviour are determined by beliefs about the behaviour and the strength of these beliefs; subjective norms are based on an individual's belief that referent persons or groups either support or condemn the behaviour and a measure of the extent to which the individual is motivated to comply with referents' wishes and perceived behavioural control is concerned with the perceived ease or difficulty in performing the behaviour and is determined by both past experience and expectations regarding the future (Ajzen, 1985). The more favourable the attitude and subjective norm with respect to a behaviour, the greater the perceived behavioural control; the stronger should be the individual's intention to perform the behaviour under consideration (Ajzen, 1985).

According to Ajzen (1988), the assumptions of TPB include the following:

- a) Intention is a precursor to behaviour
- b) Perceived behavioural control reflects past experience as well as anticipated impediments and obstacles.
- c) Perceived behavioural control has motivational implications for intentions.
- d) Perceived behavioural control can influence behaviour indirectly, via intentions and at the same time can also be used to predict behaviour directly because it may be considered a partial substitute for a measure of control. A schematic representation of the theory of planned behaviour is shown below in Figure 1.

*Figure 1. Schematic representation of the theory of planned behaviour* (Adapted from Ajzen, 2006).



In terms of its scientific status, TPB has been used to explain a variety of health-related behaviours (Blue, 1995). In a review of a group of studies utilizing this theory, Godkin and Kok (1998) concluded that it performed quite well across several types of behaviours in predicting intention to perform behaviour. For predicting actual behaviour however, the theory's efficacies were found to vary.

In another review focusing on the usefulness of the TPB in predicting condom use, Bennett and Bozionelos (2000) also concluded that the theory has proven utility in predicting both intentions to use condoms and condoms use, that attitudes are more powerfully predictive than social norms, and efficacy judgment appear to be more influenced by other perceived control factors. Bogart, Cecil and Pinkerton (1999) have used the TPB to investigate factors influencing intentions of Hispanic adults to use the female condom. In this study the TPB model was shown to have greater predictive utility for women's than men's female condom use intentions for Hispanic adults.

### **Berry's Model of Acculturation**

Acculturation is the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members

(Berry, 1980). At the group level, it entails changes in social structures and institutions and in cultural practices. At an individual level, it entails changes in a person's behavioural list (Berry, 1980). Acculturation is a process of cultural and psychological changes that comprise of different forms of mutual accommodation, leading to long-term psychological and socio-cultural adaptations between both groups (Berry, 1980).

While acculturation is a process that continues for as long as there are culturally different groups in contact, some longer-term adaptation to living in culture-contact settings takes various forms usually resulting in some form of longer-term accommodation among the groups in contact (Berry, 1980). This often entails, for example, learning each other's languages, sharing each other's food preferences, and adopting forms of dress and social interactions that are characteristic of each group. Sometimes these mutual adaptations take place rather easily through processes of culture shedding and culture learning (Berry, 1980).

Berry's (1980) model of acculturation defines acculturation as a complex interactional process involving both members of the non-dominant and dominant group undergoing change. This model posits that when any cross-cultural encounter occurs between two groups, the smaller group or the new group (migrants) in the host culture must answer two essential questions. The first question relates to the extent to which the migrants will value and maintain their traditional culture, and any predominant answer of "Yes, maintaining one's culture" or "No, giving up one's culture" each leads to two different roads along this dimension. The second question relates to the extent to which migrants would adopt the values, practices, and behaviours of the host culture. Answering *yes* or *no* to this question provides two different paths again.

According to Berry (1980), when the two questions are crossed, they create two dimensions of a  $2 \times 2$  matrix with four acculturation status groups. Individuals who answer *yes* to maintaining their own culture and *yes* to learning and adopting the host's culture,

values, practices, and behaviours are *integrationists*. These individuals are trying to adopt and integrate the best of both worlds—what they have brought to the host country and what they can take from the country (Berry, 1980). Next are the individuals who answer *no* to the first question and *yes* to the second. These individuals are strongly adopting the host's culture, values, practices, and behaviours, but have essentially given up their traditional cultures and values and are going in the direction of what is called *assimilationists* (Berry, 1980). The third group is the *separationists* who strongly maintain their traditional culture and values and reject the host cultural values. These individuals remain strongly identified with their ethnic values, practices and behaviours, and contacts, although there is day-to-day contact with the host culture, they choose to not take on the values, practices, and behaviours of the host culture (Berry, 1980). The fourth group is the *marginalists*, who have given up their traditional cultural values but at the same time have not adopted the host culture (Berry, 1980). This model provided the macro theoretical underpinning for this research study.

There is a plethora of studies on this relationship among minority groups in other parts of the world. Acculturation has been studied in relation to prevalence of chronic illnesses and utilization of health services. Aspects of the lifestyle of particular cultural groups may affect the development and acquisition of specific diseases. Beliefs about causes, treatment, and prevention of illnesses may affect the utilization of health services (Hazuda, Stern & Haffner, 1988). For example, highly acculturated Latinas have been found to have positive attitudes about condoms, but are at risk for HIV infection due to drug use and having multiple sexual partners (Marin & Marin, 1990). This was attributed to the fact that more acculturated Latinas have lived longer in American society that consists of a different behavioural pattern with regards to sex and condom use uncommon in the Latino culture and also to the fact that they have been exposed to more information on HIV/AIDS and condom use. Organista and Balla- Organista, (1997) also found that length of time in South Africa

predicted condom use among migrant workers in Orange County, California. Some national and state surveys have found that highly acculturated Latino men are more likely than less acculturated men to have multiple sexual partners (Sabogal, Faigeles, & Catania, 1993), whereas other investigations have found the opposite effect for women (Marin, Gomez & Tschann, 1993) or have found no differences in number of partners.

Knowing this is important in this study since we are going to be studying the intentions of people who have to decide or have decided on whether to or not to assimilate into the South African culture.

### **A critique of the Theory of planned behaviour and Berry's model of acculturation**

Hobbis and Sutton (2005) criticised of the theory of planned behaviour's intervention development based on modal salient beliefs. They argue that it's hard to adequately represent modal salient beliefs on which interventions may be grounded upon. Hobbis and Sutton (2005) contend that interventions based on modal salient beliefs, may not be effective, as many individuals in a group may be presented with information designed to change beliefs that are not relevant to them. Mausbach, Semple, Strathdee, & Patterson (2009) state that the theory of planned behaviour has significant support in numerous populations and for a range of health behaviours, and it is probable that within-group factors may perhaps also contribute to one's intentions to engage in safer sex behaviours. Therefore, Hobbis and Sutton (2005) propose an alternative approach which elicits beliefs specific to each individual, which would result in individually tailored interventions based on the content of each individual's idiosyncratic set of salient beliefs.

Mausbach, Semple, Strathdee, and Patterson (2009) did a study that tested a modified version of the theory of planned behaviour (TPB) for predicting both safer sex intentions and actual engagement in safer sex in a sample of HIV-negative heterosexual methamphetamine

users. Their findings supported the model, as they indicated that more positive attitudes toward condoms, greater expectations from peers to engage in safer sex behaviours, and greater control over negotiating safer sex and using condoms all significantly predicted intention to use condoms during sex (Mausbach, Semple, Strathdee, & Patterson, 2009). Similarly, in line with the theory of planned behaviour, safer sex intentions significantly predicted behavioural outcomes (i.e., future safer sex behaviour). These authors contend that persons who reported more intention to engage in safer sex actually used condoms when they had sex (Mausbach, Semple, Strathdee, & Patterson, 2009).

However, in another study Boldero, Moore, and Rosenthal (1992) examined the applicability of Ajzen and Madden's (1986) theory of planned behavior to condom use intentions and condom use behavior in specific contexts, these included the type of relationship a person was in (i.e. steady or casual), alcohol and drugs intake, sexual arousal and concern about infection with AIDS and other STDs. In assessing the consistency of intentions, intention were measured twice, the first measurement being performed prior to and independent of a sexual encounter (prior intention) and the second immediately before a specific sexual encounter (intention in action) (Boldero et al., 1992). Findings from this study indicated that respondents had favorable beliefs towards condom use (Boldero et al., 1992). Health professionals, family and friends, in that order, were the significant others who most influenced normative beliefs (Boldero et al., 1992). The benefits and shortcomings of using condoms were acknowledged by participants (Boldero et al., 1992). The majority of respondents met the behavioral conditions of condom use in that they intended to use a condom prior to the sexual encounter, had a condom available, communicated with their sexual partners about the need to use a condom and actually used one (Boldero et al., 1992). This finding validates the link between intentions and actual behavior (Boldero et al., 1992). Prior intention, communication about condom use and condom availability was also

significant predictors of condom use in their study (Boldero et al., 1992). Additional findings postulated that contextual factors of sexual arousal, condom availability and communication with a partner about using a condom have direct effects on condom use (Boldero et al., 1992). Overall the research provided a shortcoming of Ajzen and Madden's (1986) theory of planned behaviour, in that there was little proof that condom use was predicted by theoretical constructs in the absence of contextual factors (Boldero et al., 1992).

Additionally, Rudmin (2003) posits that acculturation has been studied scientifically since 1918 and that several theories and definitions were formulated to describe elements of the acculturative process. Rudman states that research and theory have essentially focused on the adjustments and adaptations made by minorities such as immigrants, refugees, and indigenous peoples in response to their contact with the dominant majority, and how variations in acculturation affect how well individuals adapt to their society. The strength of these theories is that they help in explaining, measuring and predicting behaviour. However, both the theory of planned behaviour and the theory of acculturation fail to provide guidance and techniques that can be used to promote behaviour and influence change (Hobbis and Sutton, 2005).

## CHAPTER FOUR: METHODOLOGY

In this chapter, the researcher describes the methodology that was used for such a research effort, elucidating on how the research was conducted. This includes the research design, hypotheses, population, sampling framework, data collection procedure and instruments (i.e. measures), the reliability of the measures, data management and analysis, ethical considerations and finally limitations of the study will complete the chapter.

### **Research design**

Babbie and Mouton (2009) define a research design as the general overview of how a researcher will conduct research. These authors posit that a research design tries to answer the question, ‘What kind of data is required in order to address the research question adequately?’

The theory of planned behaviour also referred to as TPB requires the development and conduction of an elicitation interview on beliefs about the behaviour(s) to be studied, the results (after consent analysis) was used in the design of the final instrument. In accordance with this protocol of Ajzen and Fishbein (1980), an elicitation study was conducted by (Tantoh, 2014) with a preliminary instrument that contained three open-ended questions for each primary TPB construct.

Tantoh’s (2014) study had a purposive sample of 20 African migrant youth (comprising of 13 males and seven females) in the 18-35 age cohort as it participants. Findings from Tantoh’s study indicated that migrants had a positive attitude towards condom use. However, the free distribution of condoms might have created risky sexual behaviour as a consequence to the increased number of girlfriends based on the availability of condoms. Additionally, the researcher found that, individuals who are significant to the participants i.e. parents, siblings, pastors, partners and friends, have the potential of either influencing the

behavioural intentions of migrants positively or otherwise, towards testing for HIV and condom use. Further findings indicated that health workers may to a certain degree have increased migrant youth's susceptibility to health care barriers and challenges. However, considering that this study had a small sample size, these findings cannot be generalized to the entire migrants' population (Tantoh, 2014).

This research utilised the quantitative research design. In quantitative research, the goal is to determine the relationship between one thing (an independent variable) and another (a dependent or outcome variable) in a population (Babbie, 2010). Quantitative researchers try to recognise and isolate specific variables contained within the study framework, seek correlation, relationships and causality, and attempt to control the environment in which the data is collected to avoid the risk of variables, other than the one being studied, accounting for the relationships identified (Babbie, 2010).

The adoption of this research paradigm was best fitted for this topic because it allowed for a broader study, involving a greater number of subjects, and enhanced the generalization of the results. Furthermore, it allowed for greater objectivity and accuracy of results (Babbie, 2010). Additionally, the structure of this research paradigm has not changed for centuries, so it is standard across many scientific fields and disciplines, therefore applying a well-established standard means that this research can be replicated, and analyzed and compared with similar studies (Babbie, 2010).

Furthermore, quantitative experiments sift out external factors, so the results gained can be seen as real and unbiased. Quantitative experiments are useful for testing the results gained by a series of qualitative experiments, leading to a final answer, and a narrowing down of possible directions for follow up research to take place.

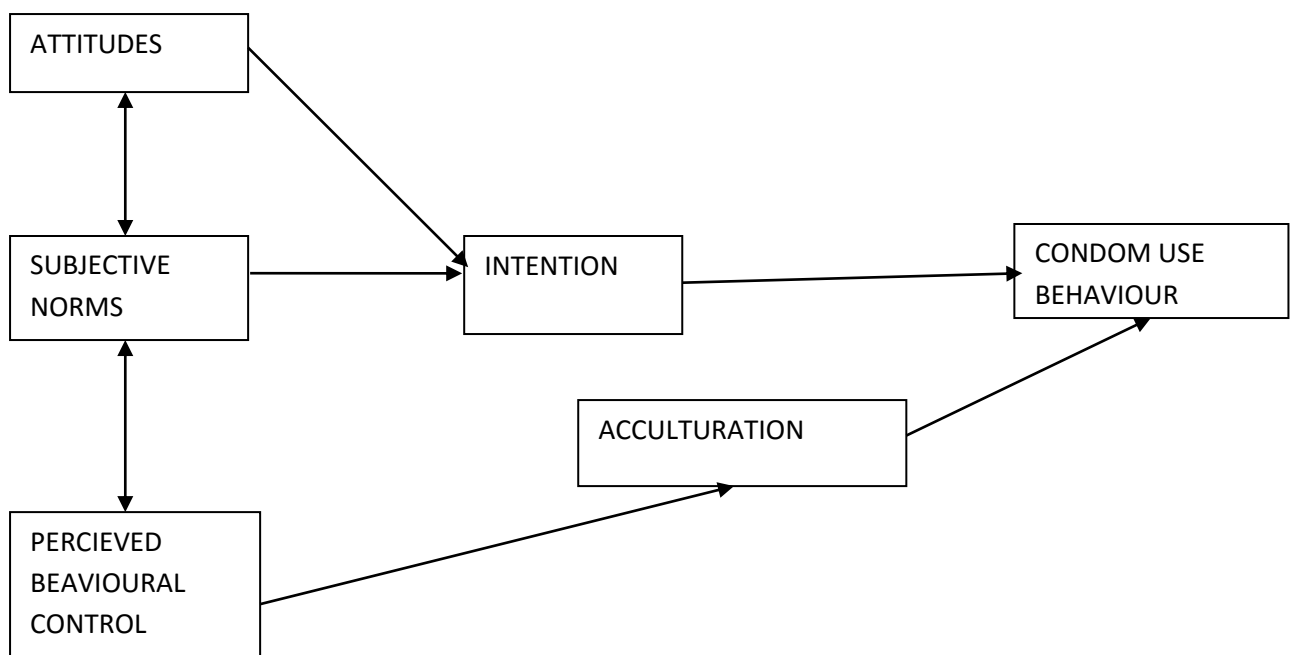
## Hypotheses

Based on the Theory of Planned Behaviour, this study hypothesised that:

1. Attitudes will predict condom use behaviour
2. Subjective norms will predict condom use behaviour
3. Perceived behavioural control will predict condom use behaviour
4. Intentions mediate the relationship between attitudes and condom use behaviour
5. Acculturation mediates the relationship between intention and condom use behaviour.

The hypothesised model of the central study variables is shown in Figure 2.

*Figure 2: Hypothesized Model of the Central Study Variables*



## Variables

The central study variables include the following, the independent variable, dependant variable and mediating variables. These are presented below.

### ***Independent variables***

*Attitudes.* This was operationalized as the degree to which a person has a favourable or unfavourable evaluation of the male condom.

*Subjective norm.* The referent group norms scale was used to assess subjective norms of condom use. Higher scores will indicate higher approval for condom use.

*Perceived behavioural control.* Was assessed using condom self-efficacy scale. This scale consists of six sub-domains they are; *Technical skills, Image confidence, Emotion control, Purchase, Assertiveness, and Sexual control.*

### ***Dependent variable***

*Condom use behaviour.* Questions to measure sexual activity and male condom use were adapted from Dixon, Peters and Saul (2003). Sexual activity and condom use with primary partner was assessed. Participants were asked if they have had sex with their primary partner during the past six months prior to the interview. They were asked if they used a condom the last time they had sexual intercourse.

### ***Mediating variables***

*Acculturation.* This was measured using a modified version of the *Pan-Acculturation Scale*, it was used to measure the degree of acculturation.

*Intention.* This was measured using questions from (Turchik & Gidycz, 2012) study. Participants were asked “If you have sex with a casual partner over the next 2 months, do you intend to use a condom?”, “If you have sex with a casual partner over the next 2 months, do you expect to use a condom?” and “How likely is it that you will use a condom if you have vaginal and/or anal sex with a casual partner in the next 2 months?”

## **Population and Sampling**

Population in research refers to the totality of persons or human units from which a sample is drawn in order to study a particular research problem (Babbie & Mouton, 2009). The target population of this study was African youth migrants. Sampling refers to the process of selecting participants who will provide the data that is required for the purposes of the research (Babbie & Mouton, 2009).

The sampling procedure for this study was a time location probability sampling of African youth migrants aged 18-35 years, currently residing in Cape Town, South Africa. Time location sampling (TLS) is used to collect information from hard-to-reach populations by sampling individuals at locations at which participants can be reached (Karon & Wejnert, 2012). This sampling procedure was very fitting for this study considering that migrants are hard to reach populations. Participants were recruited through a non-profit organisations working with African migrants in Cape Town called Agency for Refugee educations, Skills Training and Advocacy (ARESTA). This organisation provides education and skills training to refugees, asylum seekers in efforts to help them develop their knowledge and skills to become self-reliant individuals. They also provide refugee legal assistance, policy reform, refugee rights awareness and health interpretation through its advocacy departments. Moreover, the organisation aims to empower South African and foreign national social cohesion. Some of the African migrants that Aresta provides its services to come from Congo, Burundi, Somalia etc. The researcher went to the organisation only from Monday to Friday, between 9:30am to 12:30pm and participants were only recruited on these days and only between these times.

## Sample size determination

Barlett, Kotrlik and Higgins (2001) posit that sample size determination is the process of selecting the number of participants to include in a statistical sample. That sample size is a significant feature of any empirical study in which the goal is to make inferences about a population from a sample. Sample size determination is a very significant issue because samples that are too large may waste time, resources and money, while samples that are too small may lead to inaccurate results (Barlett, Kotrlik & Higgins, 2001). Practically, the sample size used in a study is determined based on the expense of data collection, and the need to have sufficient statistical power (Barlett, Kotrlik & Higgins, 2001).

To calculate the minimum sample size for this study, the margin of error was first calculated. A margin of error tells us how many percentage points the results will differ from the real population value (Barlett, Kotrlik & Higgins, 2001). When sample data is already collected and the sample mean  $\bar{x}$  is calculated, that sample mean is typically different from the population mean  $\mu$ . This difference between the sample and population means can be thought of as an error. The margin of error  $E$  is the maximum difference between the observed sample mean  $\bar{x}$  and the true value of the population mean  $\mu$  (Barlett, Kotrlik & Higgins, 2001).

$$E = z_{\alpha/2} \cdot \frac{\sigma}{\sqrt{n}}$$

Where:

$z_{\alpha/2}$  is known as the critical value, the positive  $z$  value that is at the vertical boundary for the area of  $\alpha/2$  in the right tail of the standard normal distribution.

$\sigma$  is the population standard deviation.

n is the sample size. Below is this study's margin of error calculation.

$$E = z_{\alpha/2} \cdot \frac{\sigma}{\sqrt{n}}$$

$$= (1.96) (0.50/\sqrt{91})$$

$$= (1.96) (0.0524)$$

$$= .10 \text{ (standard error)}$$

Rearranging this formula, allowed for the calculation of a sample size necessary to produce results accurate to the study's specified confidence interval and margin of error. See below:

$$n = \left[ \frac{z_{\alpha/2} \sigma}{E} \right]^2$$

$$= [1.96 \times 0.50/0.10]^2$$

$$= 3.84 \times 0.25/0.01$$

$$= 3.84 \times 25$$

$$n=96$$

From the sample size calculation, it was estimated that a minimum sample of 96 participants was required for the study. A total of 98 migrant youth participated in the study.

### **Data collection procedure and instruments**

Creswell (1998: 111) defines data collection as “a series of interrelated activities aimed at gathering high-quality information to answer emerging research questions.” The research design influences the methodology; therefore, this study made use of tools suitable to quantitative research methods during the data collection process.

The teachers worked in collaboration with the researcher in terms of recruiting participants, by referring people to the researcher and the researcher would explain what the

study is about. The research interviews were conducted at Aresta which is situated in Athlone. No payment was made to participants for their participation; however, for participants who were not students at ARESTA a financial compensation equivalent to R50,000 was paid to cover for their transportation costs. Their participation was contingent upon their signed informed consent. After the completion of the questionnaire participants were given free condoms.

The instrument used was a semi-structured self-report questionnaire consisting of six sections that tap to the central study variables. *Section I* a socio-demographic information questionnaire that elicited some basic background information of the participant, *Section II* of the questionnaire was the measure of attitude toward the condoms; *Section III* was a measure of subjective norms regarding condoms; *Section IV* included a measure of perceived behavioural control to use the male condom; *Section V* included the intention to use the male condom scale; and *Section VI* is an acculturation rating scale. This questionnaire took approximately 25-45 minutes to complete depending on the person's ability to read and comprehend questions. Please see appendix B.

## **Measures**

This study utilised five measures, the attitude towards condom use scale, modified version of the referent group norm of condom use scale, condom self-efficacy scale, intention to use condom scale and the modified version of the pan acculturation scale.

*Attitudes Toward Condom Scale (ATCS; Brown 1984).* Brown's (1984) attitude toward condoms scale (ATCS) was used to measure this variable. ATCS is a 40-item likert-type scale with an established internal consistency of .93 (Cronbach's alpha) .93 and an average inter-item correlation of .24. It comprises five major factors with response options ranging from strongly agree to strongly disagree. When it comes to scoring, for favourable

statements, the strongly agree response was given a weight of 5 and the strongly disagree response a weight of 1, with other responses weighted accordingly. The scoring is reversed for unfavourable statements. Each participant was given a total score obtained by summing scores for the individual items. Thus higher scores indicate more favourable attitudes toward condoms. An example of a favourable statement in this scale is “condoms are pleasant to use” and an unfavourable statement is “condoms are uncomfortable to use”. Although specific data on the psychometric properties of the Brown scale relating to ethnic minority groups is lacking, however ATCS has been shown to be reliable and valid in measuring the attitudes of homosexual men (as a minority group) toward condoms (Ross, 1988) and attitudinal barriers to condom use in high-risk heterosexuals justifying its applicability to migrant youths in South Africa. During the piloting of this study when testing for the reliability of this scale one item was removed, this was item number 16. After having collected data for the study, item number 21’s scoring was reversed and the reliability increased to .60 rounded off into two decimal places.

*Modified version of the referent group norm of condom use Scale.* The referent group norm of Condom Use Scale was an adaptation from a study done by Johnston and White (2003). Their study topic was “Binge-drinking: A test of the role of group norms in the Theory of Planned Behaviour” Questions adapted from their study to suit the research study at hand were as follows. Three items used to measure subjective norm were: “If I drink five or more standard alcoholic beverages in a single session in the next two weeks most people who are important to me would?”; 1 approve to 7 disapprove, "Most people who are important to me think that my drinking five or more standard alcoholic beverages in a single session in the next two weeks would be": 1 undesirable to 7 desirable, and "Most others who are important to me think that I" 1 should to 7 should not "drink five or more standard alcoholic beverages in a single session in the next two weeks”. Participants responded to four

items assessing their perceptions of reference group norms for drinking five or more standard alcoholic beverages in a single session. The four items used were: "Think about your friends and peers at University. How much would they agree that drinking five or more standard alcoholic beverages in a single session in the next two weeks is a good thing to do?" 1 completely to 7 not at all, "How many of your friends and peers at University would think that drinking five or more standard alcoholic beverages in a single session in the next two weeks is a good thing to do?"; 1 none to 7 all, "How many of your friends and peers at University would drink five or more standard alcoholic beverages in a single session in the next two weeks?" 1 none to 7 all, and "Think about your friends and peers at University.

What percentage of them do you think would drink five or more standard alcoholic beverages in a single session in the next two weeks? Participants responded to four items designed to assess strength of identification with the reference group. These items were: "How much do you feel you identify with your friends and peers at University?" 1 not very much to 7 very much), "With respect to your general attitudes and beliefs, how similar do you feel you are to your friends and peers at University?" 1 very dissimilar to 7 very similar, "Think about who you are. How important is being a member of your group of friends and peers at University?" 1 very important to 7 very unimportant. For the purposes of this study, these questions were changed into 10 statements, alcohol was substituted with condom use, and scoring options were minimised to a five point Likert scale ranging from *strongly disagree* response was a weight of 1 and the *strongly agree* response assigned a weight of 5, with other responses weighted accordingly. On this study the established internal consistency was .818 (Cronbach's alpha).

*Condom Self-Efficacy Scale.* This scale was used to measure perceived behavioural control of condom use (Baele, Dusseldorp and Maes, 2001). This scale consists of six sub-domains (technical skills, image confidence, emotion control, purchase, assertiveness and

sexual control). The number of items on this scale is 32. The scale showed high reliability among the participants with the reliability scores for the sub-domains ranging from 0.84 to 0.65 justifying its applicability to the proposed study. For the purposes of this study, the scoring options were a five point Likert scale ranging from strongly disagree with a weight of 1 and the strongly agree response assigned a weight of 5, with other responses weighted accordingly. Higher scores indicated greater perceived self-control over condom use. On this study the reliability score for this scale was .745 (Cronbach's alpha).

*Intention of sexual behaviour Scale.* Intention of sexual behaviour scale was an adapted version of Turchick and Gidycz (2012) scale. This scale was used to measure the intention to use condoms. Three questions are used to measure intentions for each of the three sexual risk behaviours and for both casual and relationship partners on the study. For example, participants will be asked if they have sex with a casual partner over the next 2 months, do they intend to use a condom. This scale consists of 3 items measured on a seven-point scale, with higher scores (range 3–21) indicating increased intentions to engage in the behaviour over the next two months (Turchick & Gidycz, 2012). Intentions were recoded into a dichotomous variable, and those who scored above the midpoint on intentions (score >12) were labelled as “intenders” in the study. The internal consistencies for this measure on the original study at time 1 were .90, .97, .89, .93, .97, and .98, respectively, for condom use with a casual partner, condom use with a relationship partner, contraception use with a casual partner, contraception use with a relationship partner, dual use with a casual partner, and dual use with a relationship partner. At Time 2, the alphas were .90, .97, .80, .93, .82, and .98, respectively, therefore justifying its applicability to the study at hand (Turchick & Gidycz, 2012). On this study the 3 items were scored on a 5-point Likert scale ranging from “strongly disagree” (1) to “strongly agree” (5). Higher scores indicated greater intentions for condom

use in future sexual encounters (Sacolo et al., 2013). The reliability of this scale on this study was established at .931 (Cronbach's alpha).

*A modified version of the Pan-Acculturation Scale (PAN; Soriano 1999).* Since culture plays such a significant role in health behaviour (Landrine & Klonoff, 2001), acculturation levels help researchers understand what values and beliefs individuals subscribe to (country of origin or host culture), therefore acculturation was measured in the current study. A modified version of the Pan-Acculturation scale was used to measure the degree of acculturation, with the identity "Cultural group" replaced with "my country of origin" and "American culture" replaced with "South African" by the researcher. The PAN was used to identify where participants fall in terms of how much South African culture influences them and how much their culture of origin influences them. This scale was developed in order to assess acculturation across minority and non-minority cultural groups. It includes 23 items for which respondents compare various subject domains to their self-identified cultural group and to South African culture. In developing the measure, the original authors examined existing acculturation measures for content and structure to identify the subject domains to include in this scale. Based on this examination, six subject domains were included in the PAN: language, identity, social support, cultural practices, generational status and background, and cultural values and beliefs (Ho, Soriano, Yeh, McCabe, & Hough, unpublished manuscript as cited in Neff, 2012). Respondents selected one of four response options (American culture, their culture of origin, both cultures, or neither culture) for each item. In this study participants selected from country of origin, South African, both culture, neither culture.

In the original study internal reliability, the scale was found to be good in a sample of 295 adult Latina women. The American Cultural Affinity subscale had a coefficient alpha of .93 and the Traditional Cultural Affinity subscale had a coefficient alpha of .87. Further,

correlations between these two subscales and the Short Acculturation Scale (Ho, Soriano, Yeh, McCabe, & Hough, unpublished manuscript as cited in Neff, 2012) fell in the predicted directions indicated good convergent validity. Therefore, justifying its applicability to the study at hand.

In accordance to the study at hand the PAN has two subscales, South African cultural affinity and country of origin cultural affinity. The South African cultural affinity subscale was calculated by summing the number of times the participant responded by marking the response South African Culture. One's affinity towards one's culture was measured by summing the number of times the participant responded by marking the response my country of origin culture. The reliability of this scale on this study was .850 (cronbach's alpha).

### ***Reliability of the study measures***

Joppe (2000:1) defines reliability as “The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable”. At the core of reliability is the idea of replicability or repeatability of results or observations (Joppe, 2000). Additionally, Roberts, Priest & Traynor (2006) contend that essentially, *reliability* can be thought of as consistency. This means does the instrument consistently measure what it is intended to measure? Because it is important that any research tool provides the same information if used by different people (inter-rater reliability), or if it is used at different times (Joppe, 2000). Tools used on a research study need to be assessed for internal consistency (Joppe, 2000). Internal consistency of items such as individual questions in a questionnaire can be measured using statistical procedures such as Cronbach's alpha coefficient (Cronbach 1951). Kirk and Miller (1986) identify three types of reliability referred to in quantitative research, which relate to: (1) the degree to which a measurement, given repeatedly, remains the same (2) the stability of

a measurement over time; and (3) the similarity of measurements within a given time period. The majority of the scales used on this study prove to have been reliable. The attitude towards condom use scale has 39 items and has a reliability of .60, the referent group norms of condom use scale has 10 items and .818 reliability, the condom self-efficacy scale has 32 items and has .745 reliability, the intention of sexual behaviour scale has 3 items and .931 reliability and finally the modified version of the pan acculturation scale has 23 items and .850 reliability. The reliabilities of central study measures are presented on the Table 1.

**Table 1. Reliability coefficients of the measures**

<b>Name of scale</b>	<b>Number of items</b>	<b>Cronbach's alpha</b>
<b>Attitude towards condom use scale (ATCS)</b>	39	.60
<b>Modified version of Referent group norms of condom use scale</b>	10	.82
<b>Condom self-efficacy scale</b>	32	.75
<b>Intention of sexual behaviour scale</b>	3	.93
<b>A modified version of the Pan-Acculturation scale</b>	23	.85

### **Data management and analysis**

According to De Vos, Strydom, Fouche and Delpont (2005) data analysis is the procedure of bringing order, structure and meaning to the accumulated data. The model in the proposed study consisted of three independent variables (attitude, subjective norms, and perceived behavioural control) one dependent variable (intention to use condom); and a moderator variable (acculturation). The data collected has been analysed using the Statistical Package for Social Sciences, also referred to as SPSS (De Vos et al., 2005). This programme is suitable for this research as it enabled the researcher to enter the data and perform the

statistical computation with ease, because data quantification is made easy by such computer programmes. A multiple regression procedure was employed to examine the study's central hypothesis that intentions to use male condoms will be predicted from attitudes, subjective norms, and perceived behavioural control. First, descriptive statistical analysis was conducted to characterize the sample's demographics. Comparisons by levels of acculturation were performed on the demographic variables using independent *t*-tests and chi-square analyses. The *t*-test for unequal variances reported if Levene's test of equality of variance is significant. Mean comparisons and standard deviations of the predictor variables with intention were performed. Pearson correlation coefficient assessed the relationship between (attitude, subjective norm, perceived behavioural control and intentions).

Next, a hierarchical multiple regression (HMR) analysis was conducted on attitudes, subjective norms, perceived behavioural control and intentions for condom use behaviour. Attitudes and subjective norms was entered in the first step and perceived behavioural control and intentions in the second step to test whether these variables significantly added to the prediction of condom use behaviour, over and above the effects of attitudes and subjective norms. The HMR procedure allowed the determination of whether the variables entered at each step accounts for an additional, significant amount of variance over the preceding variable. The interaction effect of acculturation as a moderator was also tested using a moderated hierarchical multiple regression analysis.

### **Ethical considerations**

De Vos, et al. (2005) posit that research should be based on ethics. Ethics are defined as a set of principles suggested by an individual or group, that are subsequently broadly accepted and offer rules of conduct and behavioural expectations about the most correct conduct towards experimental subjects/respondents, employers, sponsors, other researchers, assistants and students (Babbie, 2007 as cited in De Vos, Strydom, Fouche & Delport.

2011). In effort to ensure the verification and authentication of this research, various codes of ethical conduct were noted.

*Human participant's protection.* This researcher is aware of the potential psychological harm that accompanies the disclosure of sensitive and personal information related to the sexual behaviours of participants. To minimize such harms this study underwent full ethical approval process of the University of Cape Town. Endorsements and clearance from the migrant organization where participants were recruited was also received before the research was conducted. In addition, because the participants are migrants from other countries, the researcher was culturally sensitive to their responses as they relate to condom use and sexual behaviour in general.

*Risks and benefits of participating in the study.* The fundamental ethical rule of research is that it must bring no harm to participants (Babbie, 2009). Respondents can be harmed in a physical or emotional manner. Emotional harm to respondents is often more difficult to predict and to determine than physical discomfort, but often has more far-reaching consequences for participants (De Vos et al., 2005). It should be noted that participants in this study were assured that there will be no physical and social risks, however due to the nature of the topic emotional or psychological risk could come about. They were informed that the benefit here is that there would mechanisms in place to address any emotional distress that may come about as the researcher is a qualified social worker who has obtained training in this area and would be able to make appropriate referrals should any emotional distress arouse. This therefore allowed the participants the opportunity to withdraw from the research if they felt uncomfortable. No emotional harm was reported or identified in this research study. The data collection process was done at ARESTA where the participants come to get services, thus ensuring a familiar environment. Another benefit is that findings from the study

would be made available to migrant organisations and therefore better policies and the improvement of education among migrants on healthy sexual reproduction system.

*Informed consent.* Informed consent entails giving participants or their legal representation adequate information pertaining to the goal of the research; the expected duration of involvement; the procedures which will be undertaken during the research; the probable advantages, disadvantages and dangers to which the participants may be exposed; as well as the credibility of the researcher (Williams, Tutty & Grinnel, 1995 as cited in De Vos et al., 2011). Before recruiting participants, a questionnaire of the research study was sent to the advocacy and the education managers at Aresta and they screened and approved it, they were also given a sanctioning letter endorsed by the University of Cape Town's Research Office. Written informed consent forms were given out to all participants. This form informed the participants on what the research is about, the nature of the questions, the duration it will take to complete the interview, their rights as far as the study is concerned, who will have access to the information they have provided and for what purpose, a chance to ask questions before participant and then the decision to participate or not through the signing of the informed consent form. Written and signed informed consents were obtained from all participants prior to participating in the study. Please see appendix A.

*Voluntary participation and privacy.* Rubin and Babie, (2005 as cited in De Vos et al., 2011) posit that participation should at all times be voluntary and that no one should be coerced into participating in a research study. In efforts to ensure voluntary participation, participants were informed about the nature of the research study prior to participation. Written informed consent forms were obtained from all participants. During interviews, in instances in which participants felt uncomfortable in answering a question the decision to not answer was allowed. This therefore ensured voluntary participation as participants got a chance to make an informed decision on whether to participate or not. Privacy is defined as

that which is not normally intended for others to see and analyse (De Vos et al., 2011). In ensuring this ethic the interviews were conducted on a one-on-one basis in a private office space where no else could overhear or see what's written on the questionnaire, therefore affording participants' privacy.

*Deception or subjects/ respondents.* Corey, Corey and Callanan (1993 as cited in De Vos et al., 2011) define deception as the deliberate withholding of information, or offering incorrect information in order to ensure the participation of respondents when they would have possibly refused to participate. In this study transparency about the purpose of the research was outlined and deception of participants was avoided.

*Anonymity/confidentiality.* Anonymity refers to ensuring that the identity of respondents is unidentifiable, confidentiality on the other hand refers to the handling of information in a confidential manner, and it refers to agreements between persons that limit others access to private information (De Vos et al., 2011). With respect to the special vulnerability of the population, anonymity and confidentiality are ensured through the electronic coding and storage of the data, which fulfilled the highest and most secure data encryption standards. The participants were informed that the information received from the research questionnaires is to be accessed by only the researcher and the researcher's supervisor; however, the use of the codes instead of names as their ID on the questionnaires will protect their identity. Confidentiality concerns were addressed by keeping all questionnaires confidential and used solely for research purposes.

*Actions and competence of researchers.* Walliman (2006 as cited in De Vos et al., 2011) argues that researchers are ethically obliged to make sure that they are competent, honest and adequately skilled to conduct research. The use of the research questionnaires as well as research scales developed by researchers enhanced the researcher's competency. In addition to this the researcher has experience in conducting one on one therapeutic

counselling, as well as experience in conducting research interviews and therefore was able to elaborate on questionnaires with sensitiveness and openly accept questions and responses without making the participants feel judged.

*Release or publication of findings.* The researcher has ensured that the final report is printed; that all the data, information and findings are accurate and authentic. The final report is clear, explicit, and contains all the necessary information (De Vos et al., 2011).

### **Limitations of the study**

According to De Vos et al., (2011), limitations exist in all research studies even when the research is carefully planned; due to this they need to be stated clearly. Strengths and limitations of the research are further discussed below.

There are noteworthy strengths of the current study. First, the data analysis lent itself to more sophisticated statistical techniques (e.g., SPSS), which allowed all variables to be examined together in one model. The current study utilized the most sophisticated tool, SPSS, for analysing path analysis that is available. The researcher has experience in interviewing participants which therefore ensured researchers competence.

It is also important to consider the limitations to this study when interpreting the findings. First, the study was limited in terms of its generalizability to the total migrant youth population. Like any other age group, youths are a very heterogeneous population. While the study sample should be quite diverse, the fact remains that certain parts of the migrant youth's population were not included. Majority of the participants on the study are from DRC. The researcher was having difficulty with having individuals from Somalia and Burundi participants on the study. The researcher then consulted with a reliable source who has done his Phd studies in social sciences, and has worked with these communities before and shared his findings. He could offer further insights as to the reason why individuals were

reluctant to participate. These are discussed in the results chapter. For these reasons, there is a need for further research in a larger more diverse scale.

Furthermore, anytime you use an instrument the results are subject to the known reliability and validity of that instrument (Joppe, 2000). Although the reliability and validity of the instrument may be known, the instruments may have limitations in measuring what they purport to measure. This study was limited in its ability to generalize the causal inferences (external validity) of the research beyond the study conditions to all migrant youth in South Africa. Consequently, the findings of this study may not only be biased toward migrant youth residing in Cape Town, but to those migrant youth accessing services from migrant services organization.

Another limitation of the proposed study design is related to the instrument and the sensitive nature of the items. Participants had to answer a semi-structured self-report questionnaire written in English and not in their native language. Language barrier was the biggest challenge when interviewing many of the participants. The self-report measures may also be biased by social desirability concerns and a reluctance to answer questions about sexual behaviour by participants. An inherent limitation of self-report measures is a social desirability response style. Thus, it is possible that some participants may have endorsed socially acceptable responses (Kazdin, 2003) therefore, correlations between observed variables may be due to response biases and not actual relationships between the constructs studied) (Kendall, Butcher, & Holmbeck, 1999).

An additional weakness of this study design concerns the Attitude Toward condom scale which is limited in construct validity (internal validity). Existing published data on its development and validation indicate that the single constituents are not correlated with standard variables to test the construct validity of each of the individual factors. This implies that the extent to which attitude as a variable relates to other variables within the system of

theoretical relationships has not been validated, thus limiting causal inference of the results of the relationship of attitude in the model. A limitation in construct validity may also affect the convergent and discriminant validity of the measure (Rubin & Babbie, 1997).

Furthermore, respondents were expected to provide information on previous behaviors (i.e., condom use) the issue with this is the authenticity of responses given due to recall bias (Neff, 2012).

The literature suggests that an individuals' national origin impacts his/her cultural traditions, values, and beliefs. Furthermore, among ethnic groups, there are significant within-group differences, including language use, reasons for migration, income, and region of residence in South Africa. The current study not only did not have enough participants from other ethnic groups, it also did not examine country of origin culture. The diversity amongst ethnicities may influence the reliability and validity of the measures.

## CHAPTER FIVE: RESULTS

This chapter reports the findings of statistical analyses in relation to the objectives of the study and the hypotheses tested. By means of presenting descriptive information, bivariate analysis which include socio-demographic influences, correlation among predictor variables, correlations with each predictor variable and condom use, intentions to use condoms, acculturation and condom use and finally multivariate analysis.

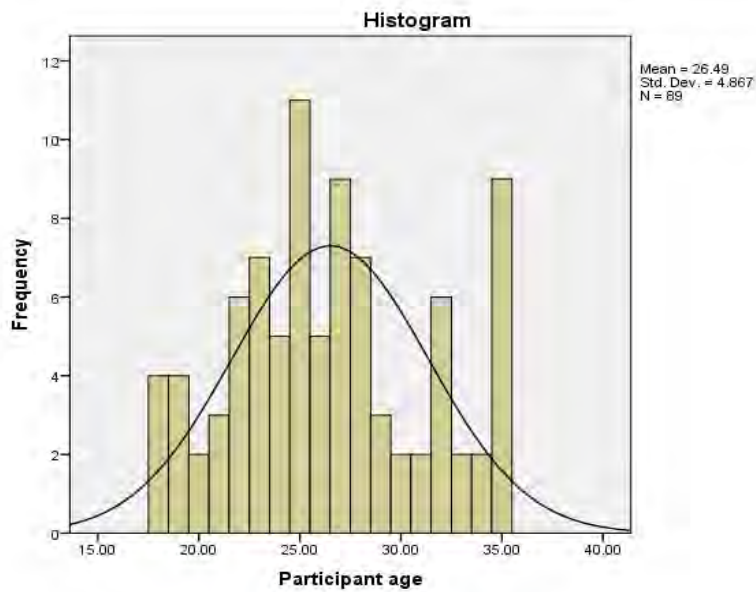
### **Descriptive information**

Descriptive statistics aim to summarize and describe data (Trochim, 2006). In this study this included participant's age, sex, relationship status, length of stay in SA, highest level of formal education, country of origin and home language. Additionally, means and standard deviations of all independent and mediator variables are presented.

#### ***Socio-demographic Characteristics of participants***

Participants comprised of 91 men and women, the age range was 18 to 35 years. The majority were between the ages of 18 to 26. The mean age as represented on the graph was 26.49, the median was 26, the mode was 25, the minimum age was 18 and maximum age was 35 as per study requirements. Age proportion by percentage was 18-25 years at 46.2%, 26-31 years at 30.8% and 32-35 years at 20.8%. See figure 3 below.

**Figure 3. Age distribution of participants**



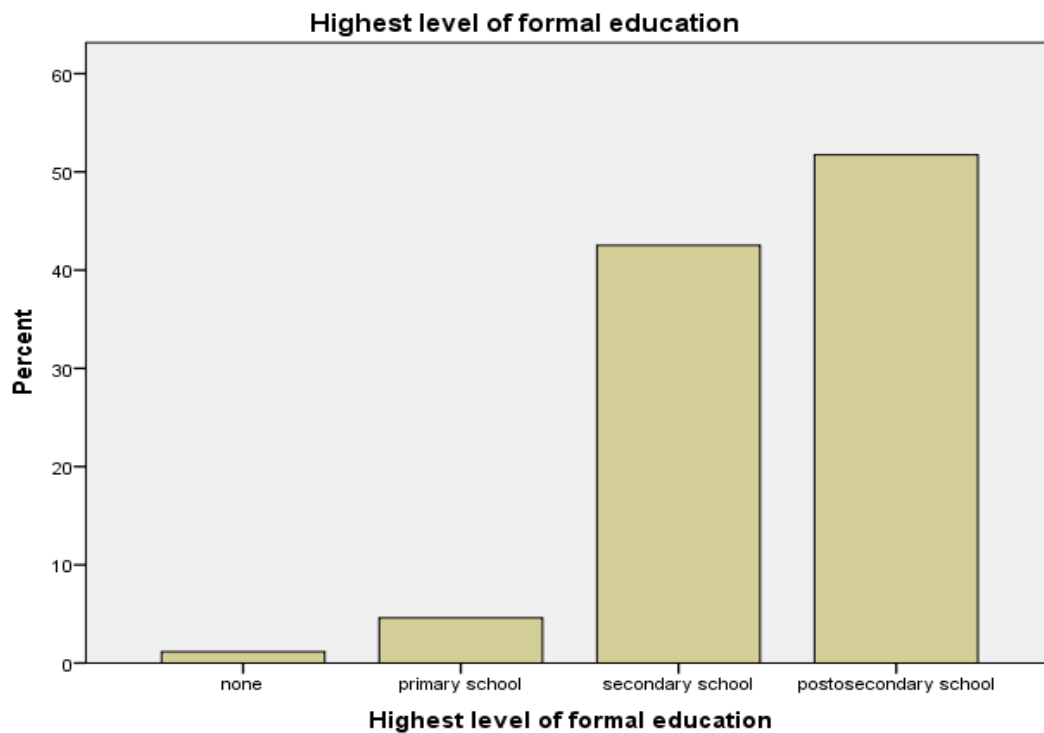
The majority of the participants were male (58.2%), they all reported to be heterosexual (100%), women were (41.8%). In terms of relationship status, married participants were (28.6%), single participants were (63.7%), separated (6.6%) and divorced (1.1%). Majority of the participants have been in South Africa for a year and less (53.9%) with one participant (1.1%) having been in South Africa the longest (14 years).

**Table 2. Participant’s Sex, Relationship status and length of stay in South Africa**

DEMOGRAPHICS	N	%
<b>SEX</b>		
1 Male	53	58.2
2 Female	38	41.8
<b>RELATIONSHIP STATUS</b>		
1 Married	26	28.6
2 Single	58	63.7
3 Separated	6	6.6
4 Divorced	1	1.1
<b>LENGTH OF STAY IN SA</b>		
1. 1 year < 1 year	48	53.9
2. 2 years-5 years	25	28.1
3. 6 years > 7 years	16	18.0

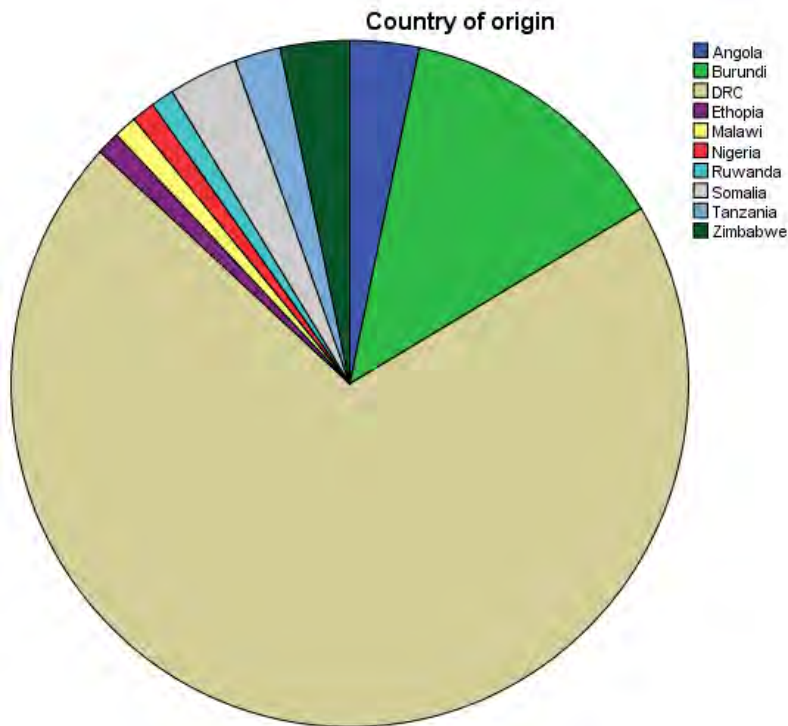
In the sample, only 1 participant reported to have never had any formal education (1.1%), 4 had primary school education (4.6%), 37 had secondary school education (42.5%) and 45 had post-secondary education (51.7%).

**Figure 4. Highest level of formal education distribution of participants**



Participants from the study consisted of African migrants only. Majority of whom were from DRC (70.3%), followed by Burundi at (13.2%), Angola (3.3%), Somalia (3.3%), Zimbabwe (3.3%), Tanzania (2.2%), Ethiopia (1.1%), Malawi (1.1%), Nigeria (1.1%) and Rwanda (1, 1%).

**Figure 5. Participants country of origin by proportion**



The majority of participants were French speaking (56.0%) followed by Kirundi at (11.0%), then Lingala at (9.9%), Kiswahili (6.6%), Somali (3.3%), Portuguese (3.3%), Shona (2.2%), Amharca (1.1%), Chichewa (1.1%), Isan (1.1%), Kikongo (1.1%), Kinyarwanda (1.1%), Ndebele (1.1%), and Tshiruba at (1.1%). Participant's home language is presented in the Table 3.

**Table 3. Participants' home language (N=91)**

<b>Home language</b>		
	<b>n</b>	<b>%</b>
Amharic	1	1.1
Chichewa	1	1.1
French	51	56.0
Isan	1	1.1
Kikongo	1	1.1
Kinyarwanda	1	1.1
Kirundi	10	11.0
Kiswahili	6	6.6
Lingala	9	9.9
IsiNdebele	1	1.1
Portuguese	3	3.3
Shona	2	2.2
Somali	3	3.3
Tshiruba	1	1.1
<b>Total</b>	<b>91</b>	<b>100</b>

Generally, participants in this study sample did not report high favorable attitudes towards condom use behaviour, participants reported peer influence towards condom use behaviour, reported higher levels of condom self-efficacy, because the standard deviation was high for perceived behavioral control. With respect to condom use in these past six months, 41 participants (45.1%) reported to have used condoms in their sexual encounters in the past six months and 35 participants (38.5%) did not use condoms in the past six months when having sex, and 15 participants did not answer this question.

**Table 4. Means and standard deviations for all independent and mediator variables**

<i>Scale</i>	<i>Mean</i>	<i>Standard deviation(SD)</i>
<b>Attitude (n=90)</b>	119.92	14.74
<b>Subjective norms (n=91)</b>	33.38	9.59
<b>Perceived behavioural control (n=91)</b>	95.12	17.58
<b>Intentions (n=91)</b>	10.24	4.56
<b>Acculturation (n=79)</b>	44.63	10.60

### **Bivariate analysis**

Bivariate analysis involves the analysis of two variables (often represented as x, y), for the purpose of determining the empirical relationship between them (Babbie, 2009). The subsequent section presents bivariate analysis on socio demographic influences and correlations among predictor variables with condom use behaviour.

### ***Socio-demographic influences***

Crosstabs were conducted to determine if there are dissimilarities in the variables of interest based on participant's level of formal education (primary, secondary and post-secondary were compared), sex (male; female), as well as relationship status (single, married, separated and divorced were compared). Table 5 depicts the findings;

**Table 5. Cross-tabulation of demographic variables and condom use**

***Highest level of formal education \* condom\_use\_score Crosstabulation***

		<b>Condom use_score</b>		<b>Total</b>	
		<b>NO</b>	<b>YES</b>		
Highest level of formal education	primary school	Count	2	2	4
		Expected Count	2.2	1.8	4.0
		% within Highest level of formal education	50.0%	50.0%	100%
		% within condom_use_score	4.9%	5.9%	5.3%
		% of Total	2.7%	2.7%	5.3%
	secondary school	Count	22	11	33
		Expected Count	18.0	15.0	33.0
		% within Highest level of formal education	66.7%	33.3%	100.0%
		% within condom_use_score	53.7%	32.4%	44.0%
		% of Total	29.3%	14.7%	44.0%
Post-secondary school	Count	17	21	38	
	Expected Count	20.8	17.2	38.0	
	% within Highest level of formal education	44.7%	55.3%	100%	
	% within condom_use_score	41.5%	61.8%	50.7%	
	% of Total	22.7%	28.0%	50.7%	

**Table 6. SEX \* condom\_use\_score Crosstabulation**

SEX			condom_use_score		Total
			NO	YES	
SEX	Male	Count	19	27	46
		Expected Count	24.8	21.2	46.0
		% within SEX	41.3%	58.7%	100.0%
		% within condom_use_score	46.3%	77.1%	60.5%
		% of Total	25.0%	35.5%	60.5%
	Female	Count	22	8	30
		Expected Count	16.2	13.8	30.0
		% within SEX	73.3%	26.7%	100.0%
		% within condom_use_score	53.7%	22.9%	39.5%
		% of Total	28.9%	10.5%	39.5%

**Table 7. Relationship status \* condom\_use\_score crosstabulation**

Relationship status			Condom use score		Total
			NO	YES	
Relationship status	Married	Count	17	6	23
		Expected Count	12.4	10.6	23.0
		% within Relationship status	73.9%	26.1%	100.0%
		% within condom_use_score	41.5%	17.1%	30.3%
		% of Total	22.4%	7.9%	30.3%
	Single	Count	23	26	49
		Expected Count	26.4	22.6	49.0
		% within Relationship status	46.9%	53.1%	100.0%
		% within condom_use_score	56.1%	74.3%	64.5%
		% of Total	30.3%	34.2%	64.5%
	Separated	Count	1	2	3
		Expected Count	1.6	1.4	3.0

	% within	33.3%	66.7%	100.0%
	Relationship status			
	% within	2.4%	5.7%	3.9%
	condom_use_score			
	% of Total	1.3%	2.6%	3.9%
Divorced	Count	0	1	1
	Expected Count	.5	.5	1.0
	% within	0.0%	100.0	100.0%
	Relationship status		%	
	% within	0.0%	2.9%	1.3%
	condom_use_score			
	% of Total	0.0%	1.3%	1.3%

Of the four participants with primary school education 2 reported to have used condoms and 2 reported to have not. Of the 33 participants with secondary education 22 reported having used condoms in the past six months and 11 did not and of those with post-secondary education 17 reported to have used condoms (which is less than that of people with secondary education) and 21 of them did not. Overall, Participants with the highest level of education reported higher levels of condom use in the past six months as compared to the other groups however the difference between them and individuals with secondary school education was not very significant. Male participants reported more condom use as compared to females this is seen in the 35.5% (27 respondents) as compared to 10, 5% (8 respondents) of condom use between male and females among those who used condoms (see Table 6.). To further support this, the researcher found that the participants were not practicing safe sex because of advancements in treatments. A reliable source who's worked with Muslim females from Somalia and Burundi as his clientele, informed the researcher that according to their religion condom use is considered to be taboo, a temper to nature as the purpose behind sex is to procreate and multiply. Among these women, condom use was not within their volition, it depended on whether or not their husbands wanted to use it. When asked of HIV/AIDS risk, the notion was that they were not afraid of contracting HIV because there's

ARVs, and that they would rather get the disease and take treatment than disobey their husbands. Additionally, a majority of single participants reported using condoms in the past six months in their sexual encounters as compared to married, separated and divorced participants.

***Correlations among predictor variables***

The hypothesized model explored the relationship between attitudes, subjective norms, perceived behavioural control and intentions on condom use behaviour; the mediating effect of intention between peer norms and condom use behaviour, the moderating effect of acculturation between perceived behavioural control and condom use behaviour. (See the relationships presented in the model, Figure 1.1).

***Table 8. Correlation matrix of predictor variables***

<b>Scales</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1. Attitude towards condom use</b>	--	.250**	.062	.180*
<b>2. Referent group norm</b>	.250**	--	.480**	.476**
<b>3. Condom self-efficacy</b>	.062	.480**	--	.607**
<b>4. Intention of sexual behaviour</b>	.180*	.476**	.607**	--

\*= p<0.05 (95% confidence interval)

\*\*= p<0.01 (99% confidence interval)

***Correlation with each predictor variable and condom use***

Pearson correlation was run with each predictor variable and condom use. The results demonstrated that the attitudes towards condom use scale had .014 correlations, referent group norm scale had a .378 correlation (significant at 0.01 level), Brown, DiClemente & Reynolds, (1991) state that social networks and cultural norms can have an impact on

labeling behavior as high risk through disapproval, peer pressure, and social stigmatization. Developmentally, late adolescents depend on peer groups to provide a structure for making decisions, thus further indicating a need to focus on peer group norms in intervention strategies with college students (Ratliff-Crain, Donald, & Dalton, 1999) this is in support of the study results that indicates a significant relationship between peer norms and condom use behaviour. Condom self-efficacy score had a .412 ( $p < .001$ ) correlation and the intention scale had a .365 ( $p < .001$ ) correlation. The mediating effect of intention on attitude towards condom use behaviour is .365\*\* ( $p < .001$ ). Acculturation had a .096 correlation. Overall the scales did not have a highly significant correlation with condom use behaviour, with attitudes having the least significance. This therefore means that a person's attitude towards condom use will not result in the actual behaviour itself. For example, a person's attitude may be favorable towards condom use but they don't use condoms or it may be against condom use but they will still use condom as a means of protection even though they have a negative attitude towards it.

### ***Intention to use condoms***

Hypothesis four predicted that intentions will mediate the relationship between one of the combined TPB variables (i.e. attitude), which would predict a significant extent of condom use behaviour. A partial correlation was found in this study. This is in support of previous research that has found that intentions to use condoms have a moderate to strong correlation of 0.44 with self-reported condom use (Sherran & Orbell, 1994), although such correlational research does not prove that intentions cause behaviour.

### ***Acculturation and condom use***

This study also explored the relationships between perceived behavioural control, acculturation, and condom use. It was expected that there would be a significant relationship

between perceived behavioural control and condom use. This relationship would be moderated by acculturation. Results did not support the hypothesized relationship. The majority of participants identified with their country of origin. However, according to the current findings, different categories of acculturation did not have a significant relationship among acculturation and condom use behaviour.

### **Multivariate analysis**

Multivariate Analysis refers to any statistical technique utilised to analyse data that arises from more than one variable. This basically models reality where each situation, product, or decision involves more than one variable (Schervish, 1987). The subsequent section will present this study’s multivariate analysis, by use of tables as well as the interpretation of the tables.

The variables entered were referent group norms and attitudes in step one and intentions and condom self-efficacy in step two.

Table 9 shows the percentage of variability in the dependent variable that can be accounted for by all the predictors collected (that is the interpretation of R-square). The change in  $R^2$  is a way to evaluate how much predictive power was added to the model by the addition of another variable in step 2. In this case, the % of variability accounted for increased from 15.0% to 22.5% – which is somewhat a significant increase.

***Table 9: Model summary of hierarchical multivariate analysis of condom use***

<b>Model</b>	<b>R</b>	<b>R Square</b>	<b>Adjusted R square</b>	<b>Std Error of the estimate</b>	<b>R Square change</b>	<b>F</b>	<b>df1</b>	<b>df2</b>
<b>1.</b>	.387 <sup>a</sup>	,150	,127	,46887	,150	6,443	2	73

2.	.476 <sup>b</sup>	,227	,183	,45343	,077	3,528	2	71
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- a. Predictors: (Constant), sum\_referentnorm, sum\_of\_attitudes\_score  
b. Predictors: (Constant), sum\_referentnorm, sum\_of\_attitudes\_score, sum\_of\_intentions\_score, sum\_of\_condomself\_efficacy  
c. Dependent Variable: condom\_use\_score

Table 10 presents that the first model (referent group norm and attitudes) and the second model (intention and condom self-efficacy) predicted scores on the dependant variable (condom use behaviour) to a statistically significant degree. (Please see the “sig” column for p-values, which need to be below .05 to conclude that there a statistically significant result). The first set of predictors was significant at  $p < .003$  as well as the second at  $p < .001$  as they are both below 0.05.

**Table 10. ANOVA of referent group norm, attitudes, intention and condom self-efficacy**

Model	Sum of Squares	df	Mean square	F	Sig.
<b>1. Regression</b>	2.833	2	1.416	6.443	.003 <sup>b</sup>
<b>Residual</b>	16.049	73	.220		
<b>Total</b>	18.882	75			
<b>2. Regression</b>	4.284	4	1.071	5.209	.001 <sup>c</sup>
<b>Residual</b>	14.598	71	.206		
<b>Total</b>	18.882	75			

- a. Dependent Variable: condom\_use\_score  
b. Predictors: (Constant), sum\_referentnorm, sum\_of\_attitudes\_score  
c. Predictors: (Constant), sum\_referentnorm, sum\_of\_attitudes\_score, sum\_of\_intentions\_scale, sum\_of\_condomself\_efficacy

Hierarchical multiple regression was used to assess the ability of two control measures (Attitude, and referent group norm) to predict condom use behaviour, after controlling for perceived behavioral control and intentions to use condom to test whether these variables significantly added to the prediction of condom use over and above the effects of attitudes and subjective norms (see table 9 below). Preliminary analyses were conducted to ensure no violation of assumptions of normality, linearity, multicollinearity and homoscedasticity. Attitudes and subjective norms were entered in the first step explaining 15% of the variance on condom use behaviour. After entry of perceived behavioral control and intentions at step 2 the total variance explained by the model as whole was 22.7%. The two control measures explained an additional 7.7%, this means that perceived behavioral control and intentions explain an additional 7.7% ( $.077 \times 100$ ) of the variance in condom use behaviour of variance on condom use behaviour, even when the effects of attitudes and subjective norms are statistically controlled for.  $R$  square change = .077,  $F$  change = 3.53. In terms of how well each of the variables contributed to the final equation, the coefficient calculations demonstrated that there are no variables that made a unique statistically significant contribution that was less than .05.

*Table 11. Coefficients of multivariate analysis of condom use*

<b>Model</b>	<b>B</b>	<b>Std. error</b>	<b>Beta</b>		<b>Zero-order</b>	<b>Partial</b>	<b>Par t</b>	<b>Tolerance</b>
<b>1. constant</b>	.111	.451		.246	.806			
<b>sum_of_attitude_score</b>	-.033	.004	-.085	-.767	.446	.014	-.089	.083
<b>_sum_ referentnorm</b>	.021	.006	.400	3.587	.001	.378	.387	.387
<b>2. (Constant)</b>								
<b>sum_of_attitudes_ score</b>	-.374	.521		-.718	.475			
<b>sum_referent</b>	-.003	.004	-.080	-.737	.464	.014	-.807	.077
<b>sum_of_comdom</b>	.012	.007	.225	1.784	.079	.378	.207	.186
<b>self_efficacy</b>	.006	.004	.227	1.652	.103	.412	.192	.172
<b>sum_of_intentions_ score</b>	.015	.015	.135	.981	.330	.365	.116	.102

a. Dependent Variable: condom\_use\_score

In conclusion, this chapter presented findings of statistical tests used to test the hypotheses outlined in Chapter 5. In terms of the predictive usefulness of the theories of planned behaviour and the theory of acculturation, findings indicated some of the theoretical variables predicted condom use behaviour. Most of the discrepancies in condom use behaviour was elucidated by subjective norms and perceived behavioural control, while attitudes did not predict any significant variance.

## CHAPTER SIX: DISCUSSION

The purpose of this study was to identify predictors of condom use behaviour and intentions of African migrant youth in South Africa, where the prevalence of HIV is relatively high. Particularly, the present study examined the relationships among the variables, attitudes, subjective norm, perceived behavioural control and the outcome variable (condom use) utilizing SPSS. Though the moderating and mediating variables in this study cannot be interpreted in their entirety given their fit, it is possible to discuss the direction of the significant effects found within the models. The theory of Planned Behaviour and the theory of acculturation were used to design this study and data collection instruments. The discussion will concentrate on whether the theories worked in a South African context in accordance with the objectives of the study. Finally, the limitations of the study and recommendations for future research will be presented.

In the study it was first hypothesized that attitudes will predict condom use behaviour. The hypothesized relationship was not supported. As results showed that a person's attitude towards condom use had no significant influence on their condom use behaviour. Past studies have indicated that young adults have misperceptions for not using condoms including the belief that birth control pill and oral sex lower the risk of contracting HIV, having sex with only one partner prevents them from being at risk of contracting HIV, the withdrawal method prevents HIV transmission (Crosby and Yarber (2001). There are also misconceptions regarding emergency contraception, and false beliefs that their partners are disease free and also have the false belief that their peers do not use condoms and do not get infected and as a result, they need not use condoms either and they are not at risk of contracting HIV/AIDS (Carey, Bosari, Carey, & Maisto, 2006). Since beliefs and attitudes work interchangeably the

researcher inferred from this that a person's attitude towards something influences their behaviour towards it. However, in support of the current study's findings, Eaton, Flisher and Aaro (2003) posited that a large body of evidence points to the complexity of sexual behaviour. HIV risk behaviour is influenced by factors at three levels: within the person (e.g attitude), within the proximal context (interpersonal relationships and physical and organisational environment) and within the distal context (culture and structural factors).

Additionally, Ferguson Quinn, Eng, and Sandelowski (2006) compared African American gender differences in a qualitative study, and highlighted that female college students did not use condoms for a number of reasons, such as: being in long-term relationships, being emotionally attached, fear of rejection from the partner, lack of communication skills regarding condom use, and the most mutual fear was that their male partners might think they were adulterous if they began this new behavior (initiating condom use). This was also evident among the female participants in the current study

Secondly it was hypothesized that subjective norms will predict condom use behaviour. This hypothesis was supported, as results showed correlation between peer norms and condom use. Previous research also supports this and has indicated that peer influence plays a significant role in the use of condoms or the lack thereof. South African research has found that low self-esteem is associated with earlier onset of sexual activity and having more sexual partners. It has been hypothesised that a person with a poor sexual self-concept may rely on others for affirmation (Perkel, Strebel, & Joubert, 1991: 401). Previous research also reports that "decisions regarding sexual risk taking are highly vulnerable to emotional interference, and, therefore, may not be as rational as decisions involving precautionary measures that are less emotion laden, such as wearing a seat belt or getting a flu shot". Neff (2012) also confirmed this on her study and states that general peer influences (e.g., peer norms, subjective norms, and peer pressure) are all contextual antecedents that can contribute

to the perception of one's risk in terms of health behaviours. However, Mberu (2008) stated that young people that away from parents and relatives are significantly more likely to use condom at sexual debut than otherwise. This finding points out evidence hindering young people from utilizing sexual-related information and services even when they are available.

Sex remains a sacred topic in many African cultures and young people who live with their parents or relatives may be discouraged from accessing sex-related services such as condoms in fear of being identified as sexually promiscuous or being reprimanded if discovered. It is for like explanations that health care providers are identified as unwelcoming to young people, consequently hindering them from seeking sexual and reproductive health information and services in the area.

Thirdly it was hypothesised that perceived behavioural control will predict condom use behaviour. Results from this study supported this hypothesis. This hypothesis aimed to illustrate that having a high level of perceived behavioral control would determine high condom use, or the reverse to be true. Current findings illustrate that high levels of condom self-efficacy are associated with condom use behaviour (Adih & Alexander, 1999). As reported in chapter two, in Africa condom use has been massively debated over the past years, facing opposition from many perspectives (Bond and Dover, 1997). Whilst both men and women have negative attitudes towards condoms, because of their economic and social dependence on men, women are in a weaker position to negotiate condom use. This is further exacerbated if the women are migrants (Zuma, Gouws, E., Williams, B., Lurie, 2003). Furthermore, several socioeconomic, cultural and religious factors have been identified as barriers to condom use, and these vary in influence between men and women (Lurie, Williams, Mkayi-Mwamburi, Garnett, Sweat, Gittelsohn, & Karim, 2003). Furthermore, persons with low self-esteem are more likely to think that condoms are offensive to their partner, to think that using condoms may make their partner think they are dirty, to be

embarrassed about using condoms and to have a negative attitude towards condoms (Perkel, Strebel, & Joubert, 1991).

Fourthly it was hypothesised that intentions mediate the relationship between attitudes and condom use behaviour. A partial correlation was found between these variables in this study. This is in support of previous research that has found that intentions to use condoms have a moderate to strong correlation of 0.44 with self-reported condom use (Sherran & Orbell, 1994), although such correlational research does not prove that intentions cause behaviour.

The last hypothesis expected to find that acculturation mediates the relationship between intention and condom use behaviour. The goal of the acculturation scale was to identify where participants fall in terms of how much South African culture influences them and how much their culture of origin influences them. Acculturation in the current study was measured by answering 23 items for which respondents compare various subject domains to their self-identified cultural group and to South African culture. Four typologies were derived from the scale and each participant was labeled with one of the typologies depending on their responses: (1) country of origin oriented, (2) South African culture oriented, (3) Bicultural (oriented in both about equally), and (4) Marginalized (oriented in neither). Finding depicted that the different categories of acculturation did not have a significant relationship between acculturation and condom use behaviour. Perhaps future studies can review how acculturation was measured. Additionally, future research could focus on identifying positive and negative attributes for each culture in order to clarify these contradictory results (Neff, 2012).

Overall, the variables which explained most of the variance in condom use were subjective norms and perceived behavioural control. This means that participants with positive peer influence and a high condom self-efficacy had higher intentions to use condoms. Attitudes did not contribute significantly to the variance in condom use.

### **Associations among demographic variables**

Correlations between participant's highest level of education, sex and relationship status were run. In terms of education, the current study hoped to clarify the knowledge gap. Findings revealed that there wasn't a significant relationship between a person's level of formal education and their use of condom. Though the current study did not explore gender differences in the model, the researcher has observed additional insight that suggests that males had more condoms use than females, this is seen in the 35.5% (27 respondents) as compared to 10, 5% (8 respondents) of condom use between male and females among those who used condoms (see Table 6.). This could be related to the fact that males rated their decision by basing it on the number of sexual partners they had. Also, the use of the male condoms is generally the norm in society. This is in support to the lack of knowledge around female condoms that the researcher discovered female participants had in this current study. Single respondents had higher condom use as compared to married, divorced, and separated individuals. This is evidenced by (among those who used condoms) 34.2% of condom use among single participants as compared to 7.9% among married respondents, 2.6% among separated respondents and 1.3% among divorced respondents. This is in support to previous research that supports that youths in the South Africa are increasingly linked to risky sexual behaviours such as casual sex and keeping of multiple partners, as well as drinking and having casual sex with different partners, some of whom may include commercial sex workers (Isiugo-Abanihe, 2003).

While the study sample should be quite diverse, the fact remains that certain segments of the migrant youth's population are difficult to find. The researcher had difficulties getting people from Somalia and Burundi who came to ARESTA to participate on the study. This was related to their Muslim religion which they argued forbids them to discuss sex openly with the researcher (stranger) and also is against the use of condoms, therefore they wish to

not participate on the study. A reliable source who's worked with the individuals as his clientele, informed the researcher that according to their religion condom use is considered to be taboo, a temper to nature as the purpose behind sex is to procreate and multiply. The female clients he had provided services to before, informed him that condom use was not within their volition, that they also engaged in prostitution due to lack of economic resources, having many children and absent fathers, that they were not afraid of contracting HIV because there's ARVs, and that they would rather get the disease and take treatment than disobeying their husbands who do not want to use condoms, they believe that there's life after death so why should their fear HIV.

In conclusion, there are many variables within the diversity that embodies ethnic groups being represented on the study, thus making it difficult to understand how to intervene. Like previously stated, it might be that participants, especially those who have been in South Africa for at least a year or more, are relatively similar in their adoption of South African values, or at least their knowledge of them.

## CHAPTER SEVEN: CONCLUSION

It is important to remember that the majority of previous sexual behavior and HIV/AIDS related research in South Africa has focused on South African citizens, on low-income communities, adolescents and youth. Migrants have not been attended to though they are a risk group since they also engage in behaviors that place them at risk for contracting HIV.

Additionally, HIV/AIDS is not decreasing proportionately among African migrants, highlighting the importance of studying sexual behavior and HIV/AIDS related topics with African migrant samples. Furthermore, the researcher found that the participants were not practicing safe sex because of advancements in treatments. Perhaps focusing more preventative than remedial approaches would help alleviate the level of HIV transmission. Research and intervention measures that are religious and culturally sensitive should be invented, thus making stigmatized topics such as sex, HIV risk behaviors more mainstream and accessible to migrants in a way that they can relate to. More discussions could be fostered among churches which could then lead to better safe practices and awareness regarding sexual behavior instead of having a society that is in denial and oblivious to issues that have a direct and indirect impact on them. Also utilizing social media (e.g., twitter, face book, whatsapp, BBM, Instagram, YouTube) and other more relatable ways to implement interventions would be instrumental in reaching out to people in order to stimulate discussions regarding HIV risk behaviors and using condoms. Interventions that contain attitude components, educational information, behavioral skills, and behavioral skills training should be focused on.

Additionally, the current study contributes to the literature by indicating a need to target beliefs about the self among migrants. There's a need to implement different

prevention interventions based on cultural identification. Furthermore, commitment to change behavior should be investigated in research in order to create appropriate interventions.

Stevens, Leybas-Amedia, Bourdeau, McMichael, and Nyitray, (2006) posit that previous research has illustrated success in decreasing negative behaviors, such as binge drinking and sexual risk behaviors through the popular opinion leader's method (POL). Because research supports the need to tailor interventions to specific cultures, religion, sexual orientation, and gender, it could also be successful to utilize popular opinion leaders (POL's) for example church leaders, chiefs or community leaders among the migrant communities. This type of intervention might be very useful in influencing optimistic bias and peer norms that are indelible and oblivious to issues related with reckless sexual behavior. For example, church leaders could go through training with professionals not only regarding HIV topics such as the benefits of using condoms, but also about the spread of the disease and facts about treatments, and practice discussions with other leaders. The goal for the training would be such that each POL would fully understand the impact of unsafe sexual behaviour and HIV, how to prevent it and how having discussions with people in the church about HIV and condom use is a positive thing to do. Perhaps people would be more accepting of this information, they would fear stigmatization and judgment less if it's coming from people they look up to for guidance in life and with whom they have established relationships, commonalities and trust.

Future interventions should also focus on assisting families with coping with stigma and reduce HIV stigma in the general public, because being stigmatized is associated with negative health outcomes (Neff, 2012).

A discussion in the literature worth mentioning highlights the need for interventions to target males and females separately (Brown, 2008). Recent research has focused on exploring gender differences, though its implications are massive in terms of social and

medical intervention, in terms of prevention efforts, appropriate and effective treatment. Yet again, emphasizing the lack of present literature that investigates gender differences related to risky sexual behaviors and the need for interventions to target males and females separately.

### **Implications for social work practice**

Social workers in particular are the best place to provide future interventions around topics as such. Implications of this study to social work practice speaks to lobbying, campaigning and advocating for the evaluation of evidence led policy to ensure that the rights and responsibilities of vulnerable groups are met (Dunk 2007). To publicise information about best practice models and approaches and lure governments' attention to what is happening among African migrant youth around sexual behaviour in South Africa and to advocate for changes, policy development, programme formulation and implementation that will deliver the best possible outcomes for healthy sexual reproductive behaviour among these communities (Dunk 2007). To empower migrant youth by educating them on healthy sexual reproductive behaviour as well as bring about awareness on sexually transmitted infections and essentially promote condom use and HIV testing. Furthermore, targeted HIV/AIDS prevention and treatment interventions like condom access, education, and utilization programs should be in place at migrant destinations and frequent sites. Additionally, social workers need to improve their level of expertise and commitment to the fundamental principles of social work and work hard towards assisting vulnerable groups which in this context are migrant youth and females particularly to protect, promote and meet their human rights.

In conclusion, this study has been unique in a sense that it utilized a population of migrants residing in an urban setting. Migrants are considered to be hard to reach population, and previous studies have used South African citizens as study samples. It is important to

keep this in mind when generalizing the results. The urban migrant population is unique in that it is a relatively educated group of diverse individuals. In addition, they are those who are most likely to be living on their own for the first time and exposed to different cultures, values, and relationships, all which could alter their previously held attitudes, beliefs and behaviors. Therefore, the nurturing of a shared accountability through interventions that take advantage of the qualities of a shared societal culture than just individual responsibility must be maximised. Evidently, previous research and current HIV/AIDS statistics put emphasis on collective responsibility because alone will not achieve the goal of having an HIV/AIDS free society.

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## Appendix A: Consent form



### UNIVERSITY OF CAPE TOWN

#### Masters Research Study

#### **Predictors of Condom Use Behaviour and Intentions of African Migrant Youth in South Africa.**

My name is Kwanele Shishane. I am a student at the University of Cape Town.

The study I am doing is about exploring the predictors of condom use behaviour and intentions of African migrant youth in South Africa, and examine the influences of acculturation on the relationship between condom use intention and condom use behaviour.

Participating in this research will take approximately 25-45 minutes of your time. Your participation is voluntary and you can decide to withdraw from the study before it commences or even when you have already agreed to participate without any consequences for you. I will ensure that no clues to your identity appear in the thesis. Everything that you fill in the questionnaire will solely be used for academic purposes and will be kept confidential.

In the questionnaire there are some private questions and it is important for you to understand that I am not from your culture, therefore if you feel uncomfortable in answering a certain question feel free not to.

I kindly ask you to respond honestly to the questions. You do not need to write your name in the questionnaire, as a code will be allocated to you, and keep in mind that your responses will be kept confidential and the use of the code will protect your identity.

The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study may be published in a research journal.

Do you have any questions before you start answering the questionnaire?

Do you agree to participate in this research study? (Please tick in the box)

Yes  No

Signature: .....

Date: .....

**Thank you for participating!**

## Appendix B: Research questionnaire

### GENERAL INFORMATION

### INTERVIEW DATA

*Please leave this section for the researcher*

Interview Date		
Participant code	_ _ _ _ _	<b>Initials interviewer and 3 digit serial No. (e.g. KS001)</b>

### PERSONAL DATA

1	Age (years)	
2	Highest level of formal education	<input type="checkbox"/> (1) none <input type="checkbox"/> (2) primary school <input type="checkbox"/> (3) secondary school <input type="checkbox"/> (4) post-secondary school
3	Gender	Male <input type="checkbox"/> (1) Female <input type="checkbox"/> (2)
4	Length of stay in South Africa	.....years
5	Country of origin	
6	Home language	
7	Relationship status	<input type="checkbox"/> (1) Married <input type="checkbox"/> (2) Single <input type="checkbox"/> (3) Separated <input type="checkbox"/> (4) Divorced <input type="checkbox"/> (5) Widowed

### *Attitudes towards condom use scale (ATCS)*

This scale seeks to get your attitude towards condoms.

	Please indicate how much you agree or disagree with each of the following statements.	Strongly disagree	Some what disagree	Neither disagree or agree	Some what agree	Strongly agree
1	In my opinion, condoms are too much trouble	1	2	3	4	5
2	Condoms are unreliable	1	2	3	4	5
3	Condoms are pleasant to use	1	2	3	4	5
4	The neatness of condoms, for example, no wet spot on the bed, makes them attractive	1	2	3	4	5
5	I see the use of a condom as adding to the excitement of foreplay if the female partner helps the male put it in place	1	2	3	4	5

6	I would be willing to try a condom, even if I have never used one before	1	2	3	4	5
	<b>Please indicate how much you agree or disagree with each of the following statements.</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither disagree or agree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
7	There is no reason why a woman should be embarrassed to suggest a condom	1	2	3	4	5
8	Women think men who use condoms show concern and caring	1	2	3	4	5
9	I intend to try condoms	1	2	3	4	5
10	I think proper use of a condom can enhance sexual pleasures	1	2	3	4	5
11	Many people make use of the condom as an erotic part of foreplay	1	2	3	4	5
12	All things considered, condoms seem safer to me than any other form of contraception except abstinence	1	2	3	4	5
13	I just don't like the idea of using condoms	1	2	3	4	5
14	I think condoms look ridiculous	1	2	3	4	5
15	Condoms are inconvenient	1	2	3	4	5
16	I see no reason to be embarrassed by the use of condoms	1	2	3	4	5
17	Condoms are uncomfortable	1	2	3	4	5
18	Using a condom makes sex unenjoyable	1	2	3	4	5
19	I would avoid using condoms if at all possible	1	2	3	4	5
20	I would be comfortable suggesting that my partner and I use a condom	1	2	3	4	5
21	Condoms ruin the sex act	1	2	3	4	5
22	Condoms are uncomfortable for both partners	1	2	3	4	5
23	Women think men who use condoms are foolish and ill mannerd	1	2	3	4	5
24	The idea of using a condom doesn't appeal to me	1	2	3	4	5
25	Use of the condom is an interruption of foreplay	1	2	3	4	5
26	What to do with a condom after use is a real problem	1	2	3	4	5
27	The thought of using a condom is disgusting	1	2	3	4	5

28	Having to stop to put on a condom takes all the romance out of sex	1	2	3	4	5
	<b>Please indicate how much you agree or disagree with each of the following statements.</b>	<b>Strongly disagree</b>	<b>Some What disagree</b>	<b>Neither agree or disagree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
29	Most women don't like for their partners to use condoms	1	2	3	4	5
30	I don't think condoms interfere with the enjoyment of sex	1	2	3	4	5
31	There is no way that using a condom can be pleasant	1	2	3	4	5
32	Using a condom requires taking time out of foreplay, which interrupts the pleasure of sex	1	2	3	4	5
33	I think condoms are an excellent means of contraception	1	2	3	4	5
34	Condoms seem unreliable	1	2	3	4	5
35	There is no reason why a man should be embarrassed to suggest using a condom	1	2	3	4	5
36	To most women, a man who uses a condom is sexier than one who leaves protection up to the woman	1	2	3	4	5
37	The condom is a highly satisfactory form of contraception	1	2	3	4	5
38	I would have no objection if my partner suggested that we use a condom	1	2	3	4	5
39	The skillful woman can make placing a condom a highly erotic experience	1	2	3	4	5

***Referent group norms of condom use scale***

This scale assesses subjective norms of condom use.

	<b>Please indicate how much you agree or disagree with each of the following statements</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither disagree or agree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
1	Most people who are important to me would think it is important to use a condom in my next sexual encounter	1	2	3	4	5
2	Most people who are important to me think that condom use is desirable	1	2	3	4	5

3	Most others who are important to me think that I should use a condom in my next sexual encounter	1	2	3	4	5
	<b>Please indicate how much you agree or disagree with each of the following statements</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither disagree or agree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
4	Thinking of my friends and peers. I think they would think that using a condom in my next sexual encounter is a good thing to do	1	2	3	4	5
5	Thinking of my parents, family. I think that they would think that using a condom in my next sexual encounter is a good thing to do	1	2	3	4	5
6	Many people from my church (pastor and congregation mates) would think that using a condom in my next sexual encounter is a good thing to do	1	2	3	4	5
7	Many of my friends would use a condom in their sexual encounter	1	2	3	4	5
8	Thinking of my friends and peers. I think many of them would use a condom in their sexual encounter	1	2	3	4	5
9	My attitudes and beliefs, are similar to that of my friends and peers	1	2	3	4	5
10	Thinking of who I am. Being a member of my group of friends and peers and having their approval is very important to me	1	2	3	4	5

### ***Condom self-efficacy scale***

This scale seeks to get your perceived control of condom use. This scale has six sub-domains (technical skills, image confidence, emotion control, purchase, assertiveness, and sexual control) The response options from this scale ranges from very unsure (1) to very sure (5)

	<b>Please indicate how much you agree or disagree with each of the following statements.</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither agree or disagree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
	<i>Factor 1: Technical skills</i>					
1	I feel confident in my ability to put on a condom to myself or my partner	1	2	3	4	5
2	I would be capable of using a condom efficiently	1	2	3	4	5

3	I think I would be able to remove a condom easily	1	2	3	4	5
	<b>Please indicate how much sure or unsure you are with each of the following statements.</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither agree or disagree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
4	Putting on a condom would make me feel uncomfortable	1	2	3	4	5
5	I think I am able to put on a condom quickly	1	2	3	4	5
6	I would be able to get condoms out of a condom machine in a pub or dance without any problem	1	2	3	4	5
	<i>Factor 2: Image confidence</i>					
7	I would not dare to propose condom use to a new partner because this might suggest my partner has an STD	1	2	3	4	5
8	I would not dare to propose condom use to a new partner because this might suggest I have an STD	1	2	3	4	5
9	I would not dare to propose condom use because this might suggest I have slept with several partners	1	2	3	4	5
10	I think I could propose condom use without causing my partner feel as if he or she were ill	1	2	3	4	5
11	If I were to propose condom use, I would be afraid to be rejected	1	2	3	4	5
12	I would not dare to propose condom use to a new partner because this might suggest homosexual experiences	1	2	3	4	5
	<i>Factor 3: Emotion control</i>					
13	None of us has got a condom, so we would have to buy one. In that case I think I would have sex without a condom	1	2	3	4	5
14	If I would have sex unexpectedly I would forget to use a condom	1	2	3	4	5
15	If I would be drunk a little, I would not be able to stop making love to put on a condom first	1	2	3	4	5
16	Even if I would be very much in love, I would think of using a condom when I have sex with my partner for the first time	1	2	3	4	5

17	If I would have sex with my partner for the first time, I would hardly be able to wait until the condom has been put on	1	2	3	4	5
	<b>Please indicate how much sure or unsure you are with each of the following statements.</b>	<b>Strongly disagree</b>	<b>Some what disagree</b>	<b>Neither agree or disagree</b>	<b>Some what agree</b>	<b>Strongly agree</b>
	<i>Factor 4: Purchase</i>					
18	I can get condoms whenever I want without difficulty	1	2	3	4	5
19	I wouldn't mind buying condoms in a department store	1	2	3	4	5
20	I would feel uncomfortable if I'd carry condoms with me	1	2	3	4	5
21	I find purchasing condoms at a pharmacist embarrassing	1	2	3	4	5
22	I dare to get condoms out of a condom machine in a pub or dance without any problem	1	2	3	4	5
	<i>Factor 5: Assertiveness</i>					
23	I feel able to convince my partner to use a condom when we have sex together	1	2	3	4	5
24	If my partner wouldn't want to use a condom, I could easily convince him/her of its necessity	1	2	3	4	5
25	I would not propose using a condom if I didn't know how my partner feels about condom use	1	2	3	4	5
26	None of us has got a condom, so we would have to buy one. In that case I think I would have sex without a condom	1	2	3	4	5
27	I think I could propose condom use without causing my partner feel as if he or she were ill	1	2	3	4	5
28	I see myself as capable of buying condoms at a duty pharmacist during the evening	1	2	3	4	5
	<i>Factor 6: Sexual control</i>					
29	I feel able to use a condom together with my partner without breaking the mood	1	2	3	4	5
30	I think I could use a condom without lessening sexual excitement	1	2	3	4	5
31	If my partner would carry a condom I would certainly manage to use one	1	2	3	4	5

32	I feel I am able to integrate putting on a condom into the foreplay	1	2	3	4	5
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### *Intention of sexual behaviour scale*

Questions in this scales will ask you whether you intend to use condoms whenever you engage in premarital/marital sex.

	Please indicate how much you agree or disagree with each of the following questions	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1	If you have sex with a casual partner over the next 2 months, do you intend to use a condom?	1	2	3	4	5
2	If you have sex with a casual partner over the next 2 months, do you expect to use a condom?	1	2	3	4	5
3	Is it likely that you will use a condom if you have vaginal and/or anal sex with a casual partner in the next 2 months?''	1	2	3	4	5

### *A modified version of the Pan-Acculturation Scale*

Everyone belongs to one country of origin or ethnic group. Some people are a mixture of several cultural groups. When this is true, a person might find one cultural group more influential than another. Cultural and ethnic groups are important because they can influence our beliefs, traditions, and how we think, feel and act. The questions that follow are for the purpose of collecting information about your historical background as well as more **RECENT** behaviours that may be related to your **CURRENT** cultural identity.

**Choose the one answer that best describes you**

	My characteristics	My country of origin	South African	Both	Niether
1	My accent in my native language sounds like people from...	1	2	3	4
2	My accent in English sounds like people from...	1	2	3	4
3	I talk like people from...	1	2	3	4
4	The words I use are from...	1	2	3	4

5	I am very proud of...	1	2	3	4
6	I am excited about being a member of...	1	2	3	4
	<b>My characteristics</b>	<b>My country of origin</b>	<b>South African</b>	<b>Both</b>	<b>Niether</b>
7	I am very close or attached to...	1	2	3	4
8	My best friends are from...	1	2	3	4
9	The people I see every day are from...	1	2	3	4
10	The people I hang out with are from...	1	2	3	4
11	The foods I eat are from...	1	2	3	4
12	The traditions I follow are from...	1	2	3	4
13	The music I listen to is from...	1	2	3	4
14	The celebrations I go to are from...	1	2	3	4
15	My cultural values and beliefs are from...	1	2	3	4
16	The culture I identify with the most is...	1	2	3	4
17	The culture that influences the way I think and see things is from...	1	2	3	4
18	My religion is from...	1	2	3	4
19	My role models are from...	1	2	3	4
20	My parents are from...	1	2	3	4
21	My relatives are from...	1	2	3	4
22	The people I like to be with are from...	1	2	3	4
23	The people I go to school or work with are from...	1	2	3	4

### Sexual Activities and Condom Use

- 1: Have you had sex with your primary patner in the past 6 months? YES  1 NO  2
2. Did you use a condom when having sex in your last sexual encounter? YES  1 NO  2

**THANK YOU FOR YOUR PARTICIPATION!!!!**