PERCEPTIONS AMONG A GROUP OF AT-RISK INDIVIDUALS: THE DISCREPANCY BETWEEN UNSAFE SEX PRACTICES AND KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION

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Perceptions among a group of at-risk individuals: The discrepancy between unsafe sex practices and knowledge about HIV/AIDS transmission

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DECLARATION

I declare that the dissertation here submitted by me for the degree Magister Artium at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the dissertation in favour of the University of the Free State.

Joy Violet Summerton
November 2001

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SECTION ONE

Chapter 1

RESEARCH DESIGN

1.1 Introduction

Numerous efforts are currently underway to reduce the rate of sexually transmitted HIV-infections in South Africa. However, judging by the increasing rate of HIV-infections, these efforts fall short of achieving their main aim. It would appear as though these efforts have successfully increased knowledge and awareness about HIV/AIDS among the population in general. However, the appropriate behaviour change has not been forthcoming. This prompted a need to investigate the underlying reasons why an increase in knowledge about HIV/AIDS has not yielded the expected change in high-risk sexual behaviour. The findings of a study that was conducted by the CHSR&D (1999) that proposes a youth multi-function Centre for the research community (Thabong/Welkom) offered further support for the need to investigate obstacles to aligning knowledge about HIV/AIDS with sexual behaviour in this particular community. This study will inform an initiative such as the proposed youth multi-function Centre in Thabong/Welkom (research population), which aims to combat HIV/AIDS in the community by addressing various needs of youth other than health.

HIV-infection is a chronic illness that is characterised by a wide range of clinical conditions that reflect varying levels of immunological injury and different predisposing factors. AIDS is an endpoint of HIV infection, resulting from severe immunological damage, namely loss of an effective immune response which renders the infected person vulnerable to specific opportunistic pathogens and tumours (HRSA, 2000).

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) describes a fatal disease defined as a syndrome of opportunistic diseases, infections and certain cancers which occur in people with acquired immune deficiency following infection with the Human Immunodeficiency Virus (HIV) (Department of National Health and Population Development, 1989). HIV is transmitted through three primary routes, namely sexual,

parenteral (blood-borne) and perinatal (HRSA, 2000). Sexual transmission of HIV is generally the predominant mode of transmission (HRSA, 2000).

1.2Problem Statement

An epidemic is defined as an outbreak of a disease, which has spread through a community. AIDS is a disease that is spreading at a rapid pace through communities and societies. As one of the societies worst affected by HIV/AIDS, it has been declared an epidemic in South Africa. The AIDS epidemic in South Africa is not stagnant, nor does it show signs of declining soon. On the contrary, it appears to be progressing at an alarming rate with devastating effects on all sectors and institutions of society. Families and communities are increasingly experiencing the direct impact of the epidemic. Efforts to provide treatment to HIV-infected individuals in South Africa are faced with numerous problems and obstacles that make the search for a solution in the form of a cure unfeasible, at least for the short and medium term. Most prevention initiatives have so far been based on the premise that increased knowledge about HIV/AIDS will lead people to adopt safe sex practices. The fact that the prevalence of HIV in South Africa remains high seems to suggest that this approach has fundamental shortcomings.

Since the predominant mode of HIV-transmission is through sexual intercourse, finding an intervention that can successfully change high-risk sexual behaviours, especially among those most vulnerable to the disease, appears to be the most viable form of prevention at present. The purpose of this study is to inform the development of prevention initiatives that can effectively and efficiently change high-risk sexual behaviour. It is based on the premise that effective and efficient interventions should be based on a sound understanding of all motivational and influencing factors of sexual behaviour.

1.3Theoretical approach to the study

This study adopts a multidisciplinary approach to analysing sexual behaviour in its relationship to HIV/AIDS and more specifically to changing sexual behaviour as a preventative measure in the fight against HIV/AIDS. In this respect, it departs from a predominantly Health Belief Model of behaviour change to a Reasoned Action Model that takes account of various factors that play a role in shaping behaviour. The Reasoned Action Model is based on a multidisciplinary approach to understanding behaviour. In this study, it will be applied specifically to sexual behaviour. It is based on the premise that

HIV-AIDS is a behavioural problem that is influenced by psychological, as well as socio-cultural forces in the social environment in which sexual behaviour is played out. This is contrary to the Health Belief view, which assumes that HIV/AIDS is a medical problem that can be prevented through rational decision-making based solely on knowledge.

1.4Focus of the study

AIDS is a global phenomenon, which is especially severe in sub-Saharan Africa. In South Africa, HIV/AIDS has been rendered an epidemic due to its high prevalence in the country. The Free State has the third highest HIV-prevalence of the nine provinces in South Africa. Although, Welkom (Thabong) has the smallest geographical area of the 6 Regions in the Free State, it has the highest HIV-prevalence rate. Thus, the selection of this area as the research population.

The study focuses on HIV/AIDS as a socio-behavioural phenomenon and specifically on influencing factors that must be taken into account when the effective and efficient prevention thereof in Thabong is at stake.

1.5Rationale for the study

So far, efforts to change high-risk sexual behaviour in an attempt to decrease the incidence of HIV-infections have had limited success, which is mainly attributed to the over-reliance of these efforts on Health Belief Model of HIV/AIDS (Cooper, Powers & Shapiro, 1998). This view of HIV/AIDS, which appears to be the view that most HIV-prevention initiatives are based upon, fails to take account of factors that influence behaviour other than knowledge. The Health Belief view of HIV-prevention assumes that knowledge about the risks and effects of a disease, including HIV/AIDS, will result in the adoption of preventative measures. In the case of HIV/AIDS, such measures would include condom use, sexual abstinence or mutual faithfulness between sexual partners. However, the progression of HIV/AIDS is rooted in the life styles of individuals. These life styles are shaped by the complex socio-economic and socio-cultural environment in which they emerge. Life styles, in turn, reflect behaviours that individuals adopt and internalise through socialisation. In addition, sexual behaviour is an emotionally charged phenomenon. These complex socio-behavioural components lie at the root of the difficulty in controlling the spread of HIV/AIDS.

Therefore, it is proposed that HIV/AIDS needs to be viewed from a socio-behavioural, rather than a Health Belief perspective in order to understand the interactive relationship between various factors that motivate and influence sexual behaviour and so contribute to the progression of the epidemic. A comprehensive analytical view of sexual behaviour in relation to HIV/AIDS would therefore be based on a psychological, sociological and anthropological perspective of behaviour. This study aims to contribute towards an enhanced understanding of the socio-behavioural and emotional motivations that influence sexual behaviour, thereby contributing towards the development of interventions that could be more effective in taking a broader view of HIV-prevention.

1.6Theoretical contextualisation of the research problem

AIDS, like other sexually transmitted diseases (STDs), is firmly rooted in sexual behaviour. The three modes of HIV-prevention, namely sexual abstinence, consistent and appropriate condom use, and mutual faithfulness between partners, are behaviours that are strongly influenced by motivations (i.e. basic human needs) and the socio-cultural environment in which these behaviours take place. This influences the effect that knowledge has on behaviour. Therefore, AIDS-prevention does not depend solely on rational thinking and individualistic decision-making based on knowledge about AIDS. This is where the health belief model of HIV-prevention falls short of achieving what it intends to achieve, namely leading people to adopt low-risk sexual behaviour by increasing their knowledge about HIV-transmission and prevention.

A socio-behavioural approach to HIV-prevention, which is based on a multidisciplinary Reasoned Action Model of behaviour, views HIV/AIDS in relation to sexual behaviour. It takes account of the influence of motivations and the socio-cultural environment on sexual behaviour. These factors include sexual motives, attitudes and subjective social norms. It also acknowledges the influence of other factors in the socio-economic environment on the manifestation of sexual behaviour. It is important to examine each of the factors that determine sexual behaviour, as well as their interactive relationship, in order to understand the progression and, ultimately, the prevention of HIV/AIDS.

Based on a multi-disciplinary perspective of determinants of behaviour, sex is perceived as serving a range of psychological and social functions that have little to do with maintaining good health and avoiding diseases. Furthermore, attitudes and subjective social norms influence the choice of behaviour. Attitudes and subjective social norms are

acquired through a process of socialisation whereby individuals learn, according to cultural norms and principles, how to react towards attitude objects. Since attitudes and subjective social norms are products of the social environment in which the individual functions, efforts to change high-risk sexual behaviour should also take account of the influence of this environment on the individual's decisions pertaining to sexual behaviour.

This complex decision-making process involved in sexual behaviour is more likely to be understood if these multiple influences on behaviour, and the interaction between them, is considered in developing and implementing interventions to reduce high-risk sexual behaviours (DiClemente & Peterson, 1994).

A socio-behavioural approach to viewing HIV-prevention is geared towards a better understanding of impediments to effective HIV-prevention. This understanding should result in the development of appropriate measures to overcome these impediments, thereby increasing the effectiveness and efficiency of prevention campaigns.

1.7Aim and objectives of the study

The aim of the study is to explore socio-behavioural and motivational factors that influence sexual behaviour among men and women aged 15 - 49 years in Thabong/Welkom with a view to informing HIV/AIDS prevention campaigns in this area.

This aim will be achieved through the following objectives:

1) conducting a comparative analysis of the limitations and advantages of various perspectives on sexual behaviour and approaches to HIV-prevention in terms of their impact on sexual behaviour;

2) with specific reference to the sexually active population of Thabong:

- identifying determinants of both high-risk and safe sexual behaviour/practices;
- identifying impediments to choosing safe sexual practices among sexually active individuals;

3) identifying factors that are perceived as conducive to practising safe sex by HIV-infected individuals, and that would have influenced their decision to choose safe sex over high-risk sexual practices prior to infection;

4) proposing community-specific measures, based on a multidisciplinary perspective of sexual behaviour, that can be used to guide the development of effective and efficient HIV/AIDS-prevention initiatives and programmes in Thabong.

1.8Structure of the report

This report consists of ten chapters which have been sub-divided into two sections. Section one (Chapter 1 to Chapter 4) consists of the theoretical analysis and theory development part of the study, whereas section two (Chapter 5 to Chapter 10) deals with the empirical part of the study.

This chapter, **Chapter 1**, provides an overview of the research problem, as well as the aim and objectives that the study intends to achieve.

Chapter 2 looks at the findings of knowledge, attitude, practice and belief (KAPB)-studies about HIV/AIDS that have been conducted by other researchers. The findings of these studies, conducted among various populations, including different age groups, men and women, and both rural and urban populations, substantiate the conviction that knowledge alone is not sufficient in changing high-risk sexual behaviour. This points towards the inadequacy of a Health Belief Model, based on rational thinking, to HIV-prevention. It concludes that knowledge is merely one of various influencing factors in the decision-making process pertaining to sexual behaviour.

According to the findings of KAPB-studies on HIV/AIDS, discussed in Chapter 2, HIV/AIDS is essentially a socio-behavioural phenomenon that manifests in ill health. This may partly explain why initiatives to control the spread of the disease have focused largely on knowledge and information, thus neglecting to take account of the socio-behavioural aspect of the disease.

Chapter 3 gives an in-depth overview of three different perspectives on behaviour, namely the psychological, sociological and anthropological perspectives. Determinants of behaviour, based on these three perspectives, are analysed in relation to manifest behaviour. This is aimed at broadening the Health Belief approach to HIV-prevention by taking account of other factors, besides knowledge, that are perceived as influencing and thus shaping behaviour.

Chapter 4 proposes a multidisciplinary analytical model for sexual behaviour, based on an integrated and comprehensive view of the three perspectives analysed in Chapter 3. It aims at expanding the Health Belief Model by taking account of factors that influence sexual behaviour subsequent to the acquisition of knowledge about HIV/AIDS. This multidisciplinary model of behaviour provides the analytical and conceptual framework for the empirical phase of this study.

Chapter 5 provides an overview of HIV/AIDS in South Africa. This includes an epidemiological profile of HIV/AIDS at a national, provincial and local level. It also gives an overview of future projections of the AIDS epidemic in South Africa. This overview aims to highlight the importance of finding a solution to the epidemic, which appears to be undeterred on its path to destroying major developmental gains made in South Africa.

Chapter 6 aims to provide an orientation to the study population by describing demographic and geographic features of this population, especially as far as this is relevant to HIV/AIDS and the prevention thereof.

Chapter 7 gives a descriptive overview of HIV-prevention initiatives and programmes in Thabong (the selected research community) according to their aims, objectives, outputs and perceived impact.

Chapter 8 gives a detailed overview of the research strategy and methodology that was adopted for the empirical investigation of determinants of sexual behaviour in the study population. Both the strengths and weaknesses of the selected methodology are described, as well as obstacles encountered during the investigation and how these obstacles were overcome.

Chapter 9 presents the findings of the research. The findings are contextualised and explained in terms of the analytical model developed in Chapter 4. The theoretical context provided by the framework informs and enriches the interpretation of the findings. The process of linking the findings to theory also serves to contribute to the further development and refinement of the socio-behavioural approach to HIV-prevention.

Chapter 10 proposes recommendations, based on the findings, aimed at informing government, NGOs and CBOs in developing "tailor-made" community-specific initiatives and programmes towards effectively reducing the rate of HIV-infections in Thabong.

Chapter 2

SELECTED KAPB-STUDIES: FINDINGS AND CONCLUSIONS

2.1Introduction

Judging by the findings of specific so-called KAPB (knowledge, attitude, practice and belief-) studies about HIV/AIDS among various populations, it would appear that AIDS awareness initiatives are based on the Health Belief Model of behaviour change. This model assumes that increasing knowledge about a phenomenon will lead to appropriate behaviour change, which in this case would refer to sexual abstinence, appropriate condom use and/or mutual faithfulness in sexual relationships. This, however, has not been the case with HIV/AIDS. Although knowledge plays an important role, there are other factors that appear to override the influence of knowledge when making decisions about sexual behaviour. This chapter gives an overview of the main findings of selected KAPB-studies on HIV/AIDS among urban and rural men and women, as well as among teenagers/adolescents in South Africa with a view of substantiating the that knowledge about HIV/AIDS does apparently not lead to the adoption of safe sexual behaviour. At the same time, it tries to identify those factors that have a stronger influence than knowledge on decisions about sexual behaviour. This will serve as an introduction to Chapter 3, whereby an alternative approach to the Health Belief approach, namely the socio-behavioural approach, is proposed when exploring alternatives to HIV-prevention. This approach proposes a multidisciplinary perspective to exploring determinants of behaviour, in addition to knowledge, in an attempt to inform initiatives aimed at the prevention of HIV/AIDS.

2.2Main findings of KAPB-studies

KAPB-studies about HIV/AIDS point toward a relatively high level of knowledge among South Africans about HIV/AIDS in general. Findings of a national survey conducted in South Africa show that 97% of women aged 15 to 49 years are aware of HIV/AIDS, although their detailed knowledge of the disease is not high (Department of Health, 1998). This would indicate that information and awareness campaigns were relatively successful in their aim, namely to increase knowledge about HIV/AIDS. However, persistently high

levels of infection appear to indicate that this knowledge has found little reflection in sexual behaviour patterns.

Findings of selected KAPB-studies about STD/HIV/AIDS that were conducted among adolescents, adults, men and women in various communities in South Africa point towards the presence of factors, other than knowledge, that influence sexual behaviour. The following findings are illustrations in point:

- In a community in the Free State, a substantial number of black adults, who have a liberal attitude towards sex and sexuality, have not reconsidered nor adapted their behaviour despite their knowledge about HIV/AIDS (Fourie & Furter (a), 1998).

- The large majority of adults in South Africa know that HIV is transmitted through sexual intercourse and that transmission can be prevented by regular condom use, yet fail to apply their knowledge to their sexual practices (Geringer *et al., 1993)*.

- In a community in the Free State, school-going teenagers' moral reasoning and knowledge about sex, STDs and AIDS contradict their sexual behaviour. They say that religion plays an important role in their lives, thus giving them strong moral principles and beliefs. However, a large proportion of these teenagers become sexually active at a very young age and have multiple sex partners, despite knowledge about HIV/AIDS and the disapproval of sex before marriage (Fourie & Furter (b), 1998).

- School-going teenagers in a community in the Free State reported having between one and five "regular" sexual partners (Fourie & Furter (b), 1998). Young boys in Welkom (Free Sate) typically have three to four sexual partners, and young girls typically have one sexual partner at any given time, despite knowledge about STDs/HIV/AIDS (Van Rensburg & Heunis, 1999).

- A large proportion of adolescents in South Africa have experienced sexual intercourse by the age of sixteen, in some cases with several partners, despite the sanctioning of sexual intercourse in this age group (Attawell, 1998).

Based on the findings of KAPB studies, the apparent weak influence that knowledge about HIV/AIDS has on sexual behaviour in various communities and among various age groups in South Africa, can mainly be attributed to the following factors:

- **Social norms**

Sex is the norm among young people. They perceive sex as part of their repertoire of intimate personal relations and a natural progression to greater intimacy at their age (Attawell, 1998; Marcus, 2001).

- **Preferences**

Many young people, as well as adults, dislike condoms for various reasons such as the perception that condoms reduce sexual pleasure during sexual intercourse. Therefore, individuals will continue to have unprotected sex in exchange for enhanced sexual pleasure, despite knowledge about the risks of their behaviour.

- **Perceived low personal risk of infection**

It would appear that young people engage in unprotected sex knowing the risks involved, but are of the opinion that they will not be infected. Findings from a study conducted in Malawi shows that most young men and women know how HIV is transmitted and prevented. Yet 90% of teenage boys perceive themselves to be at no or minimal risk of infection. Nearly half of them reported having had at least one casual sex partner during the year preceding the study, and condom use is low (Attawell, 1998; UNAIDS & WHO, 1997). This is substantiated by the findings of South African studies referred to previously.

- **Gender-role stereotypes and financial vulnerability**

In many cultures, men are expected to provide material assistance to their wives or girlfriends. If they fail to do so, their girlfriends or wives are justified in having sexual intercourse with a man who will provide them with either money or rewards such as clothing in exchange, even though women's infidelity is sanctioned (McGrath *et al.*, 1993). Especially young girls engage in sexual intercourse at an early age for material gain or favours from sexual partners (Attawell, 1998). In this view, poverty and limited economic opportunity definitely contribute to the increase in HIV-infection rates since sex becomes a sustainable livelihood opportunity for those most vulnerable, namely women.

- **Gender-related power imbalances**

Especially young girls ascribe their engagement in sex at a young age and having unprotected sex to low self-efficacy (self-control) by women regarding their sexual

behaviour. Reasons for women engaging in sexual intercourse at a young age include coercion and violence from sexual partners (Attawell, 1998). The low rate of condom use among women can also be attributed to a sense of powerlessness and lack of personal control in women's sexual relationships with men (Wohl *et al.*, 1998).

These factors that influence decision-making about sexual behaviour will be elaborated upon and explored in detail in Chapter 3. A theoretical framework based on a multidisciplinary perspective of sexual behaviour, will be developed as an extension of the Health Belief Model. This will provide the theoretical and analytical framework for the empirical phase of this study.

2.3Conclusion

Findings of selected KAPB-studies of STDs/HIV/AIDS in South Africa point towards a high level of knowledge about HIV/AIDS (Attawell, 1998; Dockrell & Joffe, 1992; Fourie & Furter, 1998). However, despite high levels of knowledge about HIV/AIDS in the general population, levels of HIV-infection remain high. The apparent discrepancy between high levels of knowledge about HIV/AIDS and persistently high levels of HIV-infection prompt the need to explore determinants of sexual behaviour other than knowledge in developing effective and efficient prevention measures. Chapter 3 aims to achieve this by adopting a multidisciplinary perspective to explore determinants of behaviour that appear to bare more weight than knowledge in sexual decision-making. An understanding of these personal and contextual motivational and influencing factors should reveal why people continue to engage in high-risk sexual behaviour, thereby exposing them to the risk of HIV-infection. This, in turn, will provide valuable insights that can inform the development of prevention initiatives.

Chapter 3

PERSPECTIVES ON DETERMINANTS OF BEHAVIOUR

3.1 Introduction

HIV/AIDS awareness initiatives are based on the Health Belief Model to decision-making in sexual relations. It rests on the assumption that increasing knowledge about HIV/AIDS will result in an increase in safe sexual practices, namely that the rate of HIV-infection will decrease because people will change high-risk sexual practices once they know about the risks associated with unsafe sex. Instead, the findings of these KAPB-studies point towards the presence of complex socio-cultural and motivational factors that interact with knowledge when decisions about sexual practices/behaviour are made.

This chapter proposes an alternative approach to HIV-prevention and behaviour change, namely a socio-behavioural approach. The socio-behavioural approach adopts a multidisciplinary perspective to understanding sexual behaviour. Three perspectives of behaviour, namely psychological, sociological and anthropological perspectives, are used to analyse sexual behaviour with a view of explaining the intricate relationship between various influencing factors of manifest sexual behaviour.

3.2 Towards a multidisciplinary analytical framework of sexual behaviour

In developing a multidisciplinary analytical framework of sexual behaviour, three perspectives of behaviour will be analysed in terms of their relevance to sexual behaviour. These perspectives point towards behavioural motivations (i.e., Maslow's hierarchy of basic human needs), attitudes (salient beliefs and evaluations of consequences of specific behaviour) and perceptions of behavioural expectations of significant others as influencing factors of sexual behaviour. However, because individuals function within a social environment, the culture-specific environment in which behaviour is shaped is also regarded in analysing sexual behaviour. These various considerations proposed by the three perspectives (psychological, sociological and anthropological) that have been selected to develop an analytical framework of sexual behaviour also propose models that explain the process of behaviour change, such as the attitude accessibility model and the

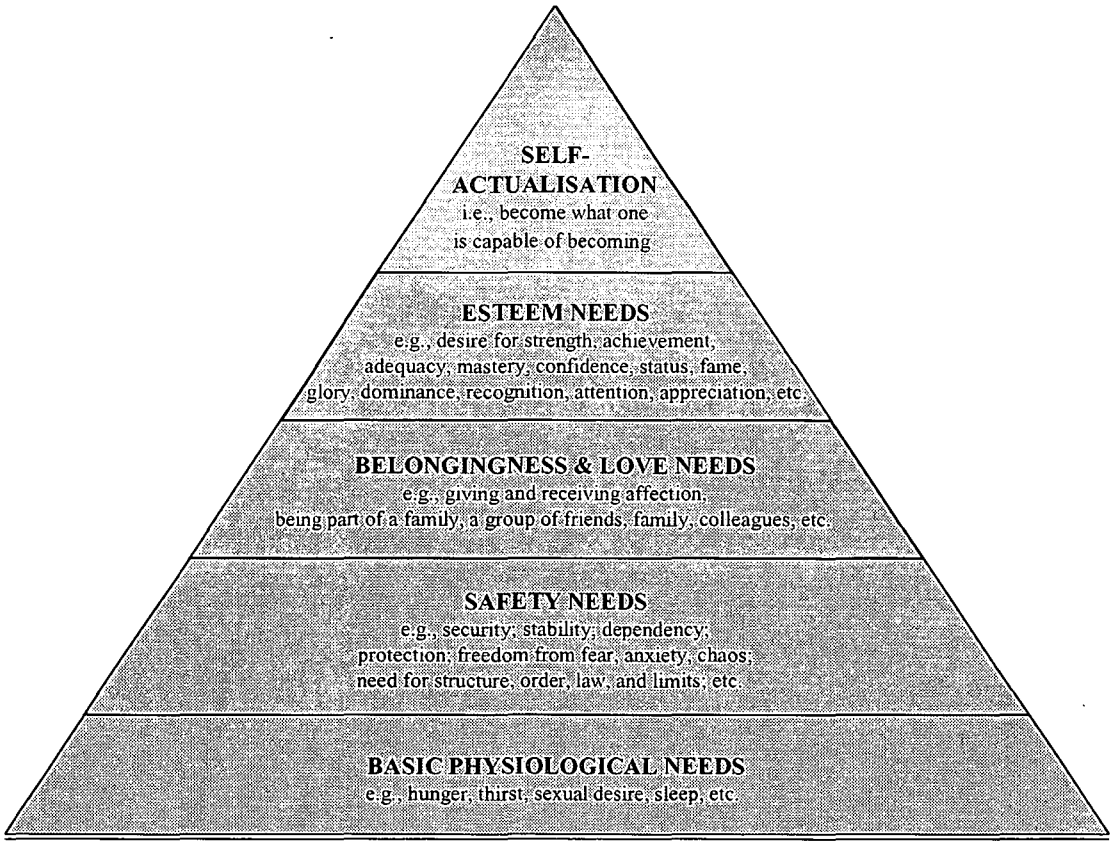
theory of reasoned action. These models will be incorporated into the multidisciplinary theoretical framework aimed towards developing a multidisciplinary model to analyse sexual behaviour in the study population, leading to the development of effective and efficient HIV/AIDS-prevention.

3.2.1 A psychological perspective of behaviour

The psychological perspective of behaviour rests on the assumption that needs and motives best explain behaviour. According to this perspective, whether people engage in different behaviours to achieve the same goals or in the same behaviours to achieve different goals, the key to understanding behaviour lies within the purposes and motives that underlie and give rise to the behaviour (Cooper *et al.*, 1998). According to Maslow (1987), our everyday conscious desires are not as important in themselves as what their underlying meanings are. Upon deeper analysis, a common characteristic of these desires is that they are driven by certain goals or needs. These needs are perceived as the basis for behaviour and are referred to as basic human needs or the basis of human motivation.

Maslow (1987) presents these needs in a hierarchy of instinctoid needs categorised into five levels, namely basic physiological needs, safety needs, belongingness and love needs, esteem needs, and self-actualisation needs (Liebert & Spiegler, 1994). According to Maslow, lower needs, such as basic physiological needs (e.g. food and sex), exert a more powerful influence on behaviour than needs higher up in the hierarchy. Thus, the higher and less basic a need is in the hierarchy, the weaker its potential influence on behaviour. However, if basic needs on the lower levels are satisfied regularly, their influence over behaviour tends to weaken and the influence of needs higher up in the hierarchy tends to become stronger. Figure 1 contains an illustration of Maslow's Hierarchy of Needs.

FIGURE 1: Maslow's Hierarchy of Needs



Source: Maslow, 1987

Maslow's Hierarchy of Needs can be explained at the hand of the following example:

If an individual's needs for sex and food are satisfied, his or her behaviour will no longer be driven primarily by the need to satisfy hunger and sexual desire. Instead, he or she will be motivated by the next level of needs on the hierarchy, namely the need to belong and be loved. Once he or she feels as though they belong and they are loved, their actions will be driven by the next level of needs, namely to enhance their self-esteem. As soon as this need has been fulfilled, the individual will strive to attain self-actualisation, which is the highest level of needs on Maslow's hierarchy of needs. Throughout this process of moving up the hierarchy of needs, each level of needs must remain satisfied. If, somewhere along the line, a specific need is not appropriately fulfilled, that need will take the forefront and exert a stronger influence on the individual's behaviour than needs that are being met.

According to the psychological perspective, basic human needs motivate individuals to behave or act in a manner that will satisfy these needs. However, unlike animals that act on instinct, human beings have to learn behaviours that satisfy/fulfil basic human needs. Thus, when the need for sex arises, an individual cannot merely act on impulse and engage in sexual intercourse regardless of the circumstances and timing. As with other social behaviour, when to have sex, how to have sex, who to have sex with, etc., is learned through a process called socialisation (social learning of behaviour). Learning behaviour involves the acquisition of attitudes and subjective social norms about attitude objects (anything in the individual's social world). These acquired attitudes and subjective social norms guide and shape behaviour. This necessitates the exploration of the context and processes that shape attitudes and subjective social norms in order to better understand how behaviour is influenced and played out, and therefore to a sociological perspective of behaviour to supplement the psychological perspective.

3.2.2 A sociological perspective of behaviour

The psychological perspective of behaviour provides an individualistic view of behaviour, whereby the individual makes decisions based on knowledge, attitudes and subjective social norms about attitude objects. Attitudes, beliefs and subjective norms are learned, and this learning takes place in the social environment in which an individual functions. The sociological perspective provides insight into how the social environment in which behaviour is learned influences the formation of attitudes and subjective social norms.

Through socialisation, individuals learn behaviour that is positively reinforced by social norms and avoid behaviour that is negatively sanctioned by social norms. Norms refer to a large number of guidelines to action/behaviour which define acceptable and appropriate behaviour in particular situations (Haralambos & Holborn, 1991). Many attitudes and subjective social norms are largely determined by relevant groups in which the individual functions, such as family, friends, peers, work associates, etc. These groups shape the individual's norms by defining what is socially appropriate, acceptable or expected, and developing techniques and mechanisms such as social rewards, threats of punishment or various other pressures to ensure conformity to these norms (Zimbardo *et al.*, 1977). However, not every possible referent is relevant in shaping norms. Only the salient (most prominent) referents, or "significant others" in an individual's frame of reference, influence subjective social norms (Ajzen & Fishbein, 1980). This means that an individual's

behaviour is influenced by perceptions of behavioural expectations of those people that are most salient in his/her life. For example, an individual's attitudes towards condom use will be determined by his/her sexual partners, friends or parents.

The significant role that culture plays in shaping and influencing behaviour points towards the need for exploring this relationship in a more systematic way. Therefore, the third pillar of a multidisciplinary approach towards understanding this relationship is found in the anthropological perspective of behaviour.

3.2.3 An anthropological perspective of behaviour

Socialisation is a culture-specific process that occurs within a cultural system. Culture refers to the way of life of a group of people living and interacting with each other. Within this context, individuals learn the "rules, laws, and norms" of behaviour, and thereupon make cognitive choices about how to behave (Haralambos & Holborn, 1991). Thus, behaviour tends to be culture-specific and should be understood within the context of the culture in which it was learned (from an anthropological perspective).

The norms that guide and shape behaviour are determined by the members of a culture, and they vary from one culture to another. Some attitudes and values are so widely accepted in a culture that the members of that culture perceive them as truisms (i.e. obviously correct or appropriate) and contrary points of view are hardly ever presented or contemplated. The use or non-use of condoms in a "steady" relationship is one example of how norms surrounding specific behaviours vary from one culture to another. In many western cultures, the use of condoms in a relationship is viewed positively. It is associated with concern for the health and safety of another, which indirectly is an expression of strong positive feelings towards another individual. In other cultures, however, the use of condoms in a relationship is associated with negative attributes, such as mistrust, infidelity, disobedience, and loss of physical pleasure. Generally, among adults and adolescents in South Africa, condom use appears to be very low due to negative perceptions such as condoms being associated with casual sex, promiscuity, and health risks for women (Attawell, 1998).

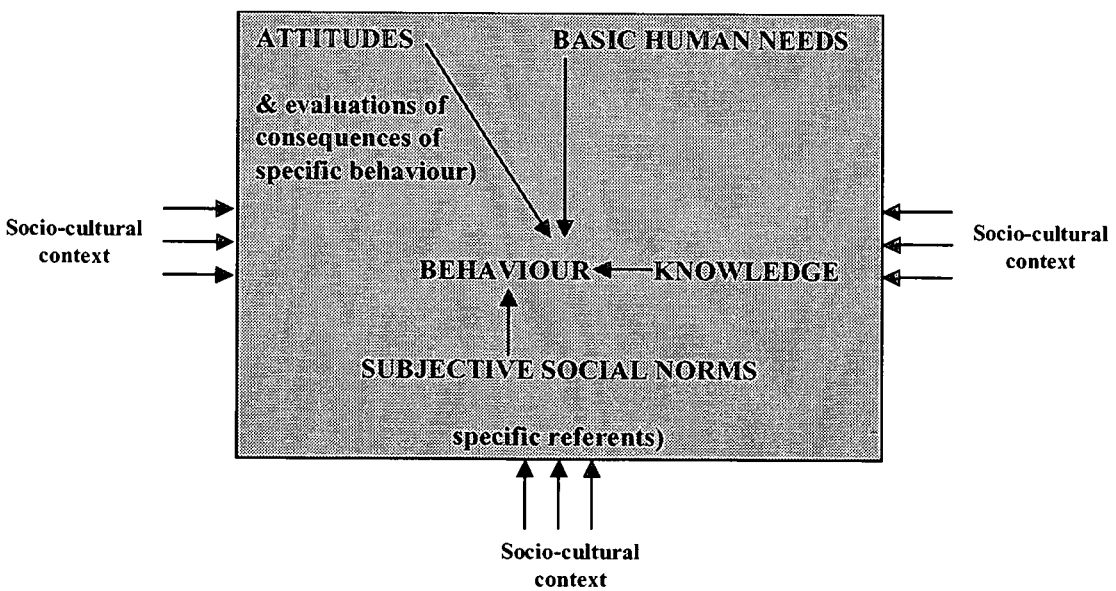
The multidisciplinary perspective of behaviour offers a comprehensive approach to understanding behaviour in general. This comprehensive approach of behaviour will be applied in the rest of this chapter to explore sexual behaviour in its relation to HIV/AIDS. This exploration is aimed at identifying specific factors that promote high-risk sexual

behaviour and impede the practice of safe sex (i.e. sexual abstinence, consistent and appropriate condom use and mutual faithfulness between sexual partners). However, the emphasis will be on condom use. Literature on findings of studies about condom use and HIV/AIDS is generally available. Also, based on the findings of this study, of the three forms of safe sex condom use is apparently regarded as the most feasible form of HIV-prevention.

3.3A multidisciplinary perspective of sexual behaviour

According to the multidisciplinary perspective of behaviour, basic human needs which serve as motivation for behaviour, attitudes which are function of salient beliefs and evaluations of consequences of specific behaviour, and subjective social norms which are perceptions about the behavioural expectations of specific referents, are important determinants of behaviour. Attitudes and subjective social norms are learned through the culture-specific process called socialisation. Therefore, attitudes and subjective social norms should be viewed and understood within the socio-cultural context in which they are learned. These determinants of behaviour need to be explored to understand the influence they have on sexual decision-making, which is the key to promoting safe sexual practices and the prevention of HIV/AIDS. These determinants of behaviour will subsequently be explored in the context of sexual behaviour.

FIGURE 2: Determinants of sexual behaviour



Each of these influencing factors of behaviour will subsequently be dealt with in relation to high-risk sexual behaviour.

3.3.1 Basic human needs and sexual behaviour

All behaviour is motivated by a need of some kind. As far as safe sex, and more especially condom use as a form of behaviour is concerned, a study among a group of African youths showed that they regard condoms as reducing sexual pleasure, feeling and sensation, with both male and females reporting that condoms hinder the experience of sex (Skinner, s.a.). What seems to be of importance is that the immediate gratification and satisfaction induced by sex is more important than the future threat of AIDS, despite knowledge that risk of infection is increased. The fact that high-risk sexual behaviours are resistant to change points strongly towards the presence of forces that promote and maintain these high-risk behaviours. These forces are described as sexual motives (Cooper *et al.,* 1998). Sex is one of the basic physiological needs in Maslow's hierarchy of needs. Thus, sexual motives form the basis of behaviour that is aimed at satisfying this basic physiological need.

In studies on sexual motivation, four categories of motives of behaviour are identified (Cooper *et al.,* 1998). These categories of motives include:

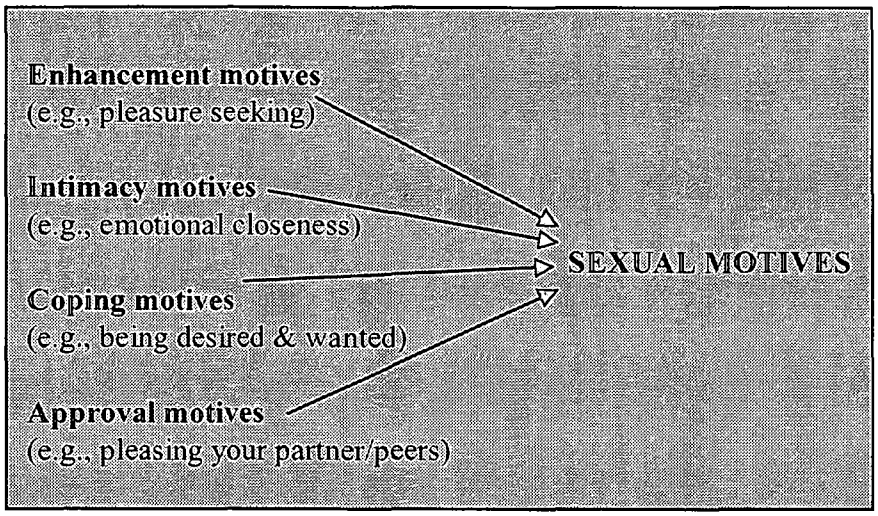
1. Enhancement motives – e.g., having sex to enhance physical or emotional pleasure;

2. Coping motives – e.g., having sex to cope with threats to self-esteem or to avoid/minimise negative emotions;

3. Intimacy motives – e.g., having sex to achieve intimacy with another;

4. Approval motives – e.g., having sex to avoid social censure or to gain another's approval.

FIGURE 3: The four categories of sexual motives



Each of the four categories of sexual motives is related to various high-risk sexual behaviours. An overview of each category in its relation to high-risk sexual behaviour will subsequently be provided to illustrate the relationship between motivations of behaviour and HIV/AIDS.

- **Enhancement motives**

Enhancement motives predict risky and indiscriminate behaviours, as well as negative outcomes associated with high-risk behaviours. Therefore, enhancement motives may predict more sexual contact and more high-risk sexual contact, because of the pleasure and excitement derived from such experiences. It may also impede the taking of preventative measures, such as condom use, because such precautions reduce the pleasure of a sexual encounter or because sex motivated by pleasure seeking is more likely to be unplanned (Cooper *et al.* 1998). Especially among young people, the concept of HIV-prevention in the case of serial monogamy does not compete with the need for sex, for which condoms is seen as a threat, nor for the desire for sexual pleasure (Skinner, s.a). In these instances, physical needs bear more weight than knowledge of protection against HIV-infection.

- **Intimacy motives**

Intimacy motives predict less high-risk behaviour in most cases, but also predict more frequent intercourse and less condom use within exclusive relationships that are not perceived as high-risk (Cooper *et al,* 1998). Generally, enhancement of emotional

intimacy between partners takes precedence over physical elements such as sexual pleasure, conquest and relief of sexual tension (Brigman & Knox, 1992; Leigh, 1989). Women, especially, engage in sexual intercourse to enhance closeness/intimacy between them and their partners, which could explain why woman often abandon the use of condoms in exchange for emotional intimacy.

- **Coping motives**

Coping motives are associated with a profile of high-risk behaviour, such as behaviours that might be termed "promiscuous", but this is not associated with failure to take precautionary measures. This could be because individuals who have sex primarily to regulate negative affect (emotions) are more likely to engage in planned sex, which is associated with adoption of preventative measures (Cooper *et al.*, 1998). However, coping motives are also positively related to high-risk practices only among unattached individuals (Cooper *et al.*, 1998). Females describe males as loosing control of their thoughts and actions, becoming confused (feelings that affect their minds) and becoming slightly "mad" when they are having sex. These feelings, in turn, are perceived by women as them being desired with overwhelming passion, and thus cause some women to feel relatively powerful. This feeling of being desired can affirm a young women's sense of identity, but ironically, it may also persuade some women to relinquish control over sexual encounters (Collins & Stadler, 2001). Again, it would appear that individuals, especially women, would compromise using a condom to protect themselves against HIV-infection, to feel desired and wanted, and for a sense of identity.

- **Approval motives**

Individuals engage in sexual intercourse for social approval and thus to acquire a sense of belonging. Although approval of the social network of the individual is important, approval of specific referents in the individual's life bear more weight in influencing an individual's sexual practices. *Approval* motives can be divided into partner-approval motives and peer-approval motives. Partner-approval motives, namely, having sex to please one's partner is primarily associated with failures to take precautions. This suggests that individuals' who are highly motivated to please their partners sexually, may find it difficult to assert themselves in sexual situations. The need to please one's partner is stronger than the need to please oneself or for self-assertion, leading individuals to compromise their own happiness and sometimes health for the satisfaction derived from seeing their partner happy. This even applies in the practice of safe sex, whereby a

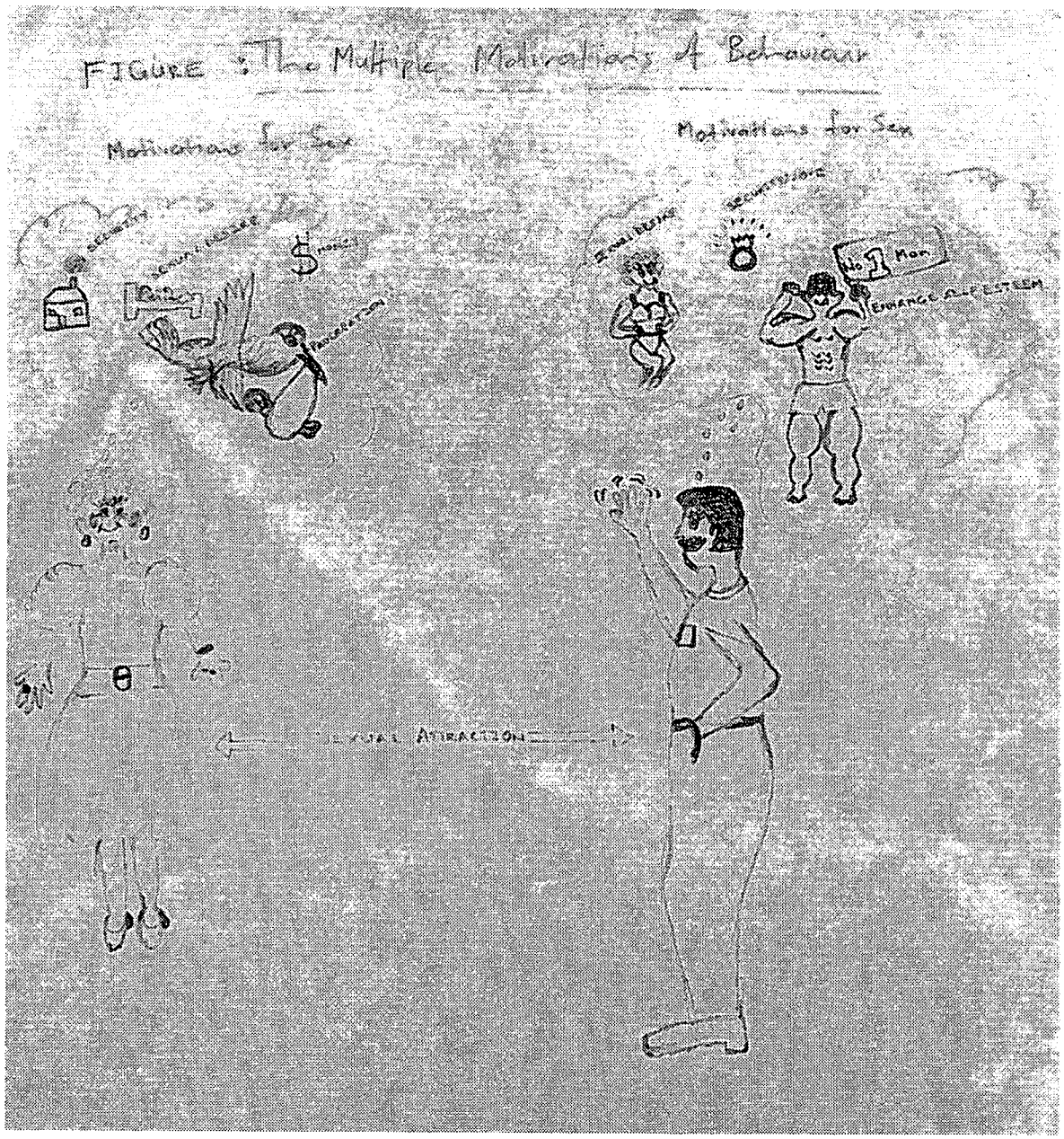
partner that is motivated by partner-approval motives will not insist on practising safe sex in a relationship so as to keep his/her partner happy and satisfied. However, interaction analyses indicate that partner-approval motives predict less high-risk behaviour among unattached individuals than among their coupled counterparts. The pattern of effects for peer-approval motives, namely, older age at first intercourse, less frequent intercourse, and fewer partners suggests that having sex for these reasons is associated with lack of experience rather than with less risk taking per se (Cooper *et al.*, 1998).

Although behaviour may appear to be motivated by a specific need, more often than not, it is motivated by more than one need at various levels of Maslow's Hierarchy of Needs.

- **The multiple motives of behaviour**

Behaviour is usually motivated by needs at more than one level, which Maslow (1987) refers to as multiple motivations. Behaviour, then, tends to be determined by several or all of the basic needs simultaneously rather than only by one need. For example, sex generally fulfils more than merely physiological needs such as the need for sexual release, but also other basic needs, such as safety needs, belongingness and love needs, and esteem needs (e.g., to convince oneself of one's sexuality, to feel powerful or to win affection). Furthermore, the same behaviour may be motivated by different needs in different individuals. For example, some people engage in sexual intercourse to fulfil esteem needs, such as sex as a conquest or to assure oneself of one's masculinity/femininity, while some engage in sexual intercourse to fulfil safety needs, such as a desire for closeness, friendliness, security or love (Maslow, 1987; Liebert & Spiegler, 1994). It can thus be concluded that needs do not necessarily determine behaviour, but serve as a strong motivation for overt behaviour/action. In this view, needs form the basis for action to take place.

FIGURE 4: The multiple motives of sexual behaviour



A study by Cooper *et al.* (1998) on sexual behaviour suggest that interventions aimed at fostering "safe" sexual behaviour should, as a first step, understand the functions and purpose served by sexual intercourse, since these functions could hold the key to explaining why individuals engage in unsafe sexual behaviour. The limited success of HIV-preventive efforts to change high-risk sexual behaviours is partially attributed to the over-reliance of these efforts on health-oriented models of sexual risk-taking behaviours, such as the Health Belief Model. These models tend to overlook the fact that sexual

behaviour, risky or safe, serve a range of psychological functions that have little to do with maintaining good health and avoiding diseases (Cooper *et al.*, 1998).

3.3.2 Attitudes and subjective social norms as determinants of behaviour

Ajzen & Fishbein (1980) define an attitude as an index of the degree to which a person likes or dislikes an object. An object refers to any aspect of the individual's world.

Attitudes are formed through social learning and personal experience, and because social learning takes place within a socio-cultural context, attitudes are a reliable determinant and predictor of an individual's overall pattern of behaviour. Since attitudes are perceived as a reliable determinant of behaviour, this study will examine the relationship between attitudes and behaviour to understand how attitudes influence behaviour, more especially sexual behaviour.

Although motives are a relatively strong predictor of sexual behaviour, they also provide a rather simplistic explanation for individuals engaging in high-risk sexual behaviours. The sexual motivational approach more strongly explains psychological motivations for sex per se (including frequency of intercourse, number of partners, and high-risk practices) than for precaution adoption (including use of condoms and abstinence) and negative outcomes (including HIV and other STDs). It also fails to take adequate account of other influencing factors such as the socio-cultural context in which the individual functions.

An individual exists within a social setting that is characterised by social and cultural norms, as well as consequences resulting from adherence and non-adherence to those norms. Thus, individual behaviour is not only shaped by the need to satisfy predispositional and trait like psychological needs and motives, as suggested by the sexual motivational approach of behaviour. Attitudes play an equally significant role in influencing behaviour, including the practice of low-risk sexual behaviour.

How attitudes are formed, types of attitudes, components of attitudes, and how the strength of an attitude is determined will be discussed first, with a view to give background knowledge of the nature of attitudes. In doing so, a more explicit understanding of how attitudes influence behaviour proceeding the acquisition of knowledge, especially in the practice of low-risk sexual behaviour, will be developed (Baron & Byrne, 1994).

(i)How attitudes are formed

Attitudes are formed either through the direct observation of the behaviour of others, or they can be acquired directly through personal experiences (Baron & Byrne, 1994). In other words, people can directly experience the consequences of their own behaviour or they can see how other people's behaviour is followed by specific consequences. So, an attitude object may be associated with a rewarding state of affairs and thus acquire positive affect (emotion/feeling), or if a person's specific behaviour is frequently followed by positive reinforcement, that person's attitudes may then develop to give justification to his behaviour (Baron & Byrne, 1994; Zimbardo *et al.*, 1977; Triandis, 1971).

Attitudes acquired through personal experience are stronger than those acquired through social learning (classical conditioning, instrumental conditioning and modelling). Social learning refers to the process of acquiring new forms of behaviour, including attitudes, by observing or interacting with others (Baron & Byrne, 1994). However, in general, very few of our attitudes are learned through direct experience. For a person to influence another, they should be trustworthy, attractive and powerful. So, at the most critical point in time in the formation of attitudes, a child's parents possess these three characteristics, and thus are the main influences on attitude formation. Later in life, the teenager's peers become more attractive and thus are the main influences in attitude formation. Even later in life, the mass media and even teachers may exert the biggest influence in attitude formation (Triandis, 1971).

FIGURE 5: How attitudes are formed through direct observation

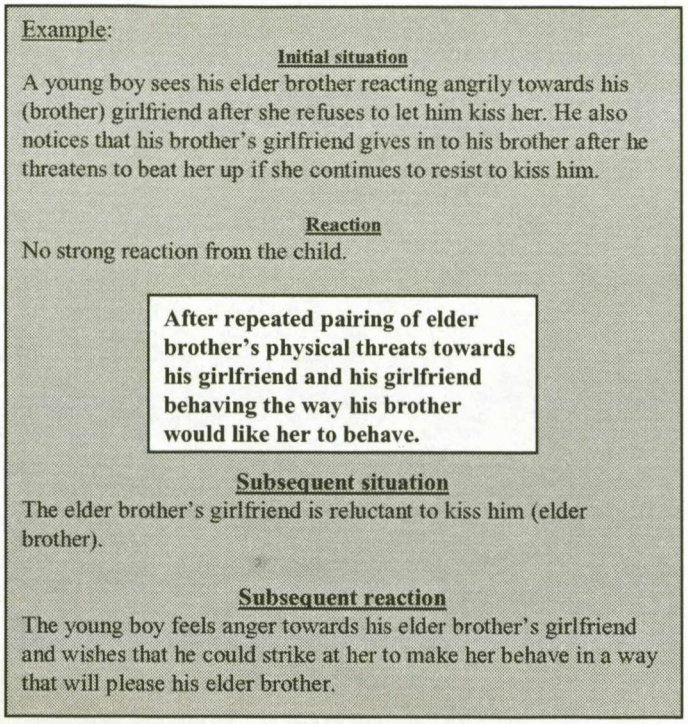
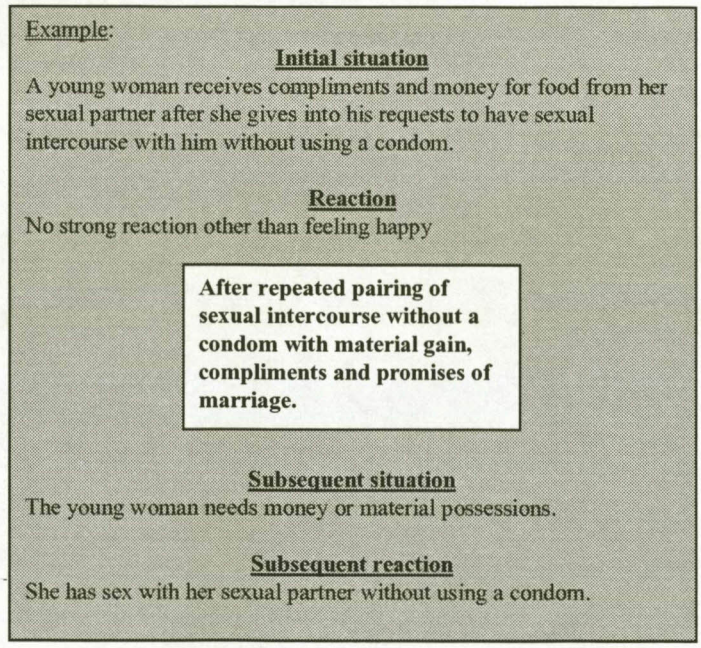


FIGURE 6: How attitudes are formed through personal experience



(ii) Types of attitudes

According to Baron & Byrne (1994), there are two types of attitudes, namely **specific attitudes** and **general attitudes**. The type of attitude determines the degree to which that attitude will influence behaviour. Consider, for example, an individual who derives physical pleasure and emotional and economic stability from having sexual intercourse (a specific attitude) and he/she opposes violence against women (a more general attitude). Will the specific attitude or the more general attitude be more strongly related to the individual's actual behaviour? If the individual enjoys the physical pleasures and emotional and economic stability brought about by engaging in sexual intercourse, the chances are very high that they will engage in such behaviour frequently. Thus, their behaviour in such situations is highly predictable from their attitude. Now consider their opposition to violence against women. The individual probably does not take every opportunity to protest such violence, such as take part in every demonstration or sign every petition relating to this important issue. As a result, their actions cannot be predicted accurately from their general attitude about violence against women. Although the individual may feel that opposing violence against women is a more important issue than engaging in sexual intercourse, his/her specific attitude toward sexual intercourse may well be a better predictor of their overt actions than their more general attitude about violence against women (Baron & Byrne, 1994).

This may explain why people who are inundated with messages about the risks posed by unsafe sexual behaviour, such as unprotected sex and having more than one sexual partner, continue to engage in unprotected sex with more than one sexual partner. If the benefits of engaging in sex with more than one partner and not using a condom (e.g. financial security or material gain) is more relevant to an individual's life than the issue of HIV/AIDS and STDs (e.g. the individual has no knowledge of having had an STD and does not know anyone who is HIV-positive), his/her behaviour is more likely to be influenced by his/her attitudes towards sexual intercourse (specific attitude) than his/her attitudes towards HIV/AIDS and STDs (general attitude).

Also, people can be pro-HIV/AIDS-prevention (general attitude) in terms of wearing the symbolic ribbon in support of the fight against AIDS yet perceive condoms as having a negative effect on their sexual pleasure (specific attitude). Will the general attitude or the specific attitude be more likely to predict this individual's sexual behaviour? It can be assumed that the individual's attitude towards condoms (specific attitude) is a better predictor of his/her sexual behaviour.

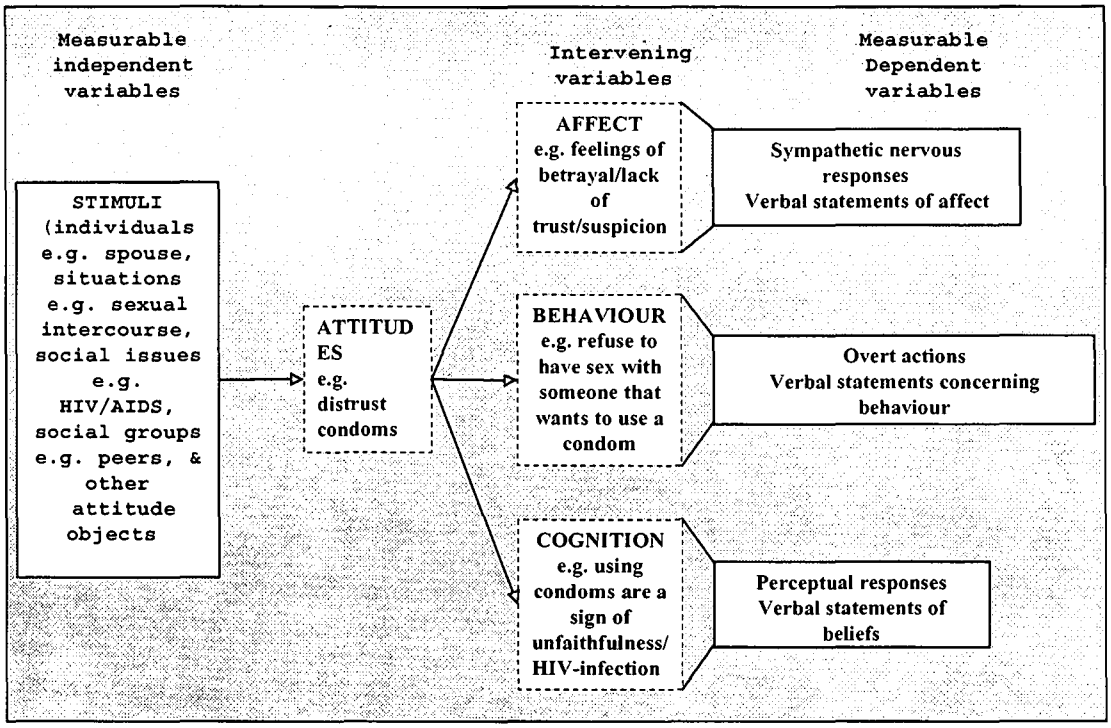
Specific attitudes, therefore, are better predictors of behaviour than general ones because of the direct relevance of specific attitudes to an individual's behaviour. It is important that interventions aimed at changing negative attitudes toward safe sexual practices take the specificity of attitudes toward such behaviours into account in order to implement programmes that will yield the desired results in their target group.

(iii) Components of attitudes

Triandis' (1971) definition of attitudes as "an idea charged with emotion which predisposes a class of actions to a particular class of social situations" suggests that attitudes have three interrelated components, namely a cognitive, affective and behavioural component. This notion is supported by other theorists such as Zimbardo *et al.* (1977; Zimbardo & Ebbesen, 1970).

The cognitive component, which refers to various forms of knowledge, is described by the person's categorisations and the relationship between his/her categories. The affective/evaluative component, which refers to feelings or emotions, is described by the way the person evaluates the objects in a particular category, and the behavioural component reflects behavioural intentions of the person toward the objects included in a particular category. The interrelationship between the three components of behaviour is illustrated by Rosenberg & Hovland's (Triandis, 1971; Ajzen & Fishbein, 1980) schematic representation of the three-component view of attitudes.

FIGURE 7: The three-component view of attitudes



Source: Triandis 1971; Ajzen & Fishbein 1980

Example:

The following example is an illustration of the three-component view of attitudes (cf. Fig 7):

A woman meets a man that she is interested in starting a sexual relationship with. They have been dating for a few months and she would like to become more intimate with him (affective component) and strengthen their relationship by engaging in sexual intercourse with him (cognitive component). However, she is concerned about the risks of being infected with HIV through sexual intercourse without the use of a condom (cognitive component). She also knows that some men associate condoms with lack of trust and promiscuity (cognitive component). Although, she would like to protect herself from HIV-infection, she is afraid that her suggestion to use a condom when having sex with this potential partner may result in him changing his feelings towards her (affective component). Therefore, she has to decide whether to start a sexual relationship with this man without the use of a

condom and risk being infected with HIV, or insist on the use of a condom and risk her relationship with this potential partner (behavioural component).

It often occurs that the affective and cognitive components are inconsistent. For instance, the affective component may be very positive, while the cognitive component is not so favourable. When this inconsistency occurs, the component that is more closely related to specific forms of behaviour will be the best predictor of behaviour (Baron & Byrne, 1994).

Example:

A young girl is enticed into a sexual relationship by a boy that she has very strong feelings for. He has told her that sex is an expression of their love for each other and their trust in each other. She "loves" this boy very much (affective component), but she knows that sexual intercourse will expose her to STDs and pregnancy (cognitive component). Which of these components will exert a stronger impact on the young girl's behaviour or is a better predictor of her behaviour?

According to Baron & Byrne (1994), when an individual is in the presence of the object of his/her affections, the affective/evaluative component is a better predictor of actions than the cognitive component. Thus, in the case of the young girl in the above example, her strong feelings for the boy (affective component) will probably predict her actions to a greater degree than the cognitive component (exposure to STDs and pregnancy). Baron & Byrne (1994) also add that, when the object of affection is not present, the cognitive component may be a better predictor of your behaviour.

Compartmentalisation, which refers to a defensive weakening of the link between the cognitive, affective and behavioural components, is another strategy utilised by individuals when confronted with new information that is inconsistent or incompatible with the individual's motives or existing attitudes. This entails either rejecting or "putting in a deep freeze" the new incompatible information so that it does not interfere with the existing integration of attitudes (Triandis, 1971). This can be observed when sexually active individuals who are not practising safe sex are confronted with information about the risks of their high-risk HIV sexual behaviour. They tend to either ignore this information by adopting beliefs that are contradictory to the information about the risk of their behaviour (e.g. believing that condoms do not prevent HIV-infection, but instead are the cause of HIV-infection). These defence mechanisms used to deal with information that is

incompatible with one's sexual practices will be discussed in Chapter 9, namely as the findings of this study.

(iv) Strength of an attitude

As in the case of motives, a specific behaviour or action may be the product of various different attitudes, and a given attitude may influence a variety of behaviours in different ways (Zimbardo *et al.*, 1977). The degree of influence that attitudes have on behaviour depends on the strength of attitudes in relation to that behaviour, namely how intensely they are held, how salient they are to the person holding them, and how central or peripheral they are to other attitudes and values that form a cluster or syndrome (Zimbardo *et al.*, 1977).

The strength of an attitude is determined by direct or indirect experience, vested interest, and self-awareness. Attitudes acquired through direct experience are much stronger than ones acquired through observation, because direct experience with the attitude object usually change all three of the components of attitudes. Indirect experience, on the other hand, tends to change the cognitive or behavioural components, since they are usually informational or normative (Baron & Byrne, 1994; Triandis, 1971). Also, when the attitude object, that is an event or issue in question, has a strong effect on a person's life the attitude toward the attitude object will thus be stronger and will predict overt behaviour more accurately.

Example:

The following example illustrates the link between the strength of an attitude and manifest behaviour:

One woman has been raised in a family with very specific gender-role norms that stipulate that a woman's role in a family is to satisfy her husband and always put his happiness before her own, while a man's role is to provide a woman with all the material amenities she requires.

Another woman has been raised to believe that she should always live her life according to what she believes is the right way to do so. She has been taught that she should not always abide to societal norms, even if it implies subjecting herself to criticism and condemnation from family, friends and peers.

When predicting each of the above women's behaviour regarding their assertiveness in their sexual relations, one can safely predict that the former woman

is less likely to be assertive towards sexual partners regarding sexual matters, whereas the latter woman will. Also, the former woman is more likely to adhere to socio-cultural norms about sexual behaviour than the latter, even if both women do not necessarily feel comfortable about these norms.

Furthermore, strong self-awareness, which is the extent to which individuals focus on their own attitudes and actions (reflection), increases the degree of consistency between privately held attitudes and manifest behaviour (Baron & Byrne, 1994).

In the former section, a theoretical overview and analysis of attitudes has been given. The latter section will provide a practical overview of the process of behaviour change, with particular reference to sexual behaviour and HIV/AIDS. The attitude accessibility model and theory of reasoned action will be used to explain the relationship between attitudes, subjective social norms and behaviour in making decisions about sexual practices.

3.4Theories of behaviour change

A number of theories attempt to explain behaviour and the behaviour change process. There are four commonly cited behaviour change theories in HIV-prevention literature. These include the **Health Belief Model**, the **AIDS Risk Reduction Model**, the **Stages of Change Model**, and the **Reasoned Action Model**. Although these theories make valuable contributions in explaining how and why people change their behaviours, the former three do not take account of environmental and economic factors, social norms and peer influences, and socio-cultural issues that influence and limit an individual's behaviour choices and ability to take action (Denison, 1996).

This study will focus on two models that explain the relationship between attitudes, subjective social norms and behaviour, namely, Ajzen & Fishbein's (1980) **reasoned action model** and Fazio's (Baron & Byrne, 1994) **attitude accessibility model**. These two models of behaviour change will be dealt with within the context of the multidisciplinary perspective of behaviour, whereby the influence of the socio-cultural context in which behaviour is played out is considered. These two model appear to take into consideration the influence of the social environment on sexual decision-making.

3.4.1 Attitude accessibility model

Fazio (Baron & Byrne, 1994) describes attitude accessibility as the ease with which specific attitudes can be retrieved from memory and brought to consciousness where they can influence or guide behaviour. The attitude accessibility model describes the process involved in behaviour change. It emphasises the importance of bringing specific attitudes to consciousness where they can influence behaviour and the very important role played by self-awareness to increase accessibility of attitudes.

Fazio's attitude accessibility model identifies three steps in how attitudes influence behaviour.

Step 1: Attitudes are activated, namely, they are retrieved from memory by presentation of the attitude object or stimulus.

Step 2: Attitudes influence the perception of the attitude object and the situation in which it is encountered.

Step 3: Perceptions influence subsequent behaviour toward the attitude object.

The attitude accessibility model thus proposes that the strength of the association (in memory) of an attitude object and its evaluation determine whether specific attitudes are activated. The stronger the association, the more readily activated is an attitude and thus the stronger the effects on subsequent behaviour (Baron & Byrne, 1994).

As discussed in the section about the three components of attitudes and the influence of specific and general attitudes on sexual behaviour, people can experience a conflict in attitudes about a specific attitude object. For example, an individual may have positive attitudes about protecting himself/herself from HIV-infection. Yet, the same individual may have negative attitudes towards using a condom with his/her sexual partner due to fear of losing his/her sexual partner to someone else who is willing to have sex with him/her without a condom. Thus, although an individual may have positive attitudes towards safe sex, these attitudes can be overshadowed by situational factors.

Self-awareness increases accessibility of attitudes. The stronger self-awareness the easier it is to bring attitudes to the conscious mind, therefore the greater the possibility that they will affect behaviour. Self-awareness can bring specific attitudes more sharply

into focus, thus allowing them to guide overt behaviours in situations where overt behaviour is required or needed (Baron & Byrne, 1994).

Strengthening self-awareness involves a process of stopping for a moment to assess self-identity and beliefs (reflection) before action is taken. This will increase the likelihood of overt behaviour or subsequent action being influenced by existing attitudes and less likely by situational factors. This illustrates the pivotal role that attitudes play in influencing behaviour.

A breakdown of the composition of attitudes has been provided (cf. Par 3.3.2) for the purpose of giving background knowledge about attitudes in relation to behaviour. The rest of the chapter is an operational overview of the process of behaviour change, with specific reference to sexual behaviour, based on the theory of reasoned action within the context of the multidisciplinary perspective of sexual behaviour.

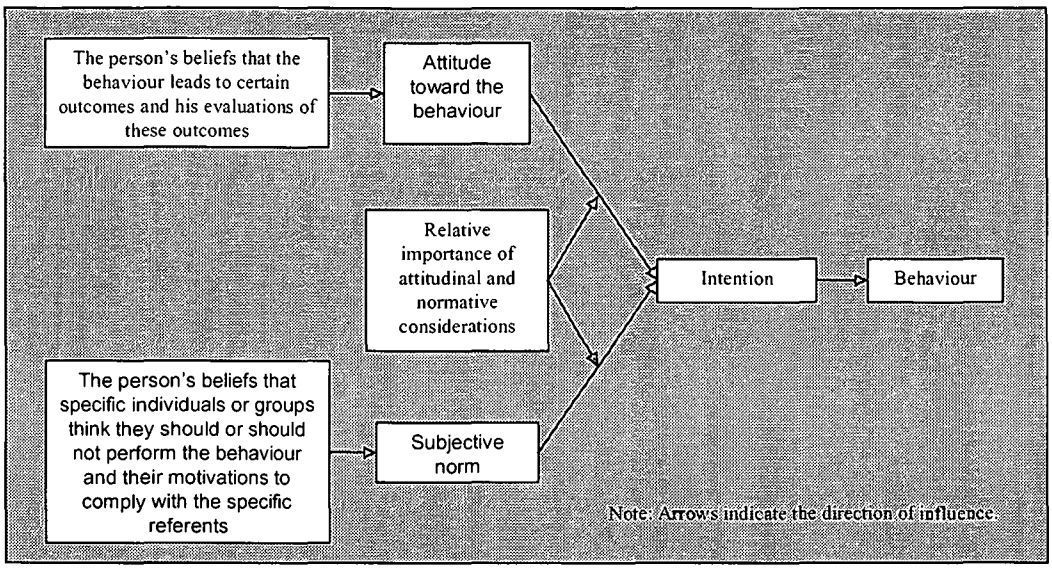
Based on the multidisciplinary perspective of behaviour that has been discussed so far, sexual behaviour is influenced by individual behavioural motives, referred to as sexual motives, that motivate individuals to adopt specific sexual practices that satisfy basic human needs. Maslow's theory on motivation for behaviour assumes that there must be a motive for behaviour (individuals do not act without a reason). These motives for behaviour are derived from basic human needs that have a biological basis, and which must be satisfied or fulfilled. However, this theory fails to explain the complex process involved in choosing behaviour that will satisfy various needs. The sociological perspective of behaviour acknowledges that individuals live within a social environment, whereby behaviour is influenced by the social norms that govern behaviour in that environment. However, because social norms are culture-specific, the anthropological approach to behaviour emphasis the importance of cultural norms in governing behaviour. Thus, the decision-making process leading to a specific behaviour does not merely involve choosing a behaviour that will satisfy a specific need (individualistic approach), as assumed by Maslow's theory. Attitudes and subjective social norms, which are learned through socialisation determine which behaviour will satisfy specific human needs. This decision-making process involves choosing behaviour that is consistent with socio-cultural norms, i.e., choosing behaviour that is socially acceptable and avoiding behaviour that is socially sanctioned.

3.4.2 Theory of reasoned action

Ajzen & Fishbein's (1980) theory of reasoned action emphasises the relationship between highly specific attitudes, subjective social norms, intentions, and behaviours (Jammott & Jammott, 1991; DiClimemte & Peterson, 1994). It is based on the assumption that human beings are rational and make systematic use of the information available to them when making decisions (Ajzen & Fishbein, 1980). According to this theory, human social behaviour is not controlled by unconscious motives or overpowering desires, but rather that individuals consider the implications of their actions before they decide to engage or not to engage in a specific behaviour.

According to the theory of reasoned action, behaviour is the result of a specific intention and a specific intention is perceived as being determined by the attitude toward the specific behaviour (an individual's positive or negative evaluation of performing the behaviour) and the subjective social norm regarding that behaviour (an individual's perception of the social pressure put on them by significant others to perform or not perform the behaviour in question). Attitudes and subjective social norms, in turn, are seen as a function of underlying cognitive structures, namely beliefs. More specifically, attitudes toward behaviour are seen as reflecting salient beliefs (behavioural beliefs) about the consequences of performing the act and evaluations of these consequences. Subjective social norms, on the other hand, are then seen as a function of perceptions (normative beliefs) of what specific referents (significant others) think should be done regarding the behaviour and motivation to comply with these referents (Jammott & Jammott, 1991; DiClimente & Peterson, 1994; Ajzen & Fishbein, 1980). In summary, behavioural intentions predict an individual's behaviour, and behavioural intentions are predicted from (a) an individual's attitudes toward that behaviour, and (b) subjective social norms (perceptions of what significant others think one should do) (Engelbrecht, 1997).

FIGURE 8: The theory of reasoned action



Source: Azjen & Fishbein, 1980.

The theory of reasoned action has been applied to understand various high-risk behaviours, such as smoking and contraception utilisation. Findings of studies that have applied the theory of reasoned action to high-risk sexual behaviour, namely condom use, will subsequently be discussed as far as it is relevant to HIV/AIDS and to the findings of this study.

- **The theory of reasoned action and condom use**

Jammott & Jammott (1991) tested the applicability of the theory of reasoned action to condom use among women by hypothesising that (a) women who express more favourable attitudes toward condoms will report stronger intentions to use condoms than will women who express less favourable attitudes, and (b) women who perceive subjective norms more supportive of condom use will report stronger intentions to use condoms than will their counterparts who perceive subjective norms less supportive of condom use. Other goals of the study were to examine beliefs that might be related to attitudes toward condom use and to identify the key sources of normative influence.

The above study was conducted among a group of sexually active, unmarried black women undergraduates from an inner-city community university in the United States of America, who had a high degree of AIDS knowledge. The results of the study provided

strong support for the theory of reasoned action. The results revealed that women who expressed more favourable attitudes toward condom use and those who perceived greater support for condom use among their significant referents reported stronger intentions to use condoms in the following three months. In this study, women's attitudes were stronger determinants of intentions to use condoms than their perceptions of normative support among key referents (Jammott & Jammott, 1991). However, it is important to note that, whether attitudes or subjective norms is the most important determinant of behavioural intentions, depend on the particular behaviour and the particular population that is studied (Fishbein & Middlestadt in Jammott & Jammott, 1991; Ajzen & Fishbein, 1980; DiClimente & Peterson, 1994).

Also suggested by the findings of the study is that beliefs about the effects of condoms on sexual enjoyment are pertinent to condom use. Women who believe more strongly that sex is more fun when a condom is used and who believe less strongly that sexual intercourse does not feel as good if a condom is used, express more favourable attitudes toward using condoms. Such attitudes, in turn, are related to intentions to use condoms (Jammott & Jammott, 1991). Some women perceive condom use as reducing sexual pleasure, feeling and sensation (Skinner, s.a.). Both women and men express a need for "flesh to flesh" with some women stating that they want to feel a man's sperm inside them, and condoms rob them of this sensation (Skinner, s.a.). According to Jammott & Jammott (1991), these results may suggest that interventions to increase condom use among women should attempt to modify the women's perceptions of diverse effects of condoms on sexual enjoyment by, for example, teaching them ways to eroticise the use of condoms. Such an approach may even reduce resistance to use condoms among the women's sexual partners.

Analyses of subjective norms reveal that women's sexual partners, as well as their mothers and fathers are key referents with respect to condom use. Their parents are perceived as referents who are very supportive of condom use, whereas their sexual partners are perceived as referents who are least supportive of condom use (Jammott & Jammott, 1991). It is warned, however, that this does not mean that the women's sexual partners are chief barriers to condom use because attitudinal influence is in actual fact stronger than normative influences. These results reinforce the importance of taking into consideration the predominant motivational factors, namely attitudes or norms, in understanding the relationship between behavioural intentions and behaviour. Understanding this relationship may be of particular value to interventions that aim to

change specific behaviours, such as the non-use of condoms among perceived high-risk individuals.

The theory of reasoned action may be applied to other forms of low-risk HIV sexual practices such as sexual abstinence and mutual faithfulness between sexual partners. However, sexual abstinence is not well accepted, neither is mutual faithfulness well practised in many communities (based on findings of studies about sexual behaviour and HIV/AIDS, including this study), thus consistent and appropriate condom use appears to be the most effective form of safe sex. The effective practice of all three forms of safe sex (sexual abstinence, mutual faithfulness between partners and consistent use of condoms) are hindered by various socio-cultural and socio-economic factors, which will be discussed in detail in the findings of this study (Chapter 9).

According to the findings of studies about HIV/AIDS and sexual behaviour that have been discussed thus far, obstacles to the effective practice of safe sex appear to be largely based on socio-cultural norms that dictate gender-roles and gender relations within a given social environment. Thus, norms play an integral role in influencing attitudes, which in turn determine behaviour. Some of these obstacles have already been identified in the findings of KAPB-studies about HIV/AIDS in Chapter 2 of this report. These obstacles to the practice of safe sex will be elaborated on and discussed in detail in Chapter 9 of this report, which constitutes the findings of this study.

The influence of the socio-cultural environment in which sexual behaviour is learned and played out will be discussed for purposes of illustrating the relationship between norms and manifest sexual behaviour.

3.5The influence of socio-cultural context on sexual behaviour

3.5.1 The relationship between cultural norms, sexual behaviour and HIV/AIDS

Taking the role of cultural norms in shaping behaviour into consideration is particularly important to interventions that strive to change high-risk behaviours, such as high-risk HIV/AIDS sexual practices. Studies about HIV/AIDS and sexual behaviour suggest that cultural norms are at the root of many women's failure to integrate the affective, cognitive and behavioural components of their attitudes so as to produce consistency between their sexual attitudes regarding safe sex, and their actual sexual behaviour. This is apparent in

the sustained fear of HIV-infection by women, despite their attempts to reduce risk of infection. This fear stems from a cultural value, common in many social groups, that deems it acceptable (permissible) for men to have multiple sexual partners. Women, thus, perceive themselves at risk of infection despite their own behaviour change, namely, remaining faithful to one partner (McGrath *et al.*, 1993).

3.5.2 The relationship between gender-role norms and self-efficacy regarding sexual practices

Self-efficacy refers to an individual's perceived control over his/her behaviour. Women bear the burden for self-protection against sexually transmitted diseases. It is difficult for women, especially those that are poor and of a minority status who are at greatest of HIV-infection, to insist on adopting self-protective measures in the face of emotional and economic dependence, coercive threat, and sub-cultural prescription of compliant roles for women. Women who are well equipped with condoms run the risk of being viewed as promiscuous, which creates a further impediment to self-protection (Bandura, 1994).

Studies about sexual behaviour and social norms suggest that sexual norms in many poor minority communities prevent women from initiating safer sex practices. Sexual behaviour among adolescents and adults is generally determined by expectations and gender role norms, whereby, women are expected to play a passive role while men make all sexual decisions. These decisions include the nature and timing of sex, which leave women with little or no opportunity to protect themselves against HIV and other STDs. Even those women who have generally high levels of HIV/AIDS awareness show little evidence of change in their sexual behaviour. This is attributed to factors that prevent women from discussing or practising safer sex, poor communication between partners about sexual issues, and male reluctance to use condoms (DiClimente & Peterson, 1994; Attawell, 1998). Norms and values regarding status and power in sexual and social relationships often condition the ability of individuals to change traditional patterns of sexual relations, and also restrict the introduction of innovative behaviours into sexual relationships, that may reduce the risk of HIV-infection (McGrath *et al.*, 1993).

A study of the cultural determinants of sexual behaviour and risk of HIV-infection in urban Uganda revealed that cultural norms permitting males to have multiple partners limit a woman's ability to control her risk reduction. Women in that study report women's infidelity as one of the most common reason for a man to leave his wife, but it is less common for a wife to leave her husband because of his extramarital affairs. This is

attributed to the cultural norm that deems it acceptable, even expected, for men in that culture (Baganda) to have multiple sexual partners (McGrath *et al.*, 1993). Furthermore, findings of that study made three very important conclusions, namely that HIV-risk reduction can only be achieved if both partners change their sexual behaviour accordingly, and that knowledge alone about AIDS is not sufficient to achieve change in sexual behaviour because sexual behaviour is linked to economics, gender relations, and other complex socio-cultural factors. Findings of the above study in Uganda are echoed by many communities in various parts of South Africa, including the target population for this study. These findings are discussed in detail in Chapter 9.

In essence, the normative influences that foster preventive measures centre on behavioural practices through which HIV is transmitted and on the cultural patterning of social relationships. The interpersonal influences within an individual's immediate social network have a stronger regulatory function on behaviour than do general normative sanctions due to their proximity, immediacy and prevalence (Bandura, 1994). This could explain why norms embedded in HIV/AIDS awareness messages are overpowered by norms about sexuality and safe sex that characterise peer groups.

3.6Conclusion

It is apparent from a psychological stance of behaviour that instinctoid needs motivate behaviour. In other words, an individual will be inclined to behave in a way that will satisfy a need or needs that he/she feels. For example, if an individual feels hungry, he/she will eat to satisfy the need for food. Likewise, if an individual feels unloved and alone, he/she will behave in a way that will make them feel loved and feel that they belong. However, individuals cannot merely act to satisfy these instinctoid needs whenever the need arises. Decisions pertaining to how and when to satisfy these needs are dependent on attitudes and subjective social norms regarding the acts of satisfying these needs. Therefore, attitudes and social norms form the basis upon which the decision to perform or not to perform a specific behaviour is made. Attitudes are, however, not inherent, but are acquired or learned within a social setting, in which they are formed and shaped. This social setting consists of cultural norms which govern behaviour through positive reinforcements and negative sanctions. It is this "learned" nature of attitudes that contributes to the difficulty of changing high-risk sexual behaviour. If a specific behaviour is repeatedly reinforced positively by socio-cultural norms, it is difficult to change that behaviour.

For instance, the decision-making process pertaining to condom use occurs within the context of an individual's social relationships and lifestyle, and the decision to use or not to use condoms is influenced by various factors such as age, gender and cultural differences regarding sexuality and gender-role relations (DiClemente & Peterson, 1994). This renders the decision-making process pertaining to safe sexual practices a complex matter, which is more likely to be understood by taking into consideration the existence of these multiple influences and the interaction between them.

Behaviour, then, seems to be primarily motivated by instinctoid human needs, but the intention to exert a specific behaviour (choice of behaviour) is determined by acquired attitudes (function of beliefs about consequences of behaviour) and subjective social norms regarding the behaviour. These, in turn, are culture-specific. Based on this assumption about behaviour, behaviour should be understood as a function of the interaction between inherent biological motivations (basic human needs that motivate behaviour) and attitudes and subjective social norms that are shaped and determined by the socio-cultural environment in which behaviour takes place (such as gender role norms and other culture-specific norms). Therefore, many obstacles to changing high-risk sexual practices can be understood in the context of norms and values that influence sexual behaviour within a specific social group.

Chapter 4

A MULTIDISCIPLINARY ANALYTICAL AND EXPLANATORY MODEL FOR SEXUAL BEHAVIOUR

4.1Introduction

Based on the multidisciplinary perspective of behaviour as presented in Chapter 3, this chapter proposes an analytical model of how behaviour is determined, with specific reference to sexual behaviour. It takes account of motivations for behaviour, as well as the socio-cultural context in which attitudes and subjective social norms are formed, which subsequently determine manifest behaviour. This model was applied in developing the research instruments for this study, as well as in analysing and interpreting the findings.

4.2A multidisciplinary analytical model of behaviour

Based on the multidisciplinary perspective (psychological, sociological and anthropological) of behaviour, as well as the attitude accessibility model and reasoned action model, as discussed in Chapter 3, the following steps are identifiable in the decision-making process leading to manifest behaviour:

Step 1:

The individual has one or more human needs that need to be satisfied. These needs serve as motives for the individual to engage in a specific behaviour that will serve the function of satisfying the specific need or needs. These motives can either be intimacy motives, enhancement motives, coping motives or approval motives (cf. Par 3.3.1)

Step 2:

The individual has a specific behavioural intention, namely how he/she intends to satisfy the specific need or needs. This behavioural intention is derived from attitudes towards the specific behaviour and subjective social norms regarding this behaviour, which have been acquired through the process of socialisation (social learning of behaviour). The attitudes towards the specific behaviour are a function of salient beliefs about the behaviour and evaluations about the consequences of this behaviour. Subjective social norms, in turn, are a function of perceptions of

behavioural expectations of significant others (specific referents). Salient beliefs, evaluations of consequences of behaviour and perceptions of behavioural expectations of significant others are derived from the cultural context within which the individual has been socialised and the social context within which behaviour is played out.

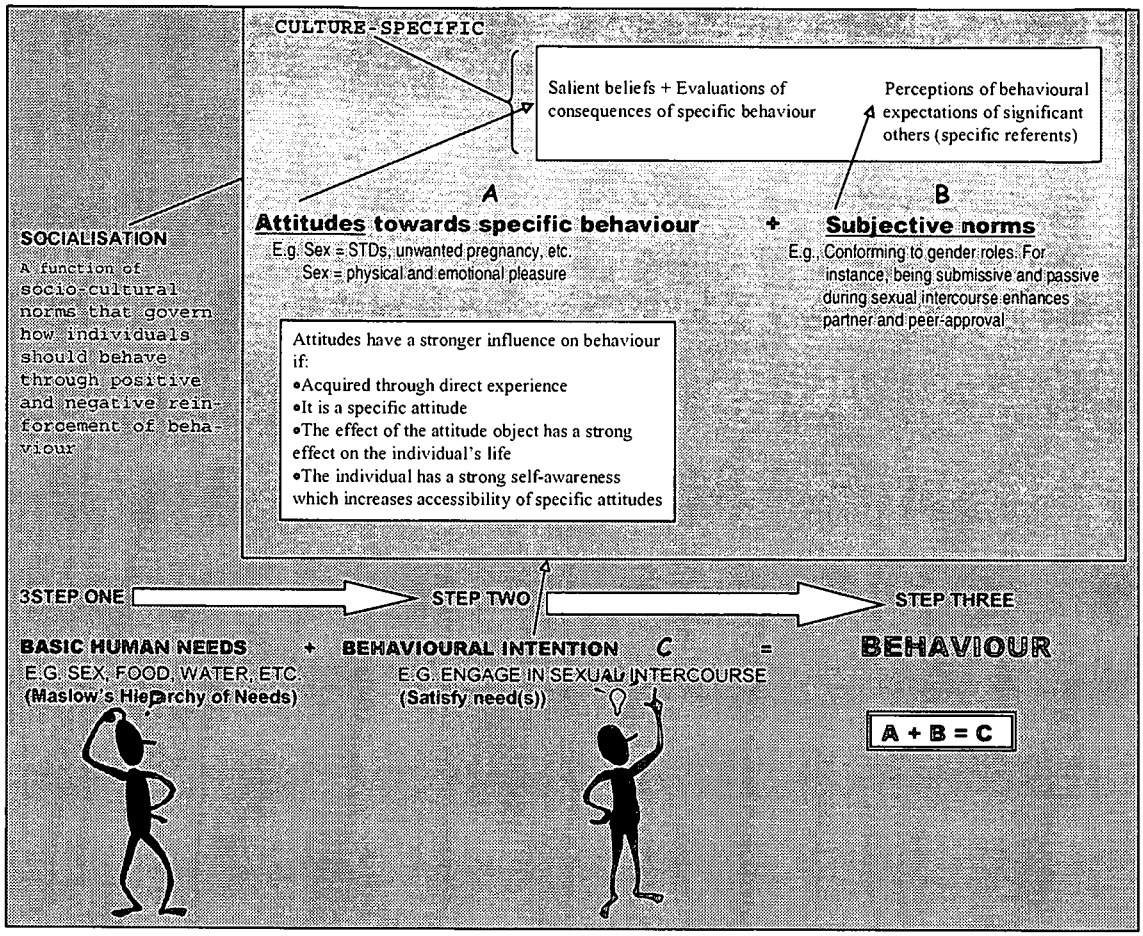
Step 3:

The individual performs a specific behaviour based on step 1 and 2.

4.3Conclusion

This multidisciplinary analytical model of behaviour does not exhaust all determinants of behaviour. However, based on a multidisciplinary perspective of determinants of behaviour and on models of behaviour change that are consistent with a multidisciplinary perspective of behaviour, it incorporates the most apparent and probably the most important factors in the decision-making process leading to overt action/behaviour (cf. Fig 9). Especially with regard to sexual behaviour, it incorporates the most prominent and important influencing factors in sexual decision-making.

FIGURE 9:A multidisciplinary analytical model of behaviour



SECTION TWO

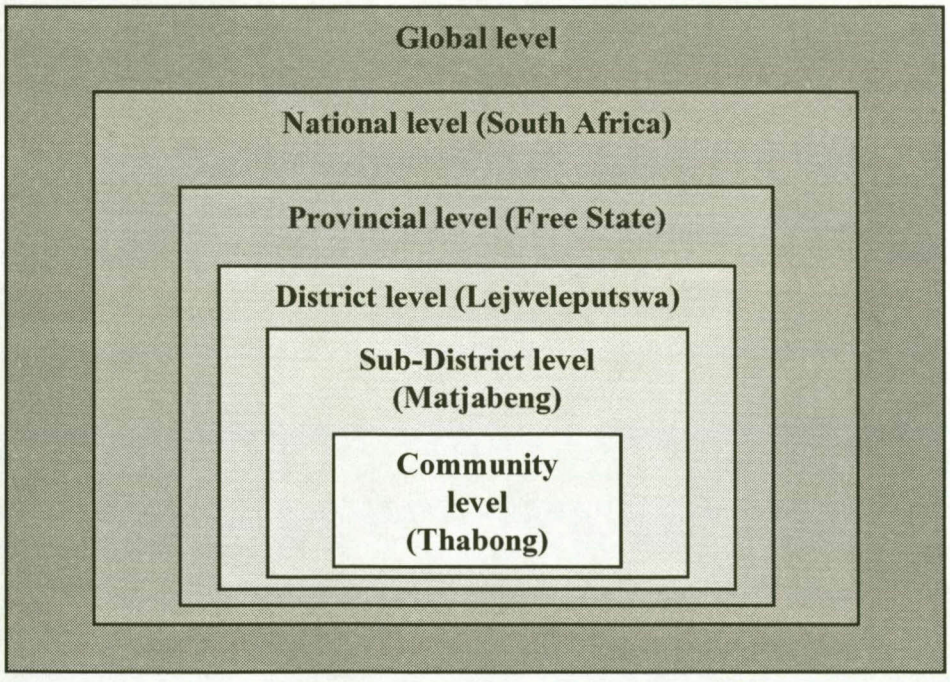
Chapter 5

BACKGROUND: THABONG/WELKOM WITHIN THE GLOBAL HIV/AIDS CONTEXT

5.1 Introduction

This chapter places Thabong/Welkom within the global and national HIV/AIDS context. It serves to illustrate the severity of the epidemic in this area and so supports the geographical focus of this study. It also provides a conceptual framework for the understanding and interpretation of the results of the study. A comparative overview of the incidence and prevalence of HIV/AIDS is provided. Future projections about the disease and the impacts of the disease on the study population are also dealt with.

FIGURE 10: Incidence, prevalence and impact of HIV/AIDS: Levels of contextual analysis



5.2Regional HIV-estimates

HIV/AIDS has become an obstacle to sustainable development in developing countries and its destructive powers are evident in all societies, more especially those in sub-Saharan Africa. It is estimated that 34.3 million adults and children worldwide are already infected with HIV, and that 24.5 million (71%) of these cases occur in sub-Saharan Africa. Of the 24.5 million people infected in sub-Saharan Africa, 23.4 million are adults (15-49 years) and 12.9 million (55%) of these adults are women (UNAIDS, 2000). In most parts of the world, the majority of infections are in young people between the ages of 20 and 29 years (Adler & Qulo, 1999).

Estimates of HIV-infections vary considerably. However, countries with the highest adult infection rate in sub-Saharan Africa in 1999 included Botswana (35.8%), Swaziland (25.25%), Zimbabwe (25.06%), Lesotho (23.57%), South Africa (19.94%) and Namibia (19.54%) (UNAIDS, 2000). These countries appear to be the worst affected by the epidemic.

5.3National HIV-estimates

A breakdown of HIV-incidence and prevalence in South Africa is given by age, gender and geographical area to give a comprehensive profile of the epidemic across the broader population. This is aimed towards highlighting the most affected and most vulnerable people to HIV-infection in the South Africa.

In South Africa, HIV prevalence in the general population increased from less than 1% in 1990 to almost 23% in 1998 (Adler & Qulo, 1999). An estimated 4.2 million adults and children are infected in South Africa, of which 2.3 million are adult women (15-49 years), 1.9 million are adult men (15-49 years), and 95 000 are children (0-14 years)(UNAIDS, 2000; Grimwood *et al.*, 2000). It is estimated that in the absence of effective interventions, the rate of infection will increase with 550 000 cases every year (Adler & Qulo, 1999).

A slight stabilising in the infection rate was observed for 1999. However, this does not necessarily indicate a decrease in infections, but rather a decline in fertility rates as women became increasingly ill due to HIV/AIDS and the birth rate of infected babies decreases (SAIRR, 2001).

Throughout, prevalence is estimated to be about 25% lower among men than among women, and women are six times more likely to be infected than their male counterparts. Thus, women in general are most vulnerable to HIV-infection in any given population. In other words, more women will suffer from HIV-related illnesses and ultimately die because of AIDS.

In South Africa in 1998, the HIV-prevalence rate for young people between the ages of 20 and 29 years was close to 27%. The prevalence among women younger than 20 years increased by 65% between 1997 and 1998 (Adler & Qulo, 1999). However, there appears to be a decrease in the infection rate among girls aged 15 - 19 years. This rate decreased from 21% in 1998 to 17% in 1999. In 1999, women aged 20 to 29 years had the highest HIV prevalence rate (26%) (SAIRR, 2001). Based on these trends of HIV-prevalence, it can be deduced that women aged 20 to 29 years are most vulnerable to HIV-infection.

What these figures imply is that up to one in three people in their economically active and reproductive years will suffer from an AIDS-related illness, many of whom will die within the next ten years.

5.4Provincial HIV-estimates

In South Africa, HIV-prevalence and the increase in the HIV-infection rate vary from one province to the other. KwaZulu-Natal has the highest HIV-prevalence rate (36.2%) of the nine provinces. By 2010, the proportion of the adult population with AIDS in the most severely affected provinces will reach 2.2% to 2.6% (Grimwood *et al.*, 2000). Table 1 shows a breakdown of provincial HIV-prevalence rates in 2000, estimated from the HIV-prevalence of women attending public antenatal clinics.

TABLE 1: Provincial HIV-prevalence rates (2000)

Province	*Prevalence rate*
KwaZulu-Natal	36.2%
Mpumalanga	29.7%
Gauteng	29.4%
Free State	27.9%
North West	22.9%
Eastern Cape	20.2%
Northern Province	13.2%
Northern Cape	11.2%
Western Cape	8.7%
All South Africans	22.4%

Source: Department of Health, 2000

The Free State has the fourth highest HIV-prevalence rate (27,9%), but the lowest HIV-infection rate of all the provinces.

5.4.1 HIV/AIDS on a district level

The Free State constitutes five District Councils (DC), which were previously six Health Regions, namely, Region A, Region B, Region C, Region D, Region E and Region F. Provincial and district HIV/AIDS estimates refer to the former Health Regions rather than the newly demarcated District Councils. Thus, HIV-prevalence rates for the Free State, in this report, are presented according to the former Health Regions. Region C refers to the current District Council 18, in which the research community (Thabong) is situated. The boundaries of the previous Regions have changed slightly with the demarcation of the new District Councils, thus the report will make use of the former Regions to compare HIV-estimates.

Of the 6 Regions in the Free State, Region C (now DC 18) has always been in the lead with the HIV-prevalence rate over the years. This trend is illustrated by table 2.

TABLE 2: HIV-prevalence rate for Regions in the Free State for 1997 to 2000 (%)

Region	*1997*	*1998*	*1999*	*2000*
Region A	17,61	23,98	26,88	29,77
Region B	Statistics for Region B are unavailable because it was excluded from the survey conducted by the Department of health due to the small sample of first antenatal visits.			
Region C (DC 18)	26,60	25,75	31,68	30,63
Region D	17,70	21,03	28,16	21,93
Region E	18,87	21,34	27,52	26,78
Region F	17,50	21,26	27,66	26,14

Source: Department of Health, 2000

Between 1997 and 2000, Region C has consistently had the highest HIV-prevalence rate of all the health regions in the Free State. In 2000, HIV was most prevalent in the age group 20 to 24 years in this Region. Table 3 gives a breakdown of HIV-prevalence rates according to age as point in illustration.

TABLE 3: HIV-prevalence in Region C (DC18) according to age group

Age group	*HIV-prevalence rate (%)*
<20 years	11,95
20 – 24 years	26,42
25 – 29 years	23,27
30 – 34 years	23,27
35 – 39 years	10,69
40 – 44 years	3,77
45 – 49 years	0,63

Source: Department of Health, 2000

Statistics of HIV-prevalence rates lower than a District level were not available for this study. Therefore, the HIV-prevalence rates for Matjabeng (sub-District of Lejweleputswa in which the research population is situated), as well as Thabong/Welkom (research population) are not included in this report.

5.5Future projections of HIV/AIDS in South Africa

5.5.1 HIV-prevalence and mortality

It is projected that, by 2005, the total number of people infected with HIV in South Africa will be 6 million. The total number of AIDS-related deaths should be 250 000 p.a. by 2002, and could reach one million p.a. by 2008 (Grimwood *et al.,* 2000). AIDS will soon be the main cause of death among adults in the economically active age groups. Already, the death rate in the general population has increased from 11/1000 to 14/1000 between 1980 and 1996. This is largely attributed to HIV/AIDS.

5.5.2 Population size and structure

Birth rates are expected to decline due to deaths among people in their prime reproductive years, as well as reduced fertility of HIV-infected women (Grimwood, 2000). It is projected that HIV/AIDS will cause a decline in the South African population growth rate, from 1.9% in 2000 to below 1% in 2004. Birth rate is expected to then decline to zero in 2011 (SAIRR, 2001). Thus, in the absence of HIV/AIDS, the South African population would have been expected to grow from 43.7 million in 1999 to 51.3 million in 2010, but due to HIV/AIDS it is expected to reach only 47 million in 2010 (Grimwood *et al.,* 2000).

Table 4 gives a breakdown of the South African population by province in 2000, with and without additional AIDS-related deaths (SAIRR, 2001).

TABLE 4: Projected population growth rate in South Africa with and without accounting for HIV/AIDS

Province	With additional Deaths from HIV/AIDS		Without additional deaths from HIV/AIDS		Decrease in population size from HIV/AIDS
	Number	Proportion of total	Number	Proportion of total	Number
Eastern Cape	6 811373	15.7%	6 847 162	15.7%	35 789
Free State	2 760 558	6.4%	2 790 733	6.4%	30 175
Gauteng	7 780 631	18.0%	7 873 205	18.0%	92 574
KwaZulu-Natal	8 857 615	20.5%	8 986 857	20.6%	129 242
Mpumalanga	3 004 916	6.9%	3 042 637	7.0%	37 721
North West	3 532 824	8.2%	3 566 777	8.2%	33 953
Northern Cape	869 248	2.0%	872 866	2.0%	3 618
Northern Province	5 495 679	12.7%	5 514 807	12.6%	19 128
Western Province	4 178 598	9.7%	4 190 656	9.6%	12 058
South Africa	**43 291 441**	**100%**	**43 685 699**	**100%**	**394 258**

SAIRR, 2001

Due to AIDS-related deaths of people in their reproductive years, the population profile is also expected to change. There will likely be more children and elderly who are less economically productive and who have lower fertility rates, and fewer economically productive people with higher fertility rates. Furthermore, it is estimated that average life expectancy will decrease from 60 years to 40 years, and that infant mortality will rise from 50 per 1000 to over 60 per 1000 between 1998 and 2008 as a result of HIV/AIDS (Adler & Qulo, 1999; SAIRR, 2001).

5.6The impact of HIV/AIDS

HIV/AIDS has grave social and economic impacts on all sectors of society and it appears to have the potential to destroy not only economic and development gains, but also the social fabric and attempts at nation-building (Whiteside, 2000). AIDS is a large impediment to economic empowerment and skills development because it renders individuals unproductive and ineffective. Thus, it diminishes a community's chances of improving its socio-economic status and ultimately prospects of eradicating poverty.

Chapter 6

THABONG/WELKOM: A DEMOGRAPHIC AND GEOGRAPHIC PROFILE

6.1Introduction

This chapter serves as an introduction and orientation to the study population. It provides a descriptive analysis of demographic, geographic and specific socio-economic aspects of Thabong and Welkom at large.

6.2Demographic and geographic features of Lejweleputswa (District Council 18)

The former six Free State Regions (Regions A to F) referred to in Chapter 5 are now 5 District Councils (DC). This chapter will refer to the newly demarcated DCs since the most recent demographic and geographic data available is reported for DCs rather than Regions. Welkom is one of 18 towns in Lejweleputswa (DC18), which is one of 5 District Councils (DC) in the Free State Province. Lejweleputswa is further segregated into 5 "clusters", namely, Masilonyana (FS181), Tokologo (FS182), Tswelopele (FS183), Matjhabeng (FS184) (within which Welkom/Thabong is situated) and Nala (FS185). Matjhabeng (FS184) has the most number of wards (36) and towns (6) and the largest population (110 725) of these clusters. The total geographical area of Matjhabeng is 5 155 square kilometres, which makes it the second smallest of the clusters in geographical size. Table 5 gives a breakdown of demographic and geographic features of Lejweleputswa (Municipal Demarcation Board, s.a.).

TABLE 5: Population Size of Lejweleputswa (DC18) – Free State

	Masilonyana	*Tokologo*	*Tswelopela*	*Matjhabeng*	*Nala*
Number of towns	5	3	2	6	2
Number of wards	10	4	7	36	12
Number of households	15 031	6 627	11 373	110 725	18 474
Total population size	65 882	26 784	51 656	476 927	82 176
Geographic size	6 796km²	9 325km²	6 523km²	5 155km²	4 128km²
DC18 TOTAL POPULATION:					**703 425**

Lejweleputswa is predominantly a mining area where, in some Local Municipality areas, the mining population constitutes over 60% of the total population. Mining communities usually contain of significant numbers of migrant workers and commercial sex workers, the latter being attracted by the large population of migrant workers. Both miners and commercial sex workers are at a high risk of HIV-infection. Sex workers are at high-risk because of their many sexual partners, and mineworkers because they have a few opportunities for entertainment and relaxation, thus resorting to alcohol and sex (William *et al.,* 2000).

A study among mine hostel dwellers in South Africa found that approximately one third of the respondents admitted to having had sex with sex workers and casual partners, but only 15% reported that they consistently use condoms (William *et al.,* 2000). Furthermore, South Africa's well-developed transport infrastructure facilitates the spread of HIV to other parts of the country including the home countries of the migrant workers, who go home to their families at regular intervals. Another study conducted in South Africa found that women whose husbands are migrant workers are at higher risk of HIV-infection than women whose husbands are not migrant workers (William *et al.,* 2000).

6.2.1 Terrain and road conditions of Matjhabeng (FS184)

Matjhabeng consists of both urban and rural settlements. The urban areas include mines, industries and smaller settlements, whereas the rural areas consist mainly of large commercial and irrigation farming communities. The main roads in Matjhabeng are tarred, while there are gravel roads in the rural settlement areas.

6.2.2 Water source, sanitation and electricity supply of Matjhabeng (FS184)

Water and sanitation is supplied by Sedibeng Water Board. Rural areas mainly make use of bore holes for their water supply, and in underdeveloped areas such as Hani Park (Thabong/Welkom) people have to walk long distances to obtain water from community taps. The majority of households make use of flush toilets, but in their absence pit and bucket latrines are used. Electricity is supplied by the Municipality and ESCOM. Electricity is fairly available in most areas, however, where there is no electricity, people make use of gas or paraffin.

6.3Demographic and socio-economic features of Welkom (Welkom, Thabong, Bronville)

6.3.1 Population size and composition

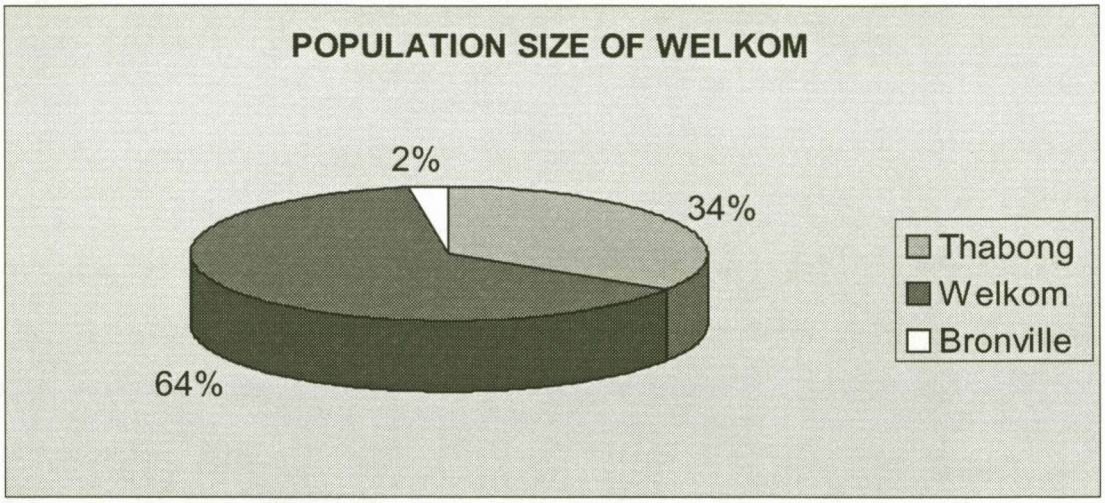
Welkom is one of six towns in Matjhabeng. It is sub-divided into three geographical areas, namely Welkom, Thabong and Bronville. Thabong is classified as a previously black township, Bronville as a previously coloured township and Welkom (town) as a previously white township, based on the Group Areas Act of the past apartheid regime. Since the abolishment of this Act, these three geographical are inhabited by various racial groups ("cosmopolitanised").

Table 6 represents the population size of Welkom by geographical area and gender (SAIRR, 2001).

TABLE 6: Population size of all three geographical areas of Welkom according to gender

Geographical Area	*Male*	*% of total population*	*Female*	*% of total population*	*Total*
Bronville	4 862	49.3	5 009	50.7	9 871
Thabong	66 149	49.2	68 360	50.8	134 509
Welkom	142 911	57.0	107 455	43.0	250 366
Total	213 922		180 824		394 746

FIGURE 11: Population size of the larger Welkom



6.3.2 Employment status of the larger Welkom (Welkom, Thabong, Bronville)

Table 7 gives an indication of employment and unemployment figures in Welkom (all three geographical areas). These figures point towards a large proportion of unemployment in the economically active population of Thabong. Therefore, it would imply that Thabong has a low socio-economic status and a high level of poverty due to high levels of unemployment.

TABLE 7: Employment status by geographical area in the larger Welkom

Geographical area	*Employed*	*% of population*	*Unemployed*	*% of population*	*Total*
Bronville	2 278	36.7	3 935	63.3	6 213
Thabong	33 043	38.0	53 671	62.0	86 714
Welkom	104 777	58.0	75 334	42.0	111

6.3.3 Age distribution of the population of Thabong

In South Africa, the rate of HIV-infection is highest among women between 20 and 29 years of age. It is estimated that 1 in 4 women in this age group are infected. It is also projected that 2 million children in South Africa will be orphaned by 2005. Life expectancy will decrease from 60 to 40 years by 2005. Table 8 presents the age profile of the population of Thabong. Based on the above projections and estimates of the impact of HIV/AIDS, one can roughly deduce what the implication are for the population of Thabong,

in terms of the section of the population that will be most affected by the AIDS epidemic. Namely, by 2005 31,9% of the population of Thabong (children 0-14 years) will be severely affected by the loss of both parents because of HIV/AIDS. Also by 2005, approximately 74% of the population of Thabong will have a life expectancy of 40 years compared to the current life expectancy of 60 years. Based on national HIV/AIDS estimates, of the 17,9% of the population of Thabong that is between 20 and 29 years of age, one in four women is HIV-positive.

TABLE 8: Age and gender distribution of Thabong

Geographical area	*<1Y*	*1 –14*	*15-19*	*20-29*	*30-39*	*40-49*	*50-59*	*60-69*	*70+*	*Total population*
Thabong	2 246	29 177	9 687	17 672	14 288	10 416	7 121	4 456	3 465	98 528

Source: ATICC (AIDS Training Information and Counselling Centre), 2001

6.4Conclusion

Thabong is a fairly large community but appears to have a low socio-economic status because of the high unemployment rate. The effect of unemployment and associated economic dependence on individuals, especially women's control over their sexual practices, makes Thabong particularly vulnerable to HIV/AIDS. More so, the fact that Thabong is largely a mining community increases the risk of HIV-infection in the population at large.

Chapter 7

HIV/AIDS-PREVENTION INITIATIVES IN THABONG

7.1Introduction

This chapter gives an overview of various initiatives embarked upon by government, CBOs and NGOs in a plight to reduce the rapid increase of HIV-infections across all social strata in Welkom. Initiatives specifically aimed at the community of Thabong will be dealt with for the purpose of relevance to the study. These initiatives will be viewed in terms of their aims, objectives, strengths and weaknesses.

7.2HIV/AIDS-prevention initiatives in Thabong

The HIV/AIDS directory for the Free State Province consists of a list of organisations involved in HIV/AIDS. It includes a description of the services that they provide, as well as their contact details. It was intended to include all organisations listed in the directory and that are involved in HIV/AIDS awareness in Thabong. However, most of the organisations listed are no longer in operation. Those that are still actively involved in HIV/AIDS awareness are included in the study.

The HIV/AIDS co-ordinator for Lejweleputswa (DC18) was approached for a list of organisations that are currently involved in HIV/AIDS awareness in Thabong. Representatives of these organisations were subsequently approached telephonically, electronically and via post, for information on their specific organisation. The information requested from them included background information of the organisation/initiative/project, their target population, their aims and objectives, their outputs, problems and obstacles to achieving their objectives (weaknesses), success stories (strengths), and the perceived impact of their initiative/project.

Some projects/initiatives have been up and running for a long period of time, whilst others are still in a planning stage. The following initiatives/projects were identified as being involved in HIV/AIDS awareness in Welkom and specifically Thabong:

- Lechabile Project
- Welkom Anti-AIDS Youth Club

- Boitelo Letsie
- FAMSA
- Bambanani (Deeper Life Ministry)
- Thabong Methodist Church
- Cancer Association
- Friends for life
- Goldfields Child Welfare
- Grace and Mercy Bible Church
- Hospice
- Life Line
- Morning Star Children Centre
- Ondersteuningsraad
- Oranje Vroue Vereeniging
- Rehahuetswe Community-based Care
- Rise and Shine Multi-project

Two of the above organisations were repeatedly reported by respondents in the study as being actively involved in HIV/AIDS awareness and prevention. These organisations are:

1. Lechabile Project
2. Welkom Anti-AIDS Youth Club

Focus will be limited to these two organisations due to their relevance to the findings of the study, according to responses by individuals living with HIV/AIDS who participated in the study.

TABLE 9: Selected HIV/AIDS-prevention initiatives in Thabong

	HIV/AIDS-PREVENTION INITIATIVE/PROJECT	
	LECHABILE PROJECT	WELKOM ANTI-AIDS YOUTH CLUB
Background information	The project started in 1996 in Virginia (Free State) and then expanded to other parts of the Free State in 1998 (Meloding informal settlement) and 1999 (Masilo informal settlement) before it was established to Welkom in June 2000.	Welkom Anti-AIDS is a community-based organisation (CBO) that was established in 1977 by the Society for Family Health (SFH). It has since been funded by government.
Target population	Their target population is woman at high risk (WAHR) of HIV-infection, which comprise the following vulnerable groups: •Women in multiple-partner relationships •Women in serial monogamous relationships •Women involved in commercial sex work •Women who have had recurrent STDs •Women who work around mine hostels They cater for women between their late teens and late fifties with the mean age being 32 years.	The Club caters for males and females aged 14 to 35 years in Welkom, particularly Thabong and Bronville, as well as surrounding farms.

	HIV/AIDS-PREVENTION INITIATIVE/PROJECT	
	LECHABILE PROJECT	**WELKOM ANTI-AIDS YOUTH CLUB**
Aim and objectives	Lechabile project aims to increase safe sexual practices and decrease risk to STD/HIV/AIDS sexual practices by: •Educating about STDs and its relationship to HIV/AIDS •Educating about STD and AIDS prevention including male and female condoms, non-penetrative sex, etc. •Educating about risk factors, e.g. STDs, multiple partnerships, serial monogamies, anal sex, etc. •Promoting the need to treat all STDs •Increasing condom availability, accessibility, affordability and acceptability (acceptability depends heavily on knowing what they are, dispelling myths and misconceptions about them and teaching women how to negotiate condom use with their partners) •Educating during awareness days through edutainment, e.g. song, dance, poetry, role-play, drama, etc. •Training members of vulnerable groups as peer educators and using them as peer condom outlets •Treating STDs syndromically and presumptively	The club aims to reduce HIV-infections through: ∘Basic HIV/AIDS education ∘Sex and sexuality education ∘Awareness campaigns ∘Pre and post-test counselling ∘Ongoing counselling ∘Life skills education for youth ∘Social marketing condoms (*Lovers Plus Condoms*) and distribution of condoms in taverns and the community by members of the Club

	HIV/AIDS-PREVENTION INITIATIVE/PROJECT	
	LECHABILE PROJECT	WELKOM ANTI-AIDS YOUTH CLUB
Obstacles/ weaknesses	The most prominent problems encountered by the project are: •Poor acceptance of this selective service by health care professionals (nurses) from local clinics •Poor utilisation as a referral service by local clinics •Stigma attached to the project due to this service being a dedicated STD service that admits only a small core group, namely women at high HIV risk (WAHR) •Poor follow-up return rate due to the high mobility of the target population •Ignorance about the existence and risks of HIV/AIDS •No funding available for voluntary counselling and testing (VCT) for the target group	Many people are still shy to take condoms in front of other people.

	HIV/AIDS-PREVENTION INITIATIVE/PROJECT	
	LECHABILE PROJECT	**WELKOM ANTI-AIDS YOUTH CLUB**
Impact/ strengths	The impact of the project is evaluated by monthly risk assessment questionnaires administered to the target group, monthly visits for education, examination and/or treatment, six monthly blood test for syphilis serology, individual and focus group meetings, and measuring impact on partners (mine workers). The following impacts have been observed: •Increased STD/HIV awareness among vulnerable groups •Decreased in STD rates in WAHR and their partners (observed in miner control group) •Increased condom distribution especially through peer outlets The projects' success has resulted in local mines and the Department of Health, provincially and nationally, supporting the programme financially. One of the mines (Anglogold) is currently conducting an evaluation of the project's impact on HIV reduction on males. A cohort in Orkney (Free State) is being used to evaluate impact on miners in the absence of a Lechabile-type intervention.	STD statistics have been reduced. The impact of the initiative is evaluated by visiting clinics and collecting STD statistics on a monthly basis.

7.3Conclusion

It appears that government (provincial and district), NGOs and CBOs are attempting to reduce the rate of HIV-infections in Thabong. These organisations have embarked upon various initiatives that are based on the assumption that increasing knowledge about the risks of HIV/AIDS and distributing condoms will change high-risk sexual behaviour, as well as through the syndromic treatment of STDs. However, the findings of this study show that attitudes, beliefs and complex socio-economic and socio-cultural factors stand in the way of the effectiveness of these initiatives and interventions in Thabong. These impediments to the full effectiveness of HIV/AIDS initiatives in Thabong need to be identified and addressed, which is what this study aims to achieve.

Chapter 8

RESEARCH STRATEGY AND METHODOLOGY

8.1 Research strategy and approach

This is an exploratory study of the relationship between various factors that influence behaviour, with specific focus on sexual behaviour of adults in Thabong. The empirical exploration of sexual behaviour in Thabong is based on the multidisciplinary model described in Chapter 4. As such, it investigates the relationship between psychological, social and cultural factors on the one hand, and manifest sexual behaviour on the other hand, with a view to identifying impediments to safe sex in Thabong and so achieve the aim of the study.

The data collection process entailed using participatory action learning methods (PAL) whereby community members, with the aid of appropriate training and supervision, collectively investigated and analysed the perceived underlying causes of unsafe sexual practices among individuals who assumedly know the risks associated with these practices. Data was collected by means of group discussions with community members who were assumedly HIV-negative, and individual interviews with community members who were confirmed HIV-positive. The data collected focused on exploring the relationship between perceived individual, social and cultural factors that influence sexual behaviour. The multidisciplinary analytical model developed in Chapter 4 was applied to explore impediments and factors that would facilitate the practice of safe sex by men and women in Thabong.

A participatory action approach was particularly appropriate for this study in view of it promoting the production of collective knowledge and creating a sense of group ownership of the knowledge. At the same time it created a situation in which the research respondents feel comfortable to express themselves, even about sensitive issues such as sexual behaviour. It also builds a sense of trust, support and solidarity among individuals who share the same problem, but may not be aware of it until they are exposed to each other. This approach created an environment and conditions that were conducive for respondents to freely express their experiences, knowledge, beliefs, conceptions and perceptions about sexual behaviour. Thus, they learnt from each other and developed a better understanding of social, cultural, religious, economic and any other factors or norms that influence their behaviour.

Participatory action research methods also minimise threats to disclosure that may not be addressed by other research approaches.

The study showed sensitivity to the fact that inappropriate attitudes and behaviour of data collectors could unconsciously sabotage a study of this nature. To prevent this from occurring, participatory research methods, with specific emphasis on the importance of participatory research principles, attitudes and behaviours was included in the training of the facilitators. The advantages of adherence to these principles, attitudes and behaviours in terms of optimising the quality of the research findings, were also consistently reinforced.

8.2Data collection instruments

Three data collection instruments were utilised for the study, namely:

- Rapid situational analysis schedule
- Focus group discussion guide
- Semi-structured individual questionnaire (interview)

1) Rapid situational analysis schedule

The schedule was used to collect secondary statistics and information from officials of relevant district departments of government. Data was also obtained from representatives of various HIV/AIDS initiatives and programmes in Thabong/Welkom.

2) Focus group discussion guide

The group discussion guide was informed by the literature study. The guide essentially focuses on determinants of behaviour, specifically sexual behaviour, as cited in literature reviewed for the purpose of this study. The focal determinants of behaviour constituted the main themes for the group discussions. Therefore, the guide consisted of four themes, namely, **a)** motives for sexual intercourse, **b)** attitudes (salient beliefs and evaluations of consequences of specific behaviour), and **c)** subjective norms (perceptions of behavioural expectations of significant others).

The finalised group discussion guide was translated into Sotho and back-translated to ensure that the questions had maintained their original meaning after translation. The phrasing of questions was also checked to ensure that they were simple and clear enough for respondents from all strata.

Furthermore, the guide was subjected to comments from the data collectors who made valuable suggestions in terms of rephrasing, adding and omitting questions. Finally, the

guide was piloted and the necessary amendments were made before it was used to collect data.

3) Individual interviews

The individual, semi-structured questionnaire consisted of open-ended questions. It was used to collect data about factors that are perceived to promote high-risk sexual behaviour and factors that are perceived to promote safe sex in the community of Thabong.

The finalised individual questionnaire was translated into Sotho and then back-translated to ensure that the questions still maintained their original meaning. Data collectors were also given an opportunity to comment on the structure and content of the questionnaire. Relevant amendments were subsequently made to the questionnaire before it was used to collect data.

8.3Target community and research participants

8.3.1 Sampling

(i)Target community

The Free State currently has the third highest HIV-prevalence rate of all provinces in South Africa. Thabong, largely a mining community in the Free State, is situated in the former health region C (now Lejweleputswa), which has the highest HIV-prevalence of the former six health regions in the Free State, namely 26%. Furthermore, the Lejweleputswa has the fourth highest HIV-prevalence rate and the fifth highest HIV-infection rate amongst pregnant women utilising public health care services, of all the health regions in South Africa (three regions in KwaZulu-Natal have higher prevalence rates) (Van Rensburg & Heunis, 1999). This makes HIV/AIDS one of the most prominent problems not only in Lejweleputswa, but also in the community of Thabong. The Centre for Health Systems Research & Development, in partnership with the community of Thabong, have recently embarked on an initiative to reduce the HIV-infection rate among the youth by proposing a multi-function centre for the youth in Thabong. Given this established relationship, Thabong was selected as target community for this study.

(ii) Research Participants

- **Data Collectors/Facilitators**

Five data collectors were selected from the community. Three of them were females aged 40 years, 25 years and 24 years respectively, and two males aged 40 years and 22 years. They were selected according to age, gender, membership of formal and informal community organisations, such as organisations that render services to HIV/AIDS affected and infected individuals, and leadership position held in the community. This set of criteria for the selection of data collectors assisted in creating an environment that was conducive for respondents to express themselves freely during data collection. Thus, the data collectors represented the age group of the respondents, namely 15 to 49 years (regarded as the most sexually active), included both males and females, and were perceived leaders in the community (had the capacity/ability to influence the behaviour of community members, e.g., peer educators) (UNAIDS, June 2000).

Two of the data collectors were recruited through their involvement as fieldworkers in a project conducted by the Centre for Health Systems Research and Development aimed at assessing the socio-economic impact of HIV/AIDS on households in Welkom. One of the data collectors was recommended by various organisations in Welkom, in light of his active role in HIV/AIDS awareness and counselling in Welkom, especially Thabong. The remaining two data collectors were recommended by representatives of HIV/AIDS awareness initiatives, as a result of the leadership role that they hold in HIV/AIDS projects and organisations in Thabong, namely co-ordinating HIV/AIDS related projects.

The data collectors underwent ten days of training on the collective exploration of problems within a group, using a semi-structured group discussion guide, and also how to conduct causal tree analyses to get to the root causes of these problems. The training included the facilitation of group discussions, encouragement of free expression of attitudes and beliefs without being domineering, directive or bias. They also received training in conducting personal in-depth, semi-structured interviews with people living with HIV/AIDS, which included training in the basics of HIV/AIDS. Training in the basics of HIV/AIDS was provided by personnel at the AIDS Training, Information and Counselling Centre (ATICC) in Welkom.

(iii) Respondents

Purposive sampling was used for this study due to the small sample size. Therefore, the findings and results of the study are not representative of the population of males and

females in the 15 to 49 years age category, and thus cannot be generalised. The findings should only be interpreted within the context of the community of Thabong.

- **Respondents for group discussions**

Respondents from various social groups in the community were involved in the study. These social groups served as strata from which 15 groups of respondents were selected. The sampling process was a collaborative effort by the researcher and five selected data collectors. The data collectors' role in the sampling process was to ensure that respondents were selected from all the geographical areas in Thabong in order to produce a representative sample of the community of Thabong.

Since the data collectors were associated with various HIV/AIDS related projects and initiatives in and around Thabong, they were better informed about the strata of social groups that exist in the population selected for the study. Eight strata were identified, namely schools (teachers and learners), sport teams, religious groups, taverns, burial societies, youth groups, HIV/AIDS support groups, and mine hostels. The following groups of respondents were collectively selected by the fieldwork team to participate in the study:

- Two groups of teachers (one male group and one female group)
- Two groups of school learners (one male group and one female group)
- One local sport team (male soccer team)
- Two religious groups (one male group-"*amadodana*" and one female group-*"oomama bebhantyi*")
- Two groups of tavern "goers" (one male group and one female group)
- One burial society (a group of women)
- Two youth groups (one male group and one female group)
- One HIV/AIDS support group (a female group)
- Two groups of hostel inhabitants (one male group and one female group).

The group discussion guide was piloted among three groups of male taxi drivers in Welkom. The guide was subsequently adapted by the researcher, where necessary, in collaboration with the data collectors, based on the findings of the pilot study.

The criteria for selection of respondents from various strata were to include members that are considered to be at relatively high-risk of contracting HIV/AIDS and those considered to be at relatively low-risk of contracting AIDS. This was achieved by not only selecting individuals that are generally perceived as most vulnerable or at the highest risk of being infected with HIV, such as commercial sex workers, migrant workers, women and

adolescents, as respondents, but also individuals who do not belong to these high-risk groups.

- **Respondents for individual interviews**

A sample of thirty (30) individuals living with HIV/AIDS was selected for the study. It was intended to select fifteen (15) males and fifteen (15) females. However, only 12 males were identified, of which only nine agreed to participate in the study.

The sampling process involved purposively sampling 18 females and 12 males from a list of individuals that are HIV-positive. The list was obtained from an organisation that offers counselling and support to individuals diagnosed as HIV-positive. Sampling was conducted by the researcher in collaboration with one of the data collectors who is also a lay counsellor for some of the HIV-infected individuals on the list. Thus, the female respondents were selected according to the perceived likelihood that they would consent to participate in the study, and all the males on the list (12) were included in the sample.

Anonymity and confidentiality was ensured by using the infrastructure for HIV/AIDS infected and affected individuals in Welkom to make contact with potential respondents. These organisations maintained confidentiality and anonymity of their members by giving the researcher a list of those members who showed interest in participating in the study.

Verbal consent was obtained from the selected participants by the data collector that was involved in the sampling process. The nature of the study was explained to all prospective respondents, after which consent was obtained and participation secured. The selection process ensured that the respondents represented the 15 to 49 years age category. However, one male respondent who was not in this age category (62 years) was included in the study to increase the sample of male respondents, which was generally limited.

8.4Data Collection

Qualitative data collection methods were used to obtain information. Triangulation was used to verify the data whereby the qualitative data obtained from the group discussions and personal interviews was amalgamated.

Data collection consisted of two phases. The first phase was the situational analysis, which involved the collection of statistics and socio-economic/socio-cultural information about Thabong. District and local authorities were approached for information about Thabong in relation to HIV/AIDS. Furthermore, information was also obtained from CBOs, NGOs and

representatives of HIV/AIDS programmes, initiatives and services. This data is presented in Chapter 6 as an overview of initiatives and programmes currently underway to reduce HIV-infections in Thabong and Welkom at large.

The second phase of data collection involved conducting group discussions and personal interviews to gather information about factors that are perceived to promote high-risk HIV/AIDS sexual behaviour and those factors that promote safe sex.

8.4.1 Justification for selection of data collection methods

For the following reasons, the study opted for group discussions rather than only for individual interviews to explore perceived impediments to the practice of safe sex. Group discussions:

- encourage individuals to express beliefs, attitudes and knowledge that they regard as common among themselves;
- encourage the expression of beliefs and attitudes as representative of a group rather than as an individual, thus eradicating fear of being judged by the data collector;
- creates an environment whereby group members can support each other's responses by clarifying and rectifying information that each member gives;
- may produce more elaborate information if group members responses' evoke conflicting beliefs and attitudes that require justification from each respondent;
- are less time consuming since more than one individual is interviewed at a time.

8.4.2 Data collection for group discussions

Wherever possible, group discussions took place in the respondents' natural environments, namely where the respondents were situated at the time of the group discussion, and the study made use of existing groups as far as possible rather than formulating artificial groups for the purpose of the study. However, where a group discussion could not take place naturally, arrangements were made for respondents to meet at a venue where they felt comfortable discussing sexual issues. For instance, discussions with religious groups were conducted outside the physical religious context (outside church grounds and on non-religious days, e.g. not Sundays and Thursdays). This was done to avoid respondents being bias towards religious expectations, which may in actual fact be contradictory to their actual sexual practices, beliefs and attitudes. However, most focus group discussions took place in the respondents' natural environment, such as taverns, mine hostels, schools, etc. Discussions were conducted in the respondents' home language.

The data collectors/facilitators located the sampled 15 social groups and utilised a semi-structured group discussion guide to explore the decision-making process pertaining to choice of sexual behaviour and knowledge about HIV/AIDS. Consent was first obtained before the group discussions were conducted. Consent was obtained where prior consent was required from authorities in order to access respondents, such as schoolteachers and learners, as well as certain religious groups. In most cases, consent was directly obtained from the respondents without consulting with authorities. The groups comprised members of the same sex. This further ensured that the group members felt comfortable to express themselves among fellow group members that they were familiar with and could identify with. Each data collector facilitated a group that was more or less the same age and also the same gender as the data collector.

The groups comprised between seven and eight members in order to render facilitation of the discussions easier and also to optimise participation of all group members. As a rule of thumb, the ideal size of a focus group should be between six and ten members (Morgan, 1997). Less than six members renders it difficult to sustain a discussion and more than ten members renders it difficult to control the discussion.

The discussions focused on identifying factors, during the decision-making process, that impede the translation of knowledge about the risks associated with engaging in high-risk sexual practices into sexual behaviour. This entailed applying the multidisciplinary analytical model that was developed during the literature review phase of the study, to explore and assess the relationship between determinants of behaviour, such as behavioural motivations (Maslow's instinctoid human needs), attitudes, subjective norms, and any other social factors that the community perceives as exerting a strong influence on their behaviour, especially on their choice of sexual practices.

- **Constraints**

Table 10 indicates the constraints encountered and subsequent steps taken to overcome these constraints during the group discussions.

TABLE 10: Constraints and solutions of focus group discussions

Constraints	Solution
1 Domineering respondents	•Encouraged other group members to respond/react to the comments made by the "dominant" respondent/s.
2 Respondents responding on behalf of the group – "spokespersons"	•Emphasised the importance and value of everyone's point of view, regardless of whether everyone in the group agrees or disagrees. Reassured group members that repetition of responses was acceptable.
3 Distraction of tape recorders	•Emphasised the purpose of the tape recorder, namely to assist in gathering data since it is difficult for the data collector to talk, listen and write down the responses of every participant at the same time. •Reassured insecure/sceptical participants of ensuring their confidentiality and anonymity throughout the research. •Reassured respondents that felt that they needed to be as close to the tape recorder as possible to be recorded, that the tape recorder was able to pick up their voices from where they were seated.
4 Versatility of groups	•The focus group discussion guide was adapted by the data collectors in accordance with the age group, gender and social profile of each group that they facilitated. For example, it was anticipated that members of religious groups and the older research participants (30 years and older) would not feel comfortable conducting role-plays. Hence, the data collectors devised alternate strategies to obtain the information required from the group discussions.
5 Voice clarity	•One of the group discussions could not be used for the study due to the poor quality of the recording – not audible. This was partly due to individuals speaking in a very low tone of voice (not loud enough). Another group discussion was conducted with the same social strata, but different individuals. Data collectors continuously encouraged group discussion participants to speak clearly so that all the group members could hear what each had to say.
6 Influence of facilitators	•The inclusion of the importance of adhering to the principles and rules of participatory action research in the training assisted the facilitators to avoid being dominant and judgemental when conducting the group discussions. They devised their own mechanisms to counteract "dominant" respondents who responded in a way that they felt was expected of them to respond rather than being honest and open.

Group discussions are often hampered by group members' resistance to open-up and participate fully. This is largely due to the presence of a stranger (group facilitator) and the time required for group members to grasp the purpose of the discussion and what is expected of them as participants. Refreshments were offered to all group members throughout the group discussions to speed up this "warm-up" process and also to create a relaxed environment, which assisted participants to focus and participate in the discussions.

Serving refreshments also played a significant role in preventing participants from leaving the discussions before the end. However, loss of group members before the end of the discussions could not be avoided in some instances. One such incident was that of group members that were required to go back to work during the group discussions. Other individuals discontinued their participation in group discussions due to other obligations. However, loss of individuals during group discussions was kept to a minimum.

8.4.3 Data collection for individual interviews

Individual in-depth, semi-structured interviews were conducted with 30 HIV-infected males and females. Of the 12 males that had given consent to participate, three later decided to revert their decision and not participate in the study. Thus, only 9 males were interviewed and therefore 21 females. The reluctance of HIV-positive males to accept and disclose their HIV-status was echoed by both officials and members of the community throughout the study. Individuals that utilise the services provided by organisations that support HIV-infected individuals in Thabong and Welkom are largely composed of women.

The main focus of these interviews was to determine the perceived needs of these individuals, prior to infection, that could have assisted them in their choice of sexual practices, namely, for them to choose low-risk sexual practices over high-risk sexual practices. Each data collector interviewed a respondent of the same gender and who was more or less the same age as the data collector. This was achieved by selecting data collectors that represented the age groups of the respondents. The interviews were conducted in the respondents' home language.

Most of the respondents had disclosed their HIV-status to their families and thus felt comfortable to be interviewed in their homes. Only one respondent had not disclosed her status to individuals in her household, but agreed to be interviewed at home, in private. When consent was obtained, respondents were also required to state the day and time of day that they wished to be interviewed. This avoided data collectors being inconvenienced by not finding respondents at home and also to avoid inconveniencing respondents by disrupting important household tasks.

- **Constraints**

Table 11 outlines the constraints and solutions of the individual interviews.

TABLE 11: Constraints and solutions of individual interviews

Constraints	Solutions
1 Respondent scepticism	Some respondents that had initially given consent denied being HIV-positive once approached by the data collectors. Three respondents claimed that a child that they had adopted was infected. The data collectors clearly explained the nature of the study to them, as well as reassured them of their confidentiality. This resulted in the respondents feeling comfortable enough to disclose that they were indeed HIV-positive and thus agreed to be interviewed.
2 Difficulty in recruiting male participants	Twelve males agreed to participate in the study, but when approached by the data collectors, three of them decided not to participate. Various reasons were given for the change in decision. One reason given by a respondent was that he was no longer HIV-positive. He claimed to have been "cured" by prayer. Female respondents were used as substitutes since there were no other male respondents that could be selected for the study.
3 Questionnaire structure	Respondents were reluctant to answer the very sensitive individual-specific questions at the beginning of the questionnaire. The questionnaire should have been structured so that the general questions about the community of Thabong preceded the sensitive individual-specific questions. Hence, the data collectors asked the general questions first then proceeded with the individual-specific questions as soon as rapport was built with the respondents.
4 Influence of interviewer	Due to intensive training of fieldworkers on how to conduct individual interviews, and also because of the training that the interviewers had received in the basics of HIV/AIDS, they were fully competent to conduct interviews without jeopardising the quality of the data collected. In some instances, the interviewer interviewed a respondent that they were counselling or had counselled, and thus had already established a relationship with. This facilitated open and honest responses by respondents.

The respondents were each given a food hamper as an incentive for their participation in the study. The food hamper was not used as a means to obtain consent from respondents. Rather, it was intended to make the respondents feel that they are not merely giving of themselves, and not being rewarded for their time and invaluable information. It was made clear to all respondents that the hamper was a token of appreciation for the time that they had given to be interviewed and also for them sharing information for the purpose of research.

8.5Data Analysis

The researcher was responsible for editing the data collected and for quality control throughout the data collection phase. The four processes involved in qualitative analysis, as described by Hyatt (1986), were used as a guide for analysing the data. First, the data were systematised. This served to familiarise the researcher with the content of all data collected. Second, themes were identified to contextualise the findings. Third, data were summarised according to the identified themes and findings were inferred. Where relevant, quotes were used to support findings. Lastly, conclusions that inform the research objectives were drawn from the findings. Recommendations for initiatives aimed at promoting safe sexual practices to decrease HIV-infections in Thabong are based on the conclusions.

8.6 Ethical Considerations

HIV/AIDS and sexual behaviour are sensitive issues that are not openly discussed due to stigmatisation and censorship, among other reasons. This can impede any study aimed at exploring these issues. The study showed sensitivity to the problems associated with discussing sexual behaviour, and also minimised the possibility of non-disclosure and refusal to respond, by adopting stringent measures to ensure confidentiality and anonymity of the respondents, especially those that are living with HIV/AIDS. This was achieved by utilising the infrastructure for HIV/AIDS affected and infected people in recruiting respondents and data collectors, and also providing the data collectors with skills to explore sexual behaviour and HIV/AIDS without impinging on the basic rights of respondents. In addition, verbal consent was obtained from all key informants and respondents, at all times, prior to recording of information and statistics given by them. At the same time, the researcher and the study honoured the trust

relationships and various contacts that have been established through HIV/AIDS prevention initiatives/campaigns in Thabong.

Chapter 9

RESEARCH RESULTS AND FINDINGS

9.1Introduction

The data analysis process described in Chapter 8 was followed to analyse data of both the individual interviews and focus group discussions. Repetitive themes were identified and the data will be discussed at the hand of these themes. Comparisons were made between the results of different focus group discussions and between individual interviews, as well as between group discussions and individual interviews to identify significant differences and similarities, as well as notifiable contradictions in the data. The relationship and influence of independent variables such as age, gender, education, etc. was also considered during the data analysis process. The analyses were aimed at identifying impediments to the practicing of safe sex among different groups and respondents and at isolating insights that can inform effective HIV/AIDS-prevention initiatives.

9.2Data analysis

9.2.1 Individual Interviews

All the responses from the in-depth individual interviews that were conducted with PLWA (People Living with HIV/AIDS) were categorised according to the questions in the semi-structured questionnaire that was used for these interviews (cf. Appendix III). After categorisation, themes were identified in view of informing the research objectives and main aim of the study.

PLWA were interviewed to obtain their retrospective view of factors that prevented them from practising safe sex. In addition, the interviews aimed to identify factors that are perceived by PLWA to be conducive to the practice of safe sex. Themes for these interviews were informed by the multidisciplinary theoretical framework (cf. Chapter 4). According to this, factors that prevent people from practising safe sex include indifference to HIV/AIDS, low perceived self-efficacy about sexual behaviour founded in

gender-related power imbalances, low socio-economic status, etc., while factors that would promote the practice of safe sex include internalisation of knowledge about HIV/AIDS, economic empowerment, high perceived self-efficacy, enhanced intra-gender and inter-gender communication about sex and HIV/AIDS, etc. Due to the nature of semi-structured questionnaires, respondents were free to raise and discuss issues that they perceived as relevant to the topic and the research at hand, but were not necessarily included in the questionnaire. All responses were summarised and categorised according to these themes. Care was taken to maintain the original views of respondents throughout the processing and analysis of data. Where relevant, quotations are included to support conclusions.

9.2.2 Group Discussions

The same process that was followed to analyse data from the individual interviews was followed to analyse data from the group discussions. The systematisation of data involved translating and transcribing the focus group discussions that were conducted with assumedly uninfected members from various social strata in the community (cf. Chapter 8). The transcribed data was categorised according to themes that guided the group discussion guide (cf. Appendix II). For example, data of knowledge about HIV/AIDS and safe sex constituted one category, followed by the category of data about attitudes and the category of data about subjective social norms. Comparisons were drawn between data from the different group discussions to identify differences and similarities between the groups/strata concerned. Conclusions were drawn with a view to informing the research objectives and overall aim of the study.

As with the analysis of the individual interviews, care was taken to maintain the original views of the respondents. Similarly, quotations were included where relevant to substantiate findings and conclusions.

The findings from both the individual interviews and group discussions were further categorised into more specific sub-themes. This second categorisation process assisted the identification of key focus areas that interventions aimed at changing high-risk sexual practices in Thabong should take note of. By their nature, these were based on the views of both PLWA and people whose HIV status is unknown. The findings and

conclusions of the research are only valid and generalisable to the research population due to the purposive sampling method opted for to select research participants.

In Chapter 10, the findings will be interpreted in terms of the multidisciplinary analytical model of sexual behaviour that was developed in Chapter 4. While contributing towards the development of this theory, it will also serve to extrapolate recommendations for optimising the impact of HIV/AIDS-prevention initiatives in Thabong.

9.3Discussion of findings

9.3.1 Individual interviews

The data from the individual interviews that were conducted with PLWA were categorised and themes were identified with a view to inform the research objectives and study aim. The findings will be discussed at the hand of these themes, and in light of the research objectives stated in chapter one of this report.

(i)Knowledge about HIV/AIDS

The majority of respondents reported that they were aware of HIV/AIDS before they were infected. This assumption is based on their responses to questions 1 and 2 of the individual interview questionnaire (cf. Appendix III). Although their knowledge of the disease was not extensive, they claim to have heard that HIV/AIDS is a disease that kills. Of note is that, during interviewing, it was observed that individuals who had previously reported that they had heard about HIV/AIDS ascribed their practising of unsafe sex to the lack of knowledge about HIV/AIDS. This indicates that, despite awareness about the concept of HIV/AIDS, the respondents' detailed knowledge about HIV transmission and prevention is poor, and that this leads to unsafe sexual practices. It would appear as though individuals perceive detailed knowledge about HIV/AIDS and its relevance to their lives as important in assisting them to practice safe sex.

(ii) Obstacles to internalisation of knowledge about HIV/AIDS

For an individual to take appropriate action in the light of information and knowledge about a specific issue or phenomenon, this knowledge must be internalised and viewed as applicable to the individual. If this knowledge is not perceived as applicable to the

individual's life (e.g., the individual does not perceive himself/herself at risk of HIV-infection), the chances of that individual changing his/her behaviour in accordance with this knowledge (e.g. consistent and appropriate use of condoms or practising sexual abstinence) are slim.

Only one respondent (female, 18 years) reported that knowledge about HIV/AIDS influenced her sexual behaviour. She reportedly abstained from sex upon learning about HIV/AIDS. However, she became infected because she was raped. It appears as though the majority of the other respondents had not internalised knowledge about HIV/AIDS prior to their becoming infected. Thus, they did not align their sexual behaviour with their knowledge about HIV/AIDS because they denied the risk of infection.

The following responses point towards a lack of internalisation and personalisation of knowledge about HIV/AIDS among the respondents: " I knew that it is transmitted if I sleep with a man and we are not using anything to protect ourselves. But I never thought of using prevention measures"; "I didn't take my knowledge about AIDS into consideration because I didn't care. Now, I regret not doing so"; "I didn't bring this issue of HIV/AIDS into consideration...so I was just having sex without using condoms".

Lack of internalising knowledge about HIV/AIDS appears to be associated with indifference to the disease and defence mechanisms such as denial of the disease's existence. The belief that only people from specific social groups, such as immigrants and commercial sex workers could become infected, reinforced a general indifference to the risk of HIV/AIDS. It was observed during interviewing that PLWA blame themselves for being indifferent to AIDS and for not internalising knowledge about AIDS before they were infected. This is evident in statements such as: "I was being irresponsible. I was doing it (sex) without thinking about what would happen tomorrow".

(iii) Perceived self-efficacy about sexual behaviour

The majority of respondents, both male and female, reported

a) partner coercion,

b) fear of loosing a sexual partner,

c) fear of destroying one's family,

d) satisfying a sexual partner,

e) alcohol and

f) money

as factors that influence the degree of control one has over one's sexual practices.

a) Partner coercion was the most prominent reason given for women's perceived lack of control over their sexual behaviour. It would appear as though men agree with this and acknowledge it. The following responses illustrate the impact that partner coercion has on women's relative power in sexual relations: "Men are stubborn. They force women to sleep with them without using condoms"; "Their (women's) partners force them to have unsafe sex"; "Women are afraid of men and allow men to do anything that they want to them. Some of them are raped by their boyfriends but they don't talk about it because their boyfriends give them money".

b) Fear of losing a sexual partner is based on the assumption that, by asking a sexual partner to use a condom, or even talking about HIV/AIDS with a sexual partner, is an offence to that partner. Initiating the practice of safe sex is perceived as expressing lack of trust in a sexual partner or even an indirect admission of HIV-infection by the individual initiating safe sex. This will, according to respondents, inevitably provoke a negative reaction from the other partner, which may lead to the termination of that relationship. It appears that the costs associated with initiating safe sex such as condom use with a sexual partner exceed the benefits of doing so. In other words, losing a sexual partner or being suspected/accused of being unfaithful or HIV-positive is perceived as too high a price to pay for protecting oneself from HIV-infection. The following responses are illustrations in point:

> "I thought that I would offend my partners if I used a form of prevention ... they would have thought I don't trust them"; "I thought that by using a condom, my partner would think that I am not faithful to him"; "Men usually think that when they use condoms, their sexual partners will suspect that they have other sexual partners".

c) Fear of destroying one's family was also reported as a reason for women's inability and reluctance to protect themselves from HIV-infection. Maintaining and sustaining a marriage and family is perceived as a more important priority than protecting oneself from HIV-infection. The following statements made by the respondents substantiate this viewpoint: "Women are afraid that they will lose their partners if they insist on safe sex and they don't want their partners to go elsewhere for sex without a condom"; "Even though women want to protect themselves from HIV-infection, they believe that by asking their partners to practice safe sex, they will break-up their families"; "Women don't talk about HIV/AIDS because they are afraid of breaking up their families"; "They (women) think it is better to save their marriage".

d) A few respondents, mostly women, reported satisfying the sexual needs of a partner as a reason for them engaging in unsafe sexual practices. When faced with the decision to either protect oneself from HIV-infection by using a condom or satisfying a sexual partner by placing oneself at risk of HIV-infection, it appears some people would opt for the latter.

e) Alcohol was reported to play a significant role in sexual behaviour. According to respondents, alcohol increases risk-taking behaviour, including high-risk sexual practices such as increased sexual partners and non-use of condoms. The view of alcohol as a contributing factor to high-risk sexual practices is expressed in the following statements made by male and female respondents: "I was an alcoholic and usually slept with women when I was drunk"; "... It is not going to be easy for boys to abstain from sex because of alcohol"; "I think some men forget to use condoms when they are drunk"; "Girls must stop drinking alcohol because it makes them vulnerable to boys".

f) Money was reported as the sixth factor that influences an individual's control over his/her sexual behaviour. It would appear that, because of their economic/financial dependence, women are more vulnerable to give in to unsafe sexual practices in exchange for financial gain. These unsafe sexual practices include multiple sexual partners, each partner being a source of income, and not using condoms in these

multiple sexual relationships because that would increase the financial gain to be derived from the sexual encounter.

(iv) Acceptability and misconceptions about safe sex

The consistent use of condoms, sexual abstinence and mutual faithfulness between partners were echoed by almost all respondents as the only means of preventing HIV-infection in sexual relationships. However, according to respondents, each of these methods of prevention is associated with both advantages and disadvantages.

a) Condom use

By and large, condoms are viewed as the best form of protection against HIV-infection. However, there are also concerns about the degree to which condoms can prevent HIV-transmission, as well as misperceptions about their use and about their side effects that prevent their use.

- **Misconceptions/myths about condom use**

Most respondents (male and female) said that the consistent use of condoms in their sexual relations would definitely have prevented them from being infected with HIV. Not only are condoms seen as a means of preventing infection, but they are also perceived as prolonging the life of the infected individual. According to some respondents, condoms reduce viral load during sexual intercourse. This is indicative of the myths that surround HIV/AIDS and condom use. Other myths about condom use include the belief that condoms transmit HIV, as well as the belief that condoms cause organ dysfunctions. These beliefs are predominantly reported by males, whereas females report having *heard* that condoms transmit rather than prevent HIV. These beliefs are expressed in responses such as: "condoms increase diseases and that is why men resist using them"; "Men don't trust condoms because they believe that condoms have worms which transmit the AIDS virus", "Men don't like condoms because they believe condoms have worms, and since people are using condoms, there are many infections".

It became apparent during fieldwork that the belief that condoms transmit HIV arises from the fact that condoms are lubricated with an oily substance which forms a wave-like sediment when condoms are placed in warm water. Some men seem to believe that these wave-like threads are worms that carry HIV, thus the notion that condoms spread HIV rather than preventing its transmission. Other misconceptions that were come

across during the research are that condoms affect the kidneys and cause impotence, as well as vaginal rash. Condoms are also reported to reduce sexual pleasure during sexual intercourse. The latter negative consequences associated with the use of condoms are mainly reported by men. Condoms hinder "flesh to flesh" sex. Men report reduced sexual satisfaction when using condoms and this is substantiated by responses such as: "We want to have direct contact through our private parts without anything disturbing us"; "Men say they don't feel comfortable when using condoms. They want to feel their partners during sex"; "They (men) want to sleep with their partners naturally"; "They (men) don't like condoms. Condoms don't satisfy their sexual desires during sexual intercourse".

- **Fears associated with condom use**

There are also fears associated with condom use, which include the fear that condoms will remain inside a woman's body after sexual intercourse (both the male and female condom), and fear of rejection by sexual partners. Fear of rejection by sexual partners is the most commonly reported fear associated with the use of condoms. Both men and women believe that sexual partners associate condoms with HIV-infection, unfaithfulness and mistrust. In other words, it is believed that by asking a sexual partner to use a condom, the partner will suspect you of being HIV-positive, or of having multiple sexual partners, or of not trusting him/her as a sexual partner, which will lead to you losing that sexual partner, be it a casual sexual partner, a partner in a stable relationship, or a spouse.

- **The limitations of condoms to prevent HIV transmission**

Although condoms are viewed as one of the most important means of preventing HIV transmission, they are also viewed as having limitations. Among these limitations mentioned by respondents are the following: Condoms often tear during sexual intercourse, thus losing their protective function; condoms are not accessible in the case of rape. Also, condoms are reported to be ineffective when an individual has consumed large amounts of alcohol, thus rendering the individual incapable of remembering to use a condom when engaging in sexual intercourse.

It appears that men's reasons for not using condoms are based on perceptions about the safety of condoms and their effect on sexual satisfaction, whereas women's reasons

for not using condoms are based on partner coercion and fear of losing a sexual partner as a result of suggesting condom use.

b) Sexual abstinence

In principle, sexual abstinence is viewed as the best way of protecting oneself from HIV-infection. Unfortunately, it is also not seen as a practical option by most. Sexual intercourse is perceived as an integral part of life, especially marriage. One respondent even blames marriage for her being HIV-positive. She said: "I should have avoided marriage". Abstaining from sex until marriage is reported as a form of protecting oneself from HIV-infection. Pre-marital sex appears to be discouraged in Thabong, as illustrated by the statement: "They must abstain from sex if they are single ... they must wait until they get married before engaging in sexual intercourse and married partners must be faithful to one another". One respondent said that individuals should abstain from sex until the age of twenty-one. This age is associated with a transition from childhood to adulthood. Therefore, marriage has contradictory connotations, namely marriage perceived as a form of safe sex, on the one hand, and again as high-risk behaviour on the other hand.

HIV testing was reported by one respondent as a prerequisite to sexual intercourse. In other words, sexual abstinence should be practised until the HIV-status of sexual partners is determined. Therefore, HIV-testing, also referred to as Voluntary Confidential Counselling and Testing (VCCT), is another form of low-risk sexual behaviour if it is interpreted in this context, namely as a prerequisite to sexual intercourse.

c) Mutual faithfulness between sexual partners

Faithfulness to one sexual partner was identified as a form of practising safe sex. However, many respondents reported having contracted HIV/AIDS from an unfaithful partner. This was especially apparent among women who reported that, because they were being faithful to their sexual partners, they expected the same faithfulness in return.

Furthermore, marriage appears to be seen as a guarantee of sexual faithfulness between a husband and wife. Especially women expect marriage to be synonymous with mutual faithfulness. This belief resulted in the perception that they (wives) were not at risk of HIV-infection through unprotected sexual intercourse with their husbands. It was

disturbing to see that this belief resulted in many respondents' contracting HIV. The following statements are indicative of this: "I knew that AIDS kills but it wasn't an issue that I always thought about because I only had one sexual partner"; "I didn't know much about HIV/AIDS because I stuck to one partner"; "Being married and faithful to my husband made me believe that he was also faithful to me. So, I didn't use condoms or any other prevention measure".

Being in a "stable" relationship such as marriage, or being faithful to one partner is directly associated with perceived low-risk of HIV-infection. Thus, marriage and "stable" relationships are in themselves perceived as a form of safe sex. This perception is particularly common among woman. However, it would also seem to be a dangerous perception making them vulnerable to HIV-infection by unfaithful partners.

(v) Gender relations and HIV/AIDS

The relationship between men and women in Thabong appears to be a major impediment that hinders especially women from protecting themselves from HIV-infection in their sexual relationships. Socio-cultural norms play a significant role in the control that men have over the sexual behaviour of women, and at the same time have created an environment conducive to high-risk sexual practices by men. Women attribute their lack of control over their sexual practices to:

- fear of their sexual partners;
- lack of knowledge about HIV/AIDS and their sexual and reproductive rights;
- the need to satisfy their sexual partners;
- the need to secure their sexual relationships/families/marriages; and
- for financial sustainability.

The influence of gender-power relations on perceived control over sexual behaviour will subsequently be discussed.

a) Gender-power imbalances and safe sex

The nature of the relationship between men and women in Thabong appears to play a pivotal role in decision-making pertaining to sexual behaviour. Both men and women acknowledge that the preferences and needs of men are paramount when it comes to sexual practices. This perception can be attributed to socio-cultural norms that underlie

gender roles in Thabong. Women are "expected" to be subservient and submissive, whereas men are "expected" to be authoritative and dominant.

These norms allow men to dominate women in most spheres of their lives, including their sexual behaviour. Thus, women perceive themselves as having little control over decision-making in sexual relationships, especially when it comes to negotiating issues such as condom use and mutual faithfulness between sexual partners.

The traditional practice of "Lobola" (dowry paid to a woman's parents by a man who requests her hand in marriage) is perceived to contribute to the assumption that sex is part of an unwritten agreement in a marriage. Married women do not receive support from their parents, or even from other women, when they are forced to have sex against their will in a marriage. This lack of support is based on the belief that "Lobola" is paid in exchange for a husband's control over his wife's behaviour, including her sexual behaviour.

b) Violation of sexual and reproductive health rights

Women are afraid of negotiating sexual behaviour or even discussing sex and HIV/AIDS with their sexual partners. This stems from the belief that men are the decision-makers in relationships and women are expected to play a subservient and submissive role. Women tend to entrust their well-being, which includes their reproductive health, in the hands of their sexual partners who are regarded as the decision-makers. This often results in women's sexual and reproductive rights being upstaged by the control that men have over women's sexual behaviour.

Female respondents believe that men will seek out a sexual partner that will satisfy his sexual needs and desires if his "regular" sexual partner is unwilling to do so. For example, if a woman insists on the use of a condom when her sexual partner is against such use, he will find another sexual partner who is willing to have sex with him without a condom. This may lead women to abandon safe sexual practices in order to avoid their sexual partner venturing outside their relationship to satisfy his need for sex without a condom. Therefore, women may know their sexual rights but be unable to exercise them due to their lack of influencing power over their partner's sexual behaviour.

Some women are not knowledgeable about their sexual and reproductive health rights, which make them even more vulnerable to HIV-infection. For example, one

respondent said: "If I had known my rights to safe sex and had not trusted and put my faith in my partner, I would not be infected right now". Many female respondents indeed attributed their vulnerability to HIV/AIDS to lack of knowledge about HIV/AIDS and their right to protect themselves from HIV-infection.

c) Violence

It was reported that men force women to have sex with them without a condom by using violence or the threat of violence. It appears that men derive pleasure from controlling women, which is expressed in the following response: "Males are aggressive when it comes to sex. They beat women up when women refuse to sleep with them without the use of a condom". The word "force" was used recurrently in most responses regarding obstacles that prevent women from practising safe sex such as abstinence and condom use.

d) Socio-economic status

Socio-economic status appears to play a significant role in rendering people vulnerability to HIV-infection. Unemployment and lack of employment opportunities in Thabong have resulted in a large number of financially dependent individuals, especially women. Women often have to depend on men for financial support. This reduces women's power in sexual relationships, especially when it comes to negotiating safe sex. Men appear to hold women's dependency on them for financial and material support as leverage for persuading women to engage in high-risk sexual practices such as non-use of condoms and multiple sexual partners.

A female respondent reported that "poverty contributes a lot because we (women) are unemployed. So, for us to get money, it is easier to have more than one sexual partner that will provide for us financially". Another female respondent reported "Women use their bodies to make money because of the high rate of unemployment. Those men who sleep with them don't want to use condoms, so they (women) don't have a choice because they (women) want money". This does not only apply to commercial sex workers, but to women in general in Thabong.

(vi) Summary

In summary, interpersonal relationships between men and women in Thabong appear not to be conducive for safe sexual practices. Women appear to have little power in

sexual relationships and men's authority and dominance in sexual relationships appear to remain unchallenged and undeterred.

In addition to identifying factors that are perceived to impede the practice of safe sex among individuals in Thabong, as discussed above, the study also aimed to identify factors that are perceived to promote the effective practice of safe sex among men and women in Thabong. These factors will be discussed as needs of uninfected men and women that emerged from interviewing HIV-infected men and women. These needs are summarised in tabular form in Table 12.

9.3.2 Identified needs of uninfected men and women in Thabong in relation to HIV/AIDS

The respondents (all PLWA) identified needs of both men and women in Thabong that would have assisted them to practice safe sex prior to their becoming HIV-infected. These needs are based on the respondents' retrospective views of their own situations before they became infected compared to their current situation. In other words, the respondents identified specific behavioural strategies that could have prevented them from becoming infected, as well as factors that could have assisted them to apply these HIV-prevention strategies to their sexual behaviour. These needs will be presented separately for men and women, but in juxtaposition to create a comparative and complementary overview of these needs.

TABLE 12: Effective prevention of HIV/AIDS: The views of PLWA

Need	*Women*	*Men*
HIV/AIDS education and awareness	The respondents were of the opinion that women do not look for information about HIV/AIDS from relevant organisations in the community until they are infected. There is an urgent need for women to be encouraged to seek information about HIV/AIDS and how they, as women, can protect themselves from being infected. Also, organisations should target women with specific information about HIV/AIDS more aggressively.	Like women in Thabong, men are aware of HIV/AIDS, but their knowledge about the specifics of the disease is limited. It appears, however, that men are reluctant to accept that HIV/AIDS exists due to the implications of this acknowledgement to their sexual behaviour, namely changing high-risk sexual practices that satisfy sexual needs (e.g., multiple sexual partners and non-use of condoms). Men in Thabong have many misperceptions about HIV/AIDS, which include disbelief about the existence of HIV/AIDS, misconceptions about the function of condoms (e.g., condoms transmit HIV), and negative connotations of condoms (e.g., condoms are associated with unfaithfulness, sexual promiscuity, mistrust, etc.). Although these misperceptions seem real to those that hold them, it is possible that they may be a defence mechanism to avoid changing sexual practices that satisfy various needs in men. They (men) also tend to misinterpret facts and knowledge about HIV/AIDS as a form of justification for their reluctance to change high-risk behaviour. Therefore, men need to acquire detailed information and knowledge about HIV/AIDS, in order to resolve misconceptions and misperceptions about the disease.

Need	Women	Men
Sexual rights education and awareness	Women's sexual rights tend to be overshadowed by men's control over their sexual behaviour. Greater emphasis needs to be placed on making women aware of their sexual rights and their right to protect themselves from HIV/AIDS in their sexual relationships. Women perceive themselves to have less control over HIV-prevention due to factors such as gender-power imbalances, which influence their sexual behaviour. There is a need for women to acquire the appropriate knowledge and information about their rights to protect themselves against HIV-infection, and steps that they may take to ensure that they can exercise these. One respondent said, "females must report males who force them to have sex with them to the police".	Socio-cultural norms in Thabong appear to contribute to an environment conducive for the violation of women's sexual rights. Norms that influence gender-roles and which require women to be submissive and men to be dominant, have resulted in men resorting to coercion/force, violence, economic sanctioning, etc. against women who do not conform to these norms, especially in sexual relationships. It appears that women's sexual rights, such as the right to say no to sex and the right to protect oneself from STDs and HIV/AIDS, are in conflict with norms that render men the sole decision-makers in sexual relationships. Men often perceive women's efforts to protect their sexual rights as acts of condemnation against socio-cultural norms that govern the behaviour of men and women alike.

Need	Women	Men
Inter-gender communication	Women need to be able to discuss sexual issues and HIV/AIDS with their sexual partners. Sex is regarded as an activity involving two participants and both participants should have an equal say in issues pertaining to sex. Women expressed the need to be taught how to assert themselves in their sexual relationships. This could be achieved by encouraging women to form their own support groups where they can discuss sexual issues, including HIV/AIDS and their sexual rights, and to instil a culture of information-seeking among women in Thabong. One respondent reported, "Women must know that they have a right to say no if they don't want to have unprotected sex because when we have sex we are together. Therefore, we must both co-operate regarding safe sex". Another respondent reported, "Organisations must encourage women to stand up for their rights". It appears that women need to focus on efforts to make HIV/AIDS a negotiable issue in their sexual relations and place greater emphasis on the prominent role that women should play in sexual decision-making.	The inability of men and women in Thabong to discuss sexual issues seems to be a major obstacle to HIV-prevention. Both men and women expressed a need for men and women to talk to each other about sex and HIV/AIDS. It is also important to create an environment so that such discussions will not result in negative consequences for women.

Need	Women	Men
Economic empowerment	Women need to be less dependent on men for economic and material support in order for them to increase their perceived control over their sexual behaviour. In Thabong, socio-economic conditions that govern most sexual relationships are based on the high level of unemployment among women, which places them (women) in a vulnerable position in their relationships with men.	

In summary, women in Thabong appear to need to acquire detailed information and knowledge about HIV/AIDS, which they need to apply to their respective sexual behaviours. This acquisition of knowledge must be accompanied by the economic empowerment and enhancement of assertiveness of women in their sexual relationships. Economic empowerment and assertiveness will in turn increase perceived control of women over their sexual practices, which will in effect decrease their vulnerability to HIV-infection. Support groups for women are identified as a vehicle for this process to take place. The main focus of these support groups should be to encourage discussions and sharing of experiences about sexual issues in relation to HIV/AIDS. These support groups should aim to provide a forum for women to learn about their sexual rights and to create an environment that is conducive for implementing safe sexual practices, such as negotiating safe sex with sexual partners. One respondent said: "Organisations must advise women on how to encourage their partners to use condoms".

So far, support groups in the community are targeted mainly at PLWA and women at high-risk of HIV-infection, namely commercial sex workers. There appears to be a need to extend the target group of these support groups so that they include women in general.

However, merely educating women about their sexual rights without creating an environment that will support women to exercise these rights is not effective, nor will it be sufficient. Men need to be made knowledgeable and become convinced about the significance, appropriateness and benefits of implementing these rights in the lives of both men and women, as well as the community at large.

The AIDS epidemic appears to point towards the need to abandon socio-cultural practices that fuel the epidemic in favour of practices that will ensure protection from HIV-infection. For instance, sole decision-making by men regarding sexual practices increases women's vulnerability to HIV-infection. Thus, women are increasingly required to assume more responsibility regarding decisions about their sexual practices in order for them to protect themselves from HIV-infection. Changing gender-specific behaviour that has been learned and reinforced by various rewards and sanctions makes the process of attaining effective HIV-prevention difficult.

9.3.3 Focus group discussions

Focus group discussions were conducted with males and females in the age group of 15 to 49 years from various social strata in Thabong (cf. Chapter 8 for details regarding

participants in the focus group discussions). The group discussions were based on the assumption that participants are not HIV-positive because their HIV-status was unknown. The data from the group discussions will be discussed at the hand of themes that were identified during the data analysis process, and guided by the research objectives stated in Chapter 1 of this report.

(i)Motives for sex

Reasons for engaging in sexual intercourse differ between men and women. Women tend to engage in sexual intercourse to satisfy their need for love, esteem, belongingness, approval and security motives. Men tend to engage in sex for physical pleasure. This notion is supported by the findings of this study, as well as the findings of other studies about sexual motives.

Marriage and procreation are reported as reasons for having sex. Both men and women regard sex as one of the functions of marriage. Women believe it is one of their duties and roles as wives to satisfy their husbands' sexual needs (approval and belongingness motives), whereas men believe that it is their right to have sex with their wives as part of the marriage "agreement" (enhancement motives). One respondent said: "As a married women, I must have sex with my husband. If I don't have sex with him, I am making it difficult for him. He will then have no choice but to go find sex somewhere else...with another woman. Therefore, I must have sex with my husband. I really try hard to satisfy him". Another response in support of this belief is the following: "Because of marriage I have to have sex, to have babies, so that the man doesn't leave me". Another respondent added: "In a marriage, you have to satisfy your partner's (husband's) rights (referring to sex)".

Young girls believe that sex is a privilege bestowed upon married people and adults. One school-going female respondent reported: "We don't have keys for having sex". The keys are symbolic of the transition (rite of passage) from childhood into adulthood when an individual turns 21 years of age. Another respondent in the same age group reported: "No sex before marriage". Young boys, on the other hand, view sex as natural and important for everyone, including themselves. However, they are not clear about why sex is important. They simply perceive it as something that everyone should engage in. The following statements illustrate their views: "It's natural"; "Somehow it's important"; "I just do it because it's nice". These contradictory views of sex between young males and females points towards the possibility of the playing out of coercion and power as early as this age,

where boys may coerce girls to go against their beliefs. This view is confirmed by the responses of women about their first sexual encounter, which depicts violence. This is discussed in the theme on violence in sexual relationships (cf. Par 9.3.3 iv).

(ii) Knowledge about the prevention of HIV/AIDS and impediments to safe sex

The majority of respondents are aware of STDs and HIV/AIDS. Condom use and mutual faithfulness were reported as means to prevent HIV-infection. Although sexual abstinence was not rejected as a means of preventing HIV-infection, it was also not perceived as a practical and feasible method of preventing infection because it hinges on an important basic human need (cf. Maslow's Hierarchy of Needs in Chapter 3).

a) Condom use

The majority of respondents believe that HIV-transmission can be prevented through the use of condoms. This is illustrated by responses such as the following: "Condoms are a good way of protecting you against illnesses because your fluids cannot mix during sex. For example, you can protect yourself from falling pregnant by using the pill or injection. But for STDs and HIV/AIDS, the only way to protect yourself is by using a condom". According to respondents other reasons for using condoms include:

- Contraception. This was especially reported by younger respondents who associate condom use more with prevention of pregnancy than HIV-prevention. Therefore, if an alternative form of contraception is used (e.g. injectable contraception), condom use is abandoned and along with it protection from HIV-infection.

- "Casual" sexual relations. Sex with a casual sexual partner is associated with little trust between partners, which makes it acceptable to use a condom.

- Extended periods of absence of a sexual partner are also reported as a reason to use condoms. One respondent said that men who are away from their sexual partners for long periods at a time are often "seduced" by beautiful women. Therefore, migrant workers are at a higher risk of being infected with HIV and in turn infecting their sexual partners. There appears to be a realisation among respondents that condoms should be used in stable relationships when one partner is constantly away for extended periods of time.

Various reasons are given as impediments to condom use, including the following:

- A few male respondents believed that condoms are unreliable and carry worms that transmit HIV (cf. Par. 9.2.1. (vi)). According to the respondents, only condoms that are obtained free "have worms". This myth about the use of condoms is a manipulation of messages about HIV/AIDS and safe sex, which challenges the level of detailed knowledge provided by HIV-prevention initiatives. It would appear that HIV/AIDS-prevention initiatives should provide detailed knowledge about safe sex in order to rectify misconceptions and myths that hinder the practice of safe sex.

- Condoms are also viewed as a form of killing. Sperm is personified and perceived as a form of life or prerequisite to a live human being. Thus, ejaculating into a condom, which is then destroyed, is viewed as an act of murder. Sperm is also viewed as an opportunity to produce offspring that will have a high social status in society and using a condom diminishes the chances of doing so. The following responses are points in illustration: "When using a condom you are killing because after sex you have to throw away the sperm"; "I don't use it (condoms) because my sperm are like soldiers and these soldiers will make a future doctor".

- Condoms are associated with loss of sexual pleasure during sex. It is reported that sexual pleasure is derived from the mixing of male and female genital secretions during sexual intercourse. This is referred to as "flesh to flesh" sex. Both men and women report that they want "flesh to flesh" sex in order for them to enjoy sex.

- Men and women appear to be reluctant to use condoms in their stable relationships because of the fear that their sexual partners may accuse them of mistrust and unfaithfulness, which may result in loss of trust and even the termination of the relationship or marriage. This is especially a reason for concern since mutual faithfulness in stable relationships does not appear to be reinforced or aggressively condoned to the point that it is valued.

- Although condoms are available from various outlets in the community at no cost, they can still be unavailable at the time when they are needed. Men, especially adolescents, report that they continue to engage in sexual intercourse without a condom if they do not have condoms with them when they engage in sex. Forgetting condoms at home, misplacing condoms and forgetting to refill condom supplies are cited as reasons for not having condoms when needed.

- Some respondents reported not knowing how to use condoms as reason for them not using them. Especially older women believe that condoms are only for use by younger people, which they feel justifies their (the older generation's) lack of knowledge about condoms. One female respondent said: "During our days there was no AIDS and that is why we don't like condoms". Another female respondent said: "We the older people don't know about this (condoms)...it happens to the younger people. We don't even know how to use it".

- Non-use of condoms is also attributed to difficulty in changing routine, namely, introducing condoms into a sexual relationship where condoms were never used before. The response: "I don't see any reason why I would ask my sexual partner to use a condom because we usually have sex without it" points towards this view. Although respondents did not identify the cause of difficulty, it may be attributed to the difficulty that generally accompanies any form of change in an individual's lifestyle. It is ultimately associated with a reluctance of moving from the "familiar" or certainty to the "unfamiliar" or uncertainty.

Other reasons for not using condoms include:

- the association between condom use and the occurrence of female genital rash,
- the unpleasant smell of condoms,
- condoms that are too large or small,
- poor reliability of condoms because of a tendency to tear (poor quality),
- the association between duration of sex and risk perception, i.e. the shorter the duration of sexual intercourse, the lower the risk of HIV-infection.

b) Mutual faithfulness

Mutual faithfulness as a way to prevent HIV-infection. However, it appears that mutual faithfulness is often only expected of married couples. Unmarried individuals are perceived as still seeking the most suitable partner to enter into a life long commitment with. Thus, they are exempted from "sticking to one partner". This is illustrated by the following statements: "It's better to have two partners so that you can choose the best one". However, even mutual faithfulness among married people is not well practised, despite expectations of such behaviour.

Impediments to mutual faithfulness include, inter alia the following:

- Having more than one sexual partner is viewed as a strategy to combat the repercussions of an unfaithful sexual partner. In other words, if an individual discovers that his/her sexual partner is unfaithful, he/she will have at least one other sexual partner to his/her avail, thus avoiding being single or having to find another sexual partner.

- Having multiple sexual partners is also viewed as a means of sustainability. Especially women associate sexual partners with financial or material security. This is especially relevant in the light of the high level of unemployment and limited employment opportunities for women in Thabong. Therefore, sexual relationships are perceived as a means of earning a living (source of income), and the more sexual partners an individual has, the more they "earn".

c) Sexual abstinence

The majority of male and female respondents are aware that sexual abstinence is the best safeguard against HIV-infection, yet they do not regard sexual abstinence as an option in preventing HIV/AIDS. They perceive sex as a part of human nature that cannot be denied or ignored and it plays an integral part in mental and physical well-being. It would appear as though sexual abstinence is supported only for unmarried people or for people under the age of 21 years. Especially older people are of the opinion that individuals should abstain from sex until they are at least 21 years old. Female youths and adolescents feel that sex should be reserved for marriage. However, as the findings of the study indicate, this belief is confronted with several social, cultural, economic and emotional realities that make it difficult to practice.

Impediments to sexual abstinence include the following:

- It is believed that sex is a manifestation and an expression of love. This view is expressed by statements such as the following: "We better use the condom rather than avoid it (sex) because it is difficult when you have a girlfriend...to avoid it (sex)" and "There is no love without sex".

- Sexual abstinence is associated with perceived disorders such as psychological instability, high blood pressure, stress, stomach inflammation, and general ill-health. The following responses are points in illustration: "We'll get sick if we abstain"; "I'll

have high blood pressure if I abstain"; "I have sex to work off stress" and "If you don't have sex you develop a huge stomach".

- It was almost unanimously reported that sex is part of human nature and that abstinence would be a defiance of this. This view is expressed in responses such as the following: "We can never abstain. Sex started with Adam and Eve. If Adam and Eve could abstain, then we would also abstain here on earth"; "It is difficult to abstain if you are a human being". Especially men attach gender significance to their sexuality and view sex as an expression of their masculinity. Thus, abstaining from sex renders an individual incompetent as a "man". One respondent said: "I won't be able to abstain from sex because it (sex) makes me a man". Another direct response in support of this view is the following: "If you are a man you have to have sex".

- Sex is associated with procreation, which appears to become more important as people become more aware of the dramatic increase in AIDS-related mortality. There is a basic contradiction in the need to engage in sex to maintain current levels of population growth on the one hand, and the knowledge that, in a crude sense, sex is responsible for eroding population growth.

- Sex is also associated with fertility and thus with social status. Especially men reported having to engage in sex in order to produce offspring, which will give him the status of and associated social respect as a father.

(iii) Gender-role norms/stereotypes and sexual behaviour

Gender-role norms, based on socio-cultural norms, are clearly defined and adhered to by men and women in Thabong. Gender role-norms prescribe roles that render women submissive and vulnerable to physical and psychological abuse, whereas rendering men authoritative, and granting them a large degree of control over women. These gender-specific attributes can be defined as gender stereotyping.

Gender stereotypes are evident in views that female respondents express regarding their sexual behaviour. According to female respondents, women do not have sexual desires. Rather, they have to be aroused by men in order to desire sex. Also, it is believed that women should not initiate sex, only men should. Women should be reserved and submissive during sexual intercourse, and women should always do what their sexual partners tell them to do. These stereotypes appear to be accepted in Thabong, and

condoned through various forms of social rewards, such as financial security and material gain. They are confirmed and manifested in sexual relationships in the following ways:

a) Decision-making

Both male and female respondents regard men as decision-makers in sexual relationships. Although women may give suggestions about sexual matters, the final decision pertaining to sexual practices seems to fall in the hands of men. This decision-making power granted to men undermines women's negotiating powers and violates sexual rights. Decision-making pertaining to sexual practices is illustrated by statements such as the following: "In a marriage you have to satisfy your partners rights (referring to sexual "rights")"; "I would like to use a condom but my husband doesn't want to"; "You cannot just tell your husband what to do. You must do what your husband says... I do whatever my husband tells me to do"; "If I get into bed with a woman, the woman must do as I want because I'm the man"; "Men are the only people who make decisions about sexual behaviour".

Women in Thabong do not appear to play a significant role in decision-making in general, and particularly in decisions pertaining to their sexual behaviour. Women are expected to be subservient and submissive. Therefore, they are not expected to assume a leadership role in their relationships with members of the opposite sex. Most women have been socialised to believe that their role as women is to satisfy the needs of men, to be a source of emotional support to men, and to allow men to lead while they as women should follow. This view is illustrated by the following response: "When I come back from work I should give him food and ask him how his day was and also give him water to wash".

The cumulative result is that women in Thabong appear to be reluctant to express their views and to contribute to making decisions about their sexual behaviour. Only one female respondent reported playing a significant role in making decisions about her sexual behaviour. This was evident in her response that: "My husband works out of town and doesn't sleep at home everyday. I'm a very strict person, so when my husband returns home I send him to the clinic for a check-up. This was in the past, however. Now, we use a condom. I have told my husband it is not because I don't trust him but I know that there are women who are very good at seducing men. I also told him that it would not be easy for me to just resume sex after he has been away for a long time. Sometimes those women who seduce men have STDs and I fear being infected".

b) Sexual needs

According to respondents, sex is perceived as part of the behavioural repertoire of a man. Most men appear to believe that they do not need to exercise control over their sexual desires because their sexual drive is stronger than that of women and that they (men) are genetically predisposed to giving in to sexual desires. On the other hand, they believe and expect that women should have sex with their sexual partners whenever their sexual partners so desire. This notion is evident in the following response: "Sometimes when you refuse to have sex with your husband...sometimes you just don't feel like having sex, your husband will ask you, 'where should I go...must I go to the street to find sex!'".

The belief that men are unable to control their sexual desires may explain their tendency to have sex with women that they admit not loving or even being attracted to. Most men reported that they have never and would never decline the opportunity to have sex with a woman who is willing to have sex with them (men). A respondent said: "I'll pretend to like her because I want sex ... even if I don't have any love for her, I'll just pretend". On the other hand, it appears to be a common notion in Thabong that women do not have strong sexual desires and can go without sex for long periods of time. In essence, women engage in sexual intercourse primarily to satisfy the sexual needs of men. This would appear to indicate that men's motives for having sex seems to be primarily for sexual pleasure and satisfaction, while women's motives for having sex are primarily for approval and security.

Very few women reported that they expect their sexual needs to be satisfied by their sexual partners. Women believe that they should assume a passive role during sexual intercourse, thus allowing men to dominate and assume the leadership role, in order to conform to gender-role stereotypes. Those who reportedly have attempted to assume a more active role in sexual relationships were labelled as nymphomaniacs or accused of unfaithfulness by their partners. They perceive this as a negative sanctioning of a women's influencing power in sexual relationships, which reinforces their vulnerability to the risk of HIV-infection.

c) Multiple sexual partners

Despite views that support mutual faithfulness in sexual relationships, men's engagement in multiple sexual relations appears to remain uncensored in Thabong. It appears that men are exempted from remaining faithful to one sexual partner on condition

that they fulfil their expected roles as sexual partners. One of these roles is to care for and support their regular sexual partners. This behaviour, namely caring for and supporting sexual partners despite the number of sexual partners a man has, is regarded as an expression of respect towards the relevant sexual partners. One respondent said: "If a man has another woman, he is taught to still respect his wife".

Women are expected to be faithful to their sexual partners. However, having more than one sexual partner as a means of sustaining oneself or one's family is often viewed as justification for having multiple sexual partners.

(iv) Coercion and violence in sexual relationships

In focus group discussions, violence was reiterated as the main reason for women's inability to practice safe sex. According to respondents, violence against women by their sexual partners is a common occurrence in Thabong. What is especially disturbing is that more than 75% of the female respondents described their first sexual encounter as involving violence, blackmail, physical threats and assault, all of which depict rape. One respondent related her first sexual encounter saying: "...the boy used to place a knife and rod next to me and tell me to choose between having sex with him or being stabbed and beaten with the objects...He wanted a child from me but couldn't marry me because he wasn't working. Since then I got used to always agreeing to have sex with him". Another respondent said: "The taxi driver who used to transport my mother and I to prayer meetings on Saturdays gave me an ultimatum by threatening to stop taking my mother and I to prayer meetings if I refused to enter into a sexual relationship with him. He was much older than I was so I felt forced to enter into a relationship with him".

Most female respondents associate sex with violence or coercion and some male respondents appear to derive satisfaction from using force and violence in their sexual relationships with women. A male respondent said: "I'll first take her to the bedroom and if she doesn't want to have sex, 'Ek moer haar dik!'", (translated: "I'll beat her up!"). Another male respondent supported this reaction by saying, "If I see him hitting her, I'll help him 'moer haar dik!'. Other responses that confirm that violence against women in sexual relationships is apparently the norm include the following: "As a woman I become frightened because they (men) threaten to kill us if we don't want to enter into a sexual relationship with them"; "They rape us!". One respondent describes sex with her partner as follows: "He strangles me and then I find him on top of me and then he rips my underwear off because he has power".

Because of this ever present threat of violence, women appear to be reluctant to do anything that might provoke a negative reaction from their partners, including convincing them to use a condom or to refuse sex. This fear is expressed in responses such as the following: "I love condoms, but if my partner were to walk into the room right now he would strangle me for saying so".

(v) Alcohol and safe sex

Alcohol consumption is associated with diminished control over sexual behaviour, increased high-risk sexual practices and increased sexual desire (cf. Appendix II). It reportedly has a negative influence on rational decision-making. In this study, it was associated with the non-use of condoms, heightened sexual desires of both men and women and engaging in sex with partners that an individual would not engage in sex with in the absence of alcohol consumption. Alcohol appears to be a major obstacle to practising safe sex and appears to promote high-risk sexual practices.

(vi) Influence of peers, partners and parents on sexual behaviour

Parents, partners and peers are reported to exert a significant influence on sexual behaviour. Parents tend to be the main source of influence on sexual behaviour at an early age. However, peers and sexual partners gain increasing influence over sexual behaviour as people grow older.

a) Influence of parents on sexual behaviour

According to respondents, parents teach boys and girls about sex and sexuality from an early age. This education does not appear to be explicit and seems not to rely heavily on facts. Instead, parents appear to resort to educational tactics that instil fear of sex in young boys and girls. The primary focus of sexual education by parents is on pregnancy prevention, with very little mention of HIV/AIDS-prevention. This view is illustrated by the following responses: "Our parents teach us not to play with boys" and "We are told that if we play with boys we will have babies".

It is reported that sexual education by parents is mainly geared towards young girls and not towards young boys, as expressed by the response: "Parents talk only to women when they are still young. They (parents) tell them (women) not to sleep with men till they are married".

b) Influence of friends and peers on sexual behaviour

As children develop physically and psychologically, the influence that parents have on their sexual behaviour weakens, while the influence of friends, peers and sexual partners strengthens. Among adolescents, the influence of friends over the sexual behaviour appears to be alarmingly strong. This influence is illustrated by the following responses of both young men and women: "Friends have the most influence over our sexual behaviour because we spend more time sitting in groups with friends"; "Some friends discuss their sexual experiences with you after having sex with his girlfriend"; "We give each other advise here at school on how we should behave sexually"; "Friends tell you how to treat your girlfriend".

The influence that peers and friends have on each other's sexual behaviour appears to be stronger among males than among females. This may be attributed to the fact that males spend more time with each other, in groups, than females spend with each other partly as a result of the differences in gender-specific household tasks that each is expected to fulfil.

c) Influence of sexual partners on sexual behaviour

It appears that the older individuals get, the stronger the influence of sexual partners becomes over sexual behaviour. Many women, especially married women, reported that their sexual behaviour is directed by their sexual partners or husbands. This is evident in women's inability to use condoms to protect themselves against HIV/AIDS as a result of their sexual partners' dislike of or disbelief in the use of condoms.

Men report that women influence their sexual behaviour, yet there is no clear indication as to how their sexual behaviour is influenced. It can be assumed that women's inability to talk about sex and negotiate safe sex indirectly condones men's dogmatism in sexual relationships.

(vii) Learning of sexual behaviour

Sexual behaviour in Thabong appears to be learned through the social learning of behaviour, namely classical conditioning, operant conditioning and modelling (Baron & Byrne, 1994). According to male and female respondents, sex is initially learnt through direct observation of the behaviour of adults (usually parents or older siblings) and thus modelling that behaviour. Young boys and girls take on the roles of men and woman or mothers and fathers, and they role-play the sexual relations between the two genders.

This role-play takes place in the form of a childhood game called *mantlwaneng*. *Mantlwaneng* is a game that consists of two or more players, in which one female player assumes the role of a mother and one male player assumes the role of a father. Other players often take on the role of children. The game aims to depict the functioning of a real life family. The two players acting as the mother and father imitate the sexual behaviour of a real life mother and father according to their knowledge of sex. It is reported that knowledge about how to have sex is learnt from observing parents and other adults in the community during childhood years.

As children grow older, sexual behaviour is learned through classical and operant conditioning, namely through direct positive reinforcement and negative reinforcement of behaviour.

9.4Summary of findings of group discussions and individual interviews

Based on the discussion of the main findings of the study dealt with this far in this chapter, the most prominent issues in view of the research objectives will be extrapolated in a summary table. This extrapolation and summation of the findings is aimed at providing an analysis of contradictions and similarities between the findings of the individual interviews and focus group discussions, as well as between the overall findings and existing literature/theories. It is also aimed at highlighting the relationship between independent variables such as gender, HIV-status, age, level of education, etc., and sexual behaviour.

TABLE 13: A summary of the major results and findings of the research

OBJECTIVE	FINDINGS
Factors that impede the practice of safe sex in Thabong.	•Failure to internalise knowledge about HIV/AIDS is a major obstacle to appropriate behaviour change among both men and women. Internalisation of knowledge about HIV/AIDS appears to take place only once an individual is diagnosed as HIV-positive, thus rendering it ineffective to prevent infection. •Indifference to HIV/AIDS among both men and women prevents them from internalising knowledge about HIV/AIDS prevention and transmission so that they can adapt their sexual behaviour accordingly. This indifference to HIV/AIDS (reported as disbelief in the

OBJECTIVE	FINDINGS
	existence of AIDS and subsequent continuation with high-risk sexual behaviour) may be viewed as a defence mechanism to avoid changing high-risk behaviours which serve the purpose of satisfying various human needs (cf. Chapter 4 – Maslow's Hierarchy of Needs). This indifference to knowledge about HIV/AIDS may also be linked to the view that the immediate gratification of basic human needs such as sex are perceived as more important than the future threat of HIV/AIDS (Skinner, s.a.; Cooper *et al.,* 1998). ◦Gender imbalances are at the root of women's perceived obstacles to preventing HIV-infection. Gender imbalances are manifested in gender-role stereotypes that prescribe gender-specific attributes to men and women in Thabong, based on socio-cultural norms. This finding supports the findings of other studies on sexual behaviour such as KAPB-studies about HIV/AIDS (cf. Chapter 3). For example, women are "expected" to be subservient, submissive, passive and respectful, whereas men are "expected" to be dominant, authoritative, aggressive, and decision-makers. ◦Sexual relationships are viewed differently by men and women. Men engage in sex mainly for sexual pleasure and to satisfy physical needs. Women, on the other hand, engage in sex mainly to satisfy security, emotional, esteem, and love needs. Therefore, women tend to view sexual relationships as a means of security, be it emotional, financial or physical. This finding supports literature on the gender-specificity of sexual motives (cf. Chapter 4). ◦Marriage is viewed as synonymous with mutual faithfulness. In other words, most women do not perceive themselves at risk of HIV-infection in a marriage, thus they do not see the need to use condoms. They assume that one-sided faithfulness is a form of safe sex based on the HIV/AIDS awareness slogan, "stick to one partner". However, only mutual faithfulness between sexual partners is regarded as safe sex. A significant number of women that are HIV-positive reported that they were infected by their husbands. They perceived themselves as "immune" to HIV-infection because of their marital status. This finding is consistent with the findings of other studies about relationship

OBJECTIVE	FINDINGS
	context and condom use, whereby individuals that do not use condoms are more likely to be in exclusive/stable relationships (Cooper *et al.*, 1999). ◦Women apparently have low perceived self-efficacy about their behaviour in general, but especially about their sexual behaviour. This low perceived self-efficacy among women is largely attributed to the influence of gender-role norms that create an environment conducive for men to control the behaviour of women, including their sexual behaviour. Men control the behaviour of women through the use of coercion, violence, physical and emotional threats, amongst others. This finding is in line with findings of other studies about sexual behaviour and HIV/AIDS such as the findings of KAPB-studies about HIV/AIDS (cf. Chapters 3 and 4). ◦Condom use is associated with negative connotations such as unfaithfulness, mistrust, sexual promiscuity, non-verbal admittance of HIV-infection, diminished sexual pleasure, and physical dysfunctions such as kidney malfunctioning and vaginal rash. These so-called "cons" of condom use appear to overshadow the so-called "pros" of condom use, namely HIV-prevention. •The most widely held belief (myth) about condoms is that they transmit HIV rather than preventing its transmission. This belief was reported by both men and women, but it appears to be stronger among men than women. Individuals who are HIV-positive appear to accept this belief as being a myth, but acknowledge that it is a widespread belief in Thabong. ◦The costs associated with condom use are perceived to outweigh the benefits thereof. For example, condom use, especially among women, is associated with the loss of a sexual partner who will seek out another partner that is willing to have sex with him without a condom. Since a sexual partner is a source of financial and emotional security to women, they stand too lose much more than a sexual partner if they insist on the use of condoms in a relationship. Thus, according to women, the risk of suggesting or insisting on condom use (safe sex) in a relationship outweighs the benefit of doing so (i.e., preventing HIV-

OBJECTIVE	FINDINGS
	infection). Men, on the other hand, associate condom use with HIV-infection. Therefore, the costs of using a condom with a sexual partner may lead to rejection and labelling/stigmatising, which outweighs the benefits of using a condom, namely preventing HIV-infection or transmission. Other associated costs of condom use such as reduced sexual satisfaction also appear to outweigh the benefits of condom use. This finding is in line with findings of other studies about the cost/benefit ratio of condom use, whereby condom users often discontinue its use with perceived high costs (e.g., decrease in sexual pleasure) or if the perceived benefits of not using condoms increases (e.g., increased intimacy and partner-approval) (Marcus, 2001; Cooper *et al.*, 1999). ◦Contrary to the findings of other studies about condom use, which report negotiating of condom use to be easier in a stable relationship than a casual relationship (Skinner, s.a), this study found negotiating of condom use to be easier in casual relationships where there is little trust, than stable relationships. The low level of condom use in stable relationships is attributed to the negative connotations attached to condom use in Thabong (i.e., sexual promiscuity, unfaithfulness, untrustworthiness, etc.). ◦Sexual abstinence, as a form of safe sex, is not well accepted among men and women, but even less acceptable among men. Sex is viewed as a natural and important part of life. There are age and gender differences regarding when sex is legitimate and appropriate. Young girls perceive sex as appropriate and legitimate for adults (21 years and above) and married couples, whereas young boys perceive sex as appropriate as soon as an individual develops sexual needs and desires (which they refer to as the "development stage" – puberty). Older men perceive sex as part of the unwritten marriage "agreement". Therefore, men often get married in order to legitimise sex and thus avoid rape allegations. The view that sex is the right of a man in a marriage or that men are obligated to have sex with their wives, increases women's vulnerability to HIV-infection by decreasing the control they have over decisions about their sexual behaviour.

OBJECTIVE	FINDINGS
	◦In general, both men and women agree that mutual faithfulness should be practised in a marriage. This is mainly based on religious vows that stipulate faithfulness as an integral part of a marriage. However, gender stereotypes that attribute high sexual needs/desires to men, and that point towards men being predisposed to not being able to control their sexual needs and desires, fail to condemn (may even condone) the male tendency to have multiple sexual partners to satisfy their sexual needs. Unfaithfulness of women is discouraged but there are circumstances that are perceived as justification for such behaviour, namely engaging in multiple sexual relationships to sustain oneself and one's family. This finding is in support of findings from studies conducted in other communities (cf. Chapter 4). ◦Alcohol was reported to have a negative influence on safe sexual practices. This study found a direct association between alcohol and reduced rational thinking, which leads to increased risk-taking, including high-risk sexual behaviour. This was reported by all age groups and among both males and females.

OBJECTIVE	FINDINGS
Factors that are conducive to the practising of safe sex in Thabong.	◦The ability to talk about HIV/AIDS and safe sex was reported by both men and women as a factor that may contribute to the acceptance of safe sexual practices such as condom use in a sexual relationship. However, this is not a common practice in Thabong. ◦The female condom (femidom) is perceived to increase women's chances of preventing HIV-infection. This was based more on assumptions rather than personal experience. It appears that knowledge about the female condom is very poor, with some women even reporting not ever having heard of it. This was especially so among women who were assumed to be HIV-negative (focus group discussions). ◦Voluntary confidential counselling and testing (VCCT) as a prerequisite to sex was reported as a factor that would assist individuals to internalise HIV/AIDS, and thus practice safe sex. However, in view of males being decision-makers in sexual relationships, and in the absence of internalisation of knowledge about HIV/AIDS among both men and women Thabong, this practice does not seem practical at this point in time.

OBJECTIVE	FINDINGS
The relationship between determinants of sexual behaviour in Thabong (i.e. knowledge, sexual motives, attitudes – salient beliefs and evaluations of consequences of specific behaviours, and subjective social norms (perceptions of behavioural expectations of significant others). (cf. Figure 9)	Based on the multidisciplinary analytical model of sexual behaviour (cf. Chapter 4), the following can be noted about the sexual behaviour of men and women in Thabong: ◦ Although specific and detailed knowledge about HIV/AIDS among so-called uninfected men and women is poor, awareness of the disease is generally high in Thabong. However, various defence mechanisms such as denial and indifference to the disease are used to avoid internalising knowledge about AIDS. This lack of internalising knowledge leads to sustained high-risk sexual practices. ◦ Sexual motives appear to have a very strong influence on sexual behaviour. For example, men perceive sex as natural and as an integral part of life. Sexual abstinence is associated with the occurrence of various psychological and physical dysfunctions/illnesses. Women perceive sex as satisfying emotional, security, love and esteem needs, whereas men perceive sex to mainly satisfy physical needs/desires. Therefore, sex plays an important function in the psychological and physical well-being and health of an individual. ◦ Attitudes towards safe sexual practices tend to be gender-specific. Women in Thabong generally have positive attitudes towards condom use and mutual faithfulness. Namely, that condoms and "sticking to one partner" prevent HIV-infection and transmission (salient belief). However, they also believe that asking their sexual partners to use condoms will have negative consequences such as violence, loss of a partner, coercion, etc. (evaluation of the consequences of using a condom). Thus, the cognitive component of women's attitudes towards safe sex (i.e. condoms and mutual faithfulness will protect them from HIV/AIDS), is often inconsistent with the affective component of their attitudes (i.e. condoms will result in loss of financial and emotional security, as well as violence, thus causing physical and emotional pain). In the absence of a social environment which supports women asserting themselves in sexual relationships (subjective social norms), women tend to abandon safe sexual practices in order to conform to behaviour which is approved of by socio-cultural norms and

9.5Conclusion

Obstacles to the effective practice of safe sex among men and women in Thabong are largely rooted in gender- related power imbalances, which are based on socio-cultural norms that condone male dominance and female subservience. The socio-economic profile of Thabong, which renders a large proportion of women financially dependent on males (lack of employment and employment opportunities for women), contributes to gender-related power imbalances. Various defence mechanisms such as denial of the existence of AIDS (indifference to AIDS) are used by males and females in Thabong to avoid internalising knowledge about HIV/AIDS. In the absence of internalisation of knowledge about AIDS, high-risk sexual practices that satisfy important basic needs are maintained.

The main conclusion is that Thabong may be viewed as a social environment conducive for high-risk sexual practices and less conducive for safe sex because of the inter-relationship between the following:

- Poor internalisation of knowledge about AIDS and high-risk sexual practices;
- Socio-cultural norms that reinforce gender imbalances;
- Socio-economic profile of Thabong that places women in an economically dependent and therefore vulnerable position in relation to men, again reinforcing gender-based power imbalances.

The cumulative result is that the male-dominated view of sex and sexual behaviour prevails. It would appear that this view is based on the paramount sexual needs and preferences of men, which are not geared towards safe sex.

Chapter 10

CONCLUSIONS AND RECOMMENDATIONS

10.1 Introduction

In this chapter the findings of the research will be summarised and key conclusions which inform the main aim of the study will be drawn. Based on the findings, impediments to safe sex in Thabong will be identified and community-specific measures to overcome these impediments will be proposed.

10.2 Main conclusions

Based on the findings presented in Chapter 9, the most significant findings will be summarised and presented as the main conclusions of the study. The presentation of these conclusions will be guided by the study objectives and will be presented according to the main themes that emerged from the findings.

10.2.1 Knowledge about HIV/AIDS

Knowledge about the existence of HIV/AIDS appears to be high among men and women in Thabong. However, detailed knowledge about the disease is poor, often resulting in perpetuation of high-risk sexual behaviour. This lack of detailed knowledge can be attributed to various reasons and are not necessarily based on insufficient HIV/AIDS awareness and education initiatives in Thabong.

No significant difference was found in the level of knowledge about HIV/AIDS between the various social strata of respondents. Knowledge about the basics of HIV-transmission and prevention is relatively high across all social strata in Thabong, and so are beliefs and perceptions/misperceptions (myths) about safe sex and HIV/AIDS.

10.2.2 Perceived risk of infection

The majority of individuals in Thabong do not perceive themselves to be at risk of HIV-infection. Reasons for this include:

- Non-acknowledgement of the existence of HIV/AIDS, and associated indifference to the risk of infection prevents individuals from practising safe sex. Especially men appear to manipulate knowledge about AIDS to prevent them from having to change high-risk sexual practices in favour of safe sex.

- Non-internalisation and non-personalisation of knowledge about HIV/AIDS prevents appropriate behaviour change. Individuals in Thabong tend to associate HIV/AIDS with specific high-risk social groups such as immigrants and commercial sex workers. Thus, individuals who do not fall within these "high-risk" groups are perceived to be at low-risk of HIV-infection. This prevents people who do not associate themselves with these perceived high-risk groups from practising safe sex.

- It appears that knowledge about HIV/AIDS is only internalised and accepted once an individual becomes aware that he/she is living with HIV/AIDS. Only then is sexual behaviour adapted in most cases.

10.2.3 Myths and misperceptions about safe sex

In general, condom use, mutual faithfulness and sexual abstinence are viewed as methods of preventing HIV-infection. However, the following myths and misperceptions are impediments to the practice of these methods of safe sex:

- The belief that unilateral faithfulness is a form of safe sex prevents individuals from using condoms and thus renders them vulnerable to HIV-infection. Especially women believe that by being faithful to their sexual partners, they are not susceptible to HIV-infection. This belief is based on knowledge that faithfulness is one of the modes of practising safe sex. However, this fact only holds true if both sexual partners are faithfulness. This method of safe sex is ineffective for preventing HIV-transmission and infection if only one partner is faithful, which seems to be a regular phenomenon in Thabong. The faithful partner is in this way exposed to the risk of infection by trusting an unfaithful partner.

- Marriage is regarded as another form of safe sex. This belief is based on the assumption that marriage is a formal union of trust and fidelity between two individuals. This assumption is reported more among women than men. Therefore, married women do not see it necessary to practice any other form of safe sex such as condom use and sexual abstinence. Once again, the assumption holds true only if

both partners remain faithful in the relationship, which appears often not to be the case in Thabong.

- Condoms are associated with HIV-transmission, sexual promiscuity, unfaithfulness, untrustworthiness, as well as with the perceived occurrence of physical dysfunctions/conditions. These negative associations with condom use appear to be largely used as defence mechanisms to avoid changing sexual behaviour.

- Sexual abstinence is associated with the occurrence of physical and psychological dysfunctions/illnesses as a result of the failure to satisfy a biological basic human need, namely sex. Abstaining from sex is also viewed as tampering with the laws of nature, since sex is perceived as part of human nature. Therefore, although sexual abstinence is acknowledged as a sure safeguard from HIV-infection, it is also not seen as a feasible and practical option to practising safe sex by both men and women in Thabong.

10.2.4 High-risk sexual behaviour

Various factors influence decisions about sexual behaviour. Socio-cultural norms that govern interpersonal relations between men and women in Thabong appear to be at the core of these influencing factors. Gender-role norms that prescribe gender-specific attributes to men and women in Thabong influence their sexual behaviour to a large extent. Sexual behaviour that conforms to these norms is reinforcement by various rewards such as social and financial security, social acceptance, material gain, enhancement of self-confidence and self-esteem, etc. However, these norms also fail to censor behaviour that violates sexual and reproductive rights of women. Thus, gender-role norms often render women vulnerable to HIV-infection. These norms are manifested in the following behaviours:

- Women in Thabong are expected to be subservient and submissive, while men are expected to be dominant and aggressive. Thus, men in Thabong make decisions about sexual behaviour, which inevitably affects the sexual behaviour of their female sexual partners, whereas women are expected to abide with these decisions in order to conform to gender-role norms that govern behaviour in Thabong. These norms prevent women that perceive themselves at risk of HIV-infection from practising safe sex because negotiating safe sex, such as condom use or sexual abstinence, are perceived as being assertive. Assertiveness, especially in sexual relationships,

contradicts the role that women are expected to play out in accordance with gender-role norms.

- Women are generally not expected to have strong sexual needs, whereas men are expected to have above average sexual desires and needs which they (men) perceive to have very little control over. For this reason men engaging in multiple sexual relations remain largely uncensored. Gender-role norms reinforce such behaviour among men and renders unfaithfulness among men "acceptable". Women may remain faithful to one sexual partner as a means of practising safe sex (one-sided faithfulness), but their efforts will be ineffective in protecting themselves against HIV-infection if their sexual partners are not faithful too and do not use condoms appropriately.

- Women fear violence, losing a sexual partner, and losing financial security if they insist on practising safe sex in their sexual relationships.

10.2.5 Sexual and reproductive rights

Women, especially those who are married, have very little knowledge of their sexual rights in relation to HIV/AIDS. Women in general are not aware of the extent to which their sexual relationships with men make them vulnerable to HIV/AIDS. This may be attributed to lack of knowledge about their sexual rights. Other impediments to women exercising their sexual rights pertaining to HIV-prevention include the following:

- Most sexual rights are in contradiction with socio-cultural norms that govern the behaviour of men and women in sexual relationships in Thabong. For example, women have the right to protect themselves from HIV-infection by practising safe sex such as appropriate condom use or sexual abstinence. However, women would have to portray decision-making qualities to implement such practices. Decision-making and assertiveness are culture-specific attributes of men, not women, in Thabong. Therefore, women would have to defy norms that guide their behaviour in order to protect themselves from HIV-infection, and this may result in the sanctioning of such behaviour. Due to the rewards of adhering to socio-cultural norms, behaviour that is in line with these norms such as non-use of condoms, are reinforced at the expense of safe sex.

- Women in Thabong appear to believe that they are inferior to men and that they are duty bound to satisfy the needs of their sexual partners. Behaviour that is not within the bounds of social norms is more often than not met with punishment or is negatively reinforced based on social sanctions that exist in Thabong. Punishment and negative reinforcement include, inter alia, infliction of physical pain, termination of a sexual relationship, being ostracised and loss of financial or material support. Some women compromise their sexual rights in order to prevent their sexual partners from seeking fulfilment of their sexual needs elsewhere.

- Young girls in Thabong appear to be knowledgeable about their sexual and reproductive rights. However, socio-cultural norms, especially gender stereotypes that promote male dominance and aggression, prevent young girls from exercising their right to practice safe sex.

10.2.6 Socio-economic status

The high-level of unemployment and lack of employment opportunities for women in Thabong contributes to women's vulnerability to HIV-infection. Women regard sexual relationships as a means of obtaining financial or material income. Thus, the more sexual partners a woman has, the larger the total income she receives and subsequently the higher her chances are of sustaining herself and her family. Therefore, sexual relationships are viewed in the same light as financial security. This does not apply only to commercial sex workers but to women in general in Thabong.

10.2.7 Fear of violence and coercion

Violence appears to be a major impediment to women practising safe sex in Thabong. Women associate their first sexual experiences with violence, coercion, threats, and going against their will. Most women describe their first sexual relationship as rape, whereby they were forced to have sex against their will through coercion, physical threat and blackmail. Violence against women in sexual relationships is viewed as a norm and thus encourages men to control the sexual behaviour of women and creates an environment in which women feel disempowered to take any form of action to protect themselves from HIV-infection.

10.2.8 Alcohol

Alcohol is viewed as a major impediment to safe sex. Alcohol impedes rational thinking and leads to individuals "losing control" over their sexual behaviour and not feeling accountable for their actions.

10.3 Recommendations

Specific recommendations relevant to Thabong will be proposed towards overcoming the impediments to safe sex in Thabong (cf. Par. 10.2.1 – 10.2.8).

10.3.1 Increase detailed knowledge about HIV/AIDS

Men and women in Thabong need detailed knowledge about the specifics of HIV/AIDS such as how it is transmitted during sexual intercourse (bio-medical explanation) and how condoms prevent this transmission. Increasing detailed knowledge about HIV/AIDS should be accompanied by efforts to put the issue of HIV/AIDS in the context of the gender-role norms that influence sexual relationships of men and women in Thabong. For example, information, education and counselling (IEC) material about HIV/AIDS should sensitive to and be based on the cultural and community-specific nature of sexual relationships and gender-relations in Thabong. This should assist and promote internalisation and personalisation of knowledge about HIV/AIDS.

10.3.2 Address myths and misperceptions

Misperceptions about HIV/AIDS and especially condoms (e.g., condoms transmit HIV/AIDS; condoms are synonymous with unfaithfulness and sexual promiscuity; and one-sided faithfulness is a form of HIV-prevention) need to be acknowledged and rectified. This can be achieved through increasing detailed knowledge about HIV/AIDS and safe sex, with specific emphasis on clarifying misperceptions about the function and use of condoms. A more rigorous approach should be adopted to eliminate and condemn the manipulation of knowledge about HIV/AIDS by especially men in a ploy to avoid changing their sexual behaviours.

10.3.3 Redefine advantages of condom use

Condoms are associated with negative connotations such as unfaithfulness, lack of trust, promiscuity, etc. This negative view of condom use needs to be replaced with a

positive, self-actualising view of the use of condoms in sexual relationships. A study on condom use (cf. Chapter 4) recommended eroticising the use of condoms. This is merely an example, but community-specific measures should be devised for condom use to be viewed in a positive light. A first step towards this end would be to address myths about condom use such as their association with the perceived occurrence of various physical dysfunctions/ailments.

10.3.4 Increase education about sexual rights

The sexual rights of both men and women in relation to gender-role norms and gender stereotypes that exist in Thabong should be promoted. This should take account of and could even be based on the new Domestic Violence Act (DVA) 116 of 1998, which was assented to on 28 November 1998 and became operational in December 1999. The DVA aims to afford victims of domestic violence, who are mostly women, the maximum protection from domestic abuse that the law can provide (Parenzee *et al.,* 2001). This act acknowledges an exhaustive list of abuses, which include physical, sexual, emotional, verbal, psychological and economic abuse, intimidation, and any other controlling behaviour which may cause imminent harm to the safety, health or well-being of the complainant (Parenzee *et al.,* 2001). Both men and women need to be aware of each other's sexual rights, the relevance of these rights in relation to HIV/AIDS, and the impact of gender-role norms and gender stereotypes on sexual rights and consequently on sexual health. Debates and challenging of gender-role role norms and stereotypes should be encouraged and optimised within environments that are mutually respectful of these rights and norms.

10.3.5 Optimise inter-gender and intra-gender discussions on sex, sexuality and HIV/AIDS

Discussions and debates among women and among men as well as between women and men about sex, sexuality and HIV/AIDS should be encouraged. These discussions and debates should be encouraged through the formation of small-scale informal discussion groups in the community. Existing community-based social groups/organisations such as religious groups, sport teams, support groups, etc. should be utilised as forums for such informal discussions.

The main aim of these discussion groups should be to instil a culture of challenging norms and issues such as gender-power imbalances, safe sexual practices and sexual rights, that pose a threat to individual and community development at large in Thabong.

Awareness about the present and future impact of HIV/AIDS on the community of Thabong will create a departure point for group discussions aimed towards challenging obstacles to safe sexual practices in Thabong.

10.3.6 Encourage formation of support groups for men and women that are assumedly not HIV-infected

Support groups for people living with HIV/AIDS are reported to have a positive influence on increasing knowledge about HIV/AIDS, clarifying misconceptions about HIV/AIDS and safe sex, and enhancing self-awareness and assertiveness among women regarding sexual practices. These attributes, which are associated with support groups for individuals living with HIV/AIDS, play an HIV-preventive function, but appear to be acquired once an individual is already infected with HIV.

The acquisition of the above HIV-preventive attributes needs to take place prior to infection in order for them to successfully prevent HIV-infection. This may be achieved through similar support groups for the general community rather than limiting them to perceived high-risk individuals/groups.

The main focus of these support groups should be on overcoming obstacles to practising safe sex among men and women in Thabong, as identified in the findings of this study (cf. Chapters 9 and 10). One of the issues that should steer these support groups should be addressing the imbalance between men and women in Thabong that renders women vulnerable to HIV-infection. This imbalance should be addressed in the socio-cultural context of Thabong, taking caution not to undermine deep-rooted socio-cultural norms that govern the behaviour of individuals in Thabong and so evoking resistance. A subtle and gradual approach to this initiative is necessary, rather than an aggressive and coercive approach.

The success of these support groups lies in engaging both genders since the oppressive and dominating behaviour of men is required to change in order to reverse gender imbalances.

Women cannot implement safe sexual practices in the absence of an environment that is supportive of and conducive to such practices. These support groups will encourage men and women to share experiences, concerns, expectations, etc. about gender relations and its relevance to HIV/AIDS, in an environment that supports and encourages freedom of expression. Various personnel and representatives of HIV/AIDS initiatives/programmes may be used to facilitate these support groups and train potential facilitators from the general community to act as facilitators for these support groups.

Existing CBOs and NGOs in Thabong should be utilised to "kick-start" such support groups. These support groups should remain in the informal and natural setting of group members.

10.3.7 Economic empowerment

Women need to be empowered to reduce their dependence on men. Increasing women's economic independence will in effect increase their control over their sexual behaviour. This will place women at a vantage point regarding sexual decision-making and thus render them less vulnerable to HIV-infection. Therefore, all efforts directed at reducing women's vulnerability to HIV-infection should be accompanied by complementary strategies to empower women economically in order to create an environment supportive of the implementation of proposed measures to reduce risk to HIV-infection.

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SYNOPSIS/OPSOMMING

Synopsis

Due to its rapid spreading, AIDS has been declared a global epidemic. Especially sub-Saharan Africa has been the most affected by the epidemic. South Africa is no exception to the devastating impact of the epidemic. Over the past few years, HIV-prevention initiatives have been underway on a full scale in an effort to combat the destructive powers of the epidemic in the country. These initiatives appear to have adopted a health-belief approach in their strategies to decrease HIV-infections. This approach to HIV-prevention assumes that the desired behaviour change, namely increasing safe sexual practices and decreasing high-risk HIV/AIDS behaviour, can be achieved through rational decision-making based on knowledge of the disease and its consequences. The findings of studies on sexual behaviour and HIV/AIDS such as KAPB (knowledge, attitudes, practice and belief) studies appear to reaffirm the fact that knowledge alone is not sufficient nor effective in bringing about the appropriate behaviour change to combat HIV/AIDS. These studies point towards a high level of knowledge about AIDS in the general population, yet the ever increasing HIV-infection rate remains undeterred. The discrepancy between knowledge about HIV/AIDS and the unchanged high-risk sexual practices of the population which is seemingly knowledgeable about the disease, prompts a need for research to identify the underlying causes of this discrepancy, thus the rationale for this study.

In view of the inadequacy of a health-belief approach to HIV-prevention, this study proposes an alternative approach to HIV-prevention that would supplement the health-belief approach, and thus explain the hiatus between knowledge and manifest sexual behaviour. This is approached from a socio-behavioural approach, which assumes that HIV/AIDS is a behavioural issue that is firmly rooted in sexual behaviour. In addition, it acknowledges that sexual behaviour is influenced by the interplay of psychological, sociological and cultural factors in sexual decision-making. This decision-making process often has little to do with maintaining good health and more to do with satisfying motivational needs that have a psychological basis or with options that are socially or economically or emotionally determined. Thus, a multidisciplinary approach to analysing factors that influence sexual behaviour was utilised.

Based on a multidisciplinary analytical model of sexual behaviour, the study aimed to identify factors that impede the practice of safe sex. The developing of this model was informed by various perspectives (i.e., psychological, sociological and anthropological) of behaviour and two theories that take account of the social context in explaining the behaviour change process (i.e., attitude accessibility model and theory of reasoned action). The multidisciplinary model, in turn, informed the development of the research instruments and interpretation of the findings.

The community of Thabong, in Welkom, was selected because of the high HIV-prevalence in the District and because of the involvement of the Centre for Health Systems Research & Development in the proposed Youth Multi-function Centre in Thabong. Welkom has the highest HIV-prevalence of all the districts in the Free State (30,63%). Second, the study intends to inform HIV-prevention initiatives about impediments to safe sex. Thus, this study will inform the proposed Youth Multi-function Centre in Thabong, which aims to decrease HIV-infections among the youth in the community. Towards informing the study aim and objectives, individual in-depth interviews were conducted with 30 confirmed HIV-positive males and females between the ages of 15 – 49 years. The interviews were guided by a semi-structured individual questionnaire. Also, 15 focus group discussions were conducted with males and females from various social strata in the community, and who were assumedly HIV-negative. The focus group discussions were conducted with the aid of a semi-structured group discussion schedule. The two forms of data collection served to complement each other and promoted the validity and quality of the data collected. The study design opted for was explorative in nature, as little is currently known about the community-specific obstacles to safe sex. All respondents were purposively sampled.

The main findings of the study point towards the need for HIV/AIDS to be viewed in the light of the socio-cultural and socio-economic contexts of sexual behaviour. Factors that were identified as influencing sexual behaviour, and therefore HIV/AIDS, include the unbalanced power in gender-relations, socio-economic status and perceived self-efficacy, amongst others. Also, there is a need for detailed knowledge about the specifics of HIV-prevention and transmission, as well as safe sexual practices. This will serve to address myths and misconceptions about the three modes of safe sex, namely condom use, sexual abstinence and mutual faithfulness.

Overall, the research indicates that HIV/AIDS is a socio-behavioural problem rooted in the sexual practices of individuals. Attempts to successfully change high-risk sexual behaviours should first identify factors that influence the progression of the disease in order to develop community-specific effective and efficient HIV-prevention initiatives. To a large extent, this study has identified those factors that influence and limit the options and opportunities that people in Thabong have when it comes to practicing safe sex. In this community, these are the factors that should be taken into account when HIV/AIDS-prevention initiatives are planned and implemented. These factors include, inter alia, low socio-economic status of women, gender-role stereotypes, myths and misconceptions about HIV/AIDS and safe sex, violence, socio-cultural norms and gender imbalances.

Opsomming

Weens die snelle verspreiding van MIV/VIGS word dit as 'n globale epidemie beskou. Veral die lande in sub-Sahara Afrika word swaar deur hierdie epidemie getref. Suid-Afrika het nie die vernietigende impak van die epidemie vrysgespring nie. Gedurende die afgelope tyd is aansienlike bronne in Suid-Afrika aan die voorkoming van MIV/VIGS gewy om hierdie impak te versag. Hierdie voorkomingsveldtogte is skynbaar op 'n benadering begrond wat daarop berus dat die verspreiding van die siekte voorkom kan word deur mense daaroor in te lig en hulle kennis daarvan te verbreed. Met verwysing na MIV/VIGS berus hierdie benadering op die veronderstelling dat mense sal afsien van hoë-risiko seksuele gedrag (dit is seksuele gedrag wat hulle blootstel aan die risiko van infeksie met die MI-Virus, naamlik veelvuldige seksmaats en nie-gebruik van kondome) sodra hulle bewus raak van die rol wat hierdie hoë-risiko gedrag in die verspreiding van die MIV/VIGS epidemie speel. Dit berus dus op die veronderstelling dat mense op grond van hul kennis van MIV/VIGS, sowel as die verspreiding en gevolge daarvan, rasionele besluite oor hulle seksuele gedrag sal neem. Die bevindinge van talle studies oor seksuele gedrag en MIV/VIGS bevestig egter dat kennis en inligting alleen nie voldoende of doeltreffend is om gewensde gedragsveranderinge teweeg te bring wat die verspreiding van die siekte beperk nie. Hierdie studies bevind dat mense oor die algemeen goed ingelig is oor MIV/VIGS. Tog neem die voorkoms van infeksies steeds toe. Die teenstrydigheid tussen kennis van MIV/VIGS en voortgesette hoë-risiko seksuele gedrag in 'n bevolking wat skynbaar goed ingelig is oor die siekte en die voorkonming daarvan het tot hierdie studie aanleiding gegee. Dit fokus primêr op die identifisering van onderliggende redes vir die bestaan van hierdie teenstrydigheid.

In die lig van die skynbare tekortkominge van bestaande inisiatiewe wat gerig is op die voorkoming van MIV/VIGS stel hierdie studie 'n alternatiewe bendaring voor. Dit is gerig op die aanvulling van die rol van kennis en inligting in die bekamping van MIV/VIGS, en nie op die vervanging van die rol van kennis en inligting nie. Die benadering wat in hierdie studie gevolg word berus op die veronderstelling dat MIV/VIGS 'n gedragsverwante verskynsel is, en nie 'n gesondheids- of siekteverskynsel nie. Meer spesifiek is MIV/VIGS nou verwant aan seksuele gedrag wat deur psigologiese, sosiologiese and kulturele faktore beïnvloed word. Besluitneming oor seksuele gedrag is dikwels nie verwant aan die individu se behoefte om goeie gesondheid te handhaaf en sy/haar kennis in hierdie verband nie. Eerder blyk dit nou verwant te wees aan die bevrediging van behoeftes wat 'n psigologiese grondslag het, of met keuses en opsies wat deur sosiale, ekonomiese of emosionele faktore beïnvloed word. Daarom berus hierdie studie op 'n multidissiplinêre benadering tot die ontleding van faktore wat seksuele gedrag beïnvloed.

Op grond van 'n multidissiplinêre analitiese model van seksuele gedrag is die studie gemik op die identifisering van faktore wat die beoefening van "veilige seks" (d.w.s. onthouding, wedersydse en volgehoue getrouheid aan een seksmaat en die korrekte gebruik van kondome) verhoed of beperk. Die ontwikkeling van hierdie model is gebaseer op 'n drieledige perspektief van gedrag (psigologies, sociologies and antropologies), sowel as twee teorieë wat die rol van die sosiale konteks in gedragsverandering verreken, naamlik die "attitude accessibility" model en die teorie van beredeneerde opdrede ("theory of reasoned action). Die multidissiplinêre analitiese model wat hieruit ontwikkel is, het die ontwikkeling van navorsingsinstrumente sowel as die interpretering van die bevindinge van hierdie studie gelei.

Die studie fokus op Thabong in Welkom, eerstens omdat hierdie gemeenskap gebuk gaan onder 'n baie hoë voorkoms van MIV/VIGS (in Welkom is die voorkoms van MIV/VIGS 30,63%), maar ook omdat die Sentrum vir Gesondheidsisteemnavorsing in Ontwikkeling nou betrokke is by die vestiging van 'n meerdoelige Jeugsentrum in Thabong en die navorser aanvanklik hierdeur eerstehandse kennis van die gemeenskap en sy behoeftes opgedoen het. Terwyl die studie in die algemeen kan lei tot die ontwikkeling van doeltreffende inisiatiewe ter voorkoming van HIV/VIGS in Thabong kan dit ook meer spesifiek die aard van sodanige inisiatiewe by die meerdoelige Jeugsentrum inlig.

Ten einde die doel van die studie bereik is individuele, diepte-onderhoude gevoer met 30 mans en vrouens tussen die ouderdomme van 15 en 49 jaar. Al hierdie respondente ly aan MIV/VIGS en is vanweë hiervan doelgerig vir deelname aan die studie geselekteer. Die onderhoude is aan die hand van 'n gestandaardiseerde, semi-gestruktureere skedule gevoer. Fokusgroepbesprekings is ook met mans en vrouens van vyftien verskillende groeperinge en strata in Thabong gevoer. Die MIV status van deelnemers aan die fokusgroepbesprekings was onbekend, en dus veronderstel negatief. Die fokusgroepbesprekings is aan die hand van 'n gestandaardiseerde, semi-gestruktureerde skedule gefasiliteer. Die twee datastelle wat sodoende genereer is, het mekaar aangevul en terselfdertyd die geldigheid en kwaliteit van die data bevorder. Die studie-ontwerp was verkennend van aard aangesien nie veel inligting beskikbaar is oor spesifieke faktore wat seksuele gedrag in 'n bepaalde gemeenskap beïnvloed nie. Hierdie studie was juis daarop gemik om sodanige faktore in Thabong te identifiseer en te verken.

Die belangrikste bevindinge van die studie blyk daarop te dui dat MIV/VIGS beskou moet word in die lig van die sosio-kulturele en sosio-ekonomiese konteks waarin seksuele gedrag plaasvind. Faktore wat seksuele gedrag – en dus MIV/VIGS - beïnvloed sluit onder andere in ongebalanseerde magsverhoudings tussen mans en vroue wat deursyfer na 'n ondergeskikte posisie en blootstelling van die vrou in seksuele verhoudings. Daar blyk ook 'n behoefte te wees aan gedetaileerde inligting rakende die besonderhede van die oordrag en voorkoming van MIV, sowel as die belangrikheid van "veilige" seksuele gedrag in die bekamping en voorkoming daarvan. Dit sal bydra tot die weerlegging van mites en opklaring van misverstandige rakende die rol van onthouding, kondoomgegbruik en wedersydse, volgehoue getrouheid van seksmaats in die bekamping en voorkoming van MIV/VIGS.

Die navorsing dui daarop dat MIV/VIGS 'n sosio-psigologiese probleem is wat gesetel is in seksuele gedrag. Pogings om dit te bekamp moet die oorsake van MIV/VIGS komprehensief en effektief aanspreek. Die sleutel hiertoe is die oortuiging van mense om "veilige" seks te beoefen. Dit vereis 'n erkenning en begrip van faktore wat mense se seksuele gedrag beïnvloed, en hierdie faktore kan van een gemeenskap na 'n volgende varieer. Dit dui daarop dat inisiatiewe ter voorkoming van MIV/VIGS gebaseer moet wees op faktore wat seksuele gedrag in 'n spesifieke gemeenskap beïnvloed. Hierdie studie het in 'n groot mate daarin geslaag om alternatiewe en beperkinge te identifiseer wat inspeel op die beoefening van veilige seks in Thabong. In hierdie gemeenskap is dit die

faktore wat in aanmerking geneem moet word wanneer inisiatiewe ter voorkoming van MIV/VIGS beplan en geïmplementeer word. Dit sluit onder andere in:

- die lae sosio-ekonomiese status van vroue in
- geslagsrol-stereotipering
- mites en misverstande aangaande MIV/VIGS en veilige seks
- geweld
- sosio-kulturele norme en
- die geslagsverwante wanbalans van mag.

APPENDIX I:

Rapid situational analysis schedule/guide

HIV/AIDS/THABONG PROJECT

HEALTH SYSTEMS TRUST
&
CENTRE FOR HEALTH SYSTEMS RESEARCH & DEVELOPMENT (UFS)

JULY 2001

Data Collection Instrument 1:
Situational Analysis

RAPID SITUATIONAL ANALYSIS

The study has adopted and adapted the framework for conducting a situational analysis which was developed as a guide for Health Districts in South Africa (McCoy & Bamford, 1998).

Framework of Situational Analysis

Assessment of Welkom/Thabong	***Geography*** Description of the chief physical features of the area. E.g. In relation to district, size, etc.	
	Demography Size and composition of population	❖ Total population of province ❖ Total population of Welkom ❖ Total population of Thabong as % of Welkom total (Welkom + Bronville) ❖ Welkom/Thabong population as % of provincial and district total

		❖ Disaggregation of population (Thabong) by gender No. % Male = Female = Source: ❖ Disaggregation of population (Thabong) by age group No. % 0-14yrs 15-19yrs 20-29yrs 30-49yrs 50+ Source: ❖ Disaggregation of population by home language No. % SiSotho SiTswana IsiXhosa IsiZulu Other ❖ Present data in tabular form.

	Socio-economic profile Information about the socio-economic condition of the district	❖ Main economic activities in the community ❖ Household income e.g. Average household income, and percentage of families living below the poverty line ❖ Employment and unemployment figures ❖ Education status of community ❖ Groups particularly vulnerable to HIV/AIDS

		❖ Housing conditions ❖ Provision of basic services: water, electricity, sewage and sanitation ❖ Telecommunication in the community e.g. Number of households that have telephones, accessibility of telephones to community members ❖ "Media communication" in the community e.g. Number/proportion of households that own a TV/radio, newspaper (printed media)

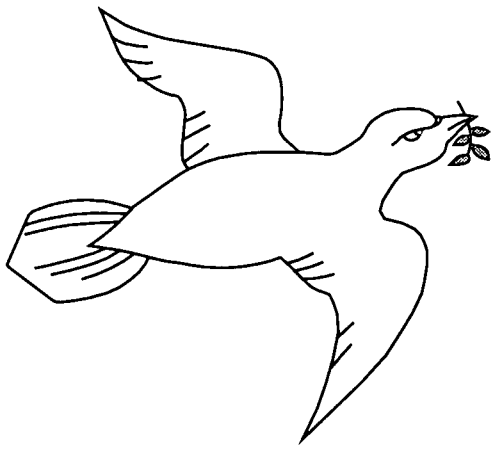
Health status and problems	***Knowledge, attitudes, beliefs about HIV/AIDS among various age groups, gender, and other strata***	
	Incidence and prevalence of HIV/AIDS in Welkom/Thabong estimate and compare among age groups and gender	

Local social dynamics identify factors that influence sexual behaviour e.g. Socio-economic status, age, gender, cultural considerations, socio-cultural norms, violence, level of education, etc.	
Organisations/programmes/projects/individuals (e.g. Traditional healers) involved in HIV/AIDS education and awareness (identify them, assess their target population, aims and objectives and perceived impact)	
Other sectors, organisations or structures that impact on sexual behaviour	

Perceived contributing factors to the HIV/AIDS problem in Welkom/Thabong (perceptions of community leaders/professionals/management working towards increasing HIV/AIDS awareness and decreasing HIV infections in Welkom/Thabong.	
Summary and Conclusions	

APPENDIX II:

Focus group discussion schedule/guide



HIV/AIDS/THABONG PROJECT

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Data Collection Instrument 2:
Focus Group Discussion

GROUP DISCUSSION GUIDE

Facilitator: _____ **Date:** _____

Language(s) of discussion: _____

Description of group: _____

No of individuals in group: _____

Ages of group members: _____

Gender of group members: _____

Employment status of group: _____

Observations:
Physical characteristics

Group dynamics e.g. participation, interpersonal interaction, etc.

Other

INTERVIEWER:

- Brief respondents about the aim of the project/study and how they were selected
- Reassure respondents of the confidentiality of the discussion
- Ask all respondents to be as open and as honest as they can
- Warn them about the sensitive topic of the discussion but at the same time reassuring them about non-judgementalism and confidentiality
- If respondent(s) has/have never had sexual intercourse, take separate note of their responses.

MOTIVATION

1. Have all of you had sexual intercourse (**ask each individual in group**).
2. Explain to me what your reasons are for having sex
3. When do you usually feel like engaging in sexual intercourse (not in terms of time, rather circumstances that induce the need for sexual intercourse)
4. What feelings and emotions do you experience from engaging in sexual intercourse.
5. Are your reasons for engaging in sexual intercourse the same for all the sexual partners you have or have had? If not, how do your reasons differ for each of your sexual partners.
6. Have you ever used a condom (**ask each individual in group**)
7. What were your reasons for using a condom (**those that say "yes"**)/What were your reasons for not using a condom (**those that say "no"**)
8. When you have sex now, do you always use a condom (**ask each individual in group**)
9. What are your reasons for using a condom when you have sex now (**those that say "yes)**/What are your reasons for not using a condom when you have sex now (**those that say "no"**)
10. Would you ever use a condom (**ask those that have never used a condom before**)
11. What would make you use a condom (**those that say "yes"**). Why would you never use a condom (**those that say "no"**)
12. Which is the most important reason for you using a condom (**ask those that have used a condom before**)
13. Have you ever refused to have sexual intercourse with someone that wanted to have sexual intercourse with you.

14. What were your reasons for refusing to have sex with those persons (**ask those that say "yes"**).
15. Have you always wanted to have sex with the people that you have had sex with (**ask those that say "no"**)

ATTITUDES

Salient beliefs

1. Generally, what are your views on the use of condoms to prevent STDs and HIV-infection
2. What are your views on sticking to one partner as a mechanism to protect yourself from STDs and HIV-infection
3. What are your views on abstinence as a mechanism to protect yourself from STDs and HIV-infection
4. How would you describe the control you have over your sexual practices, namely, when you have sex, how often you have sex, who you have sex with, how you have sex, etc. (Who makes these decisions about your sexual behaviour)
5. Who are the people that influence the decisions you make about your sexual behaviour/practices.
6. Who of these people have the most influence over your decisions about your sexual behaviour
7. How have these individuals influenced your sexual behaviour
8. How did you first learn about sexual intercourse
9. How did you find out about what role you have to play and what role your sexual partner has to play in your sexual relationships
10. Do you learn how to behave and how not to behave in a sexual relationship from experience or from what you have been told by others. Explain
11. In your life, which individuals would you say have influenced your sexual behaviour the most.
12. How do you feel about the way that these individuals have influenced your sexual behaviour
13. Describe what happens when your sexual partner wants to have sexual intercourse when you do not want to.

Evaluations of consequences of specific behaviour

1. Describe what usually happens when someone is interested in starting a sexual relationship with you. (**Preferably role play scenario**)
2. Describe what usually happens if you do not want to enter into a sexual relationship with them
3. Describe what usually happens when you are interested in starting a sexual relationship with someone.
4. Describe what happens if they do not want to enter into a sexual relationship with you
5. Have you ever decided to have sexual intercourse with someone that you do not want to have sexual intercourse with because you are afraid of what may happen if you refuse to do so. Describe what would happen if you refuse(d) to have sex with that person.
6. Describe what would happen if you had to ask your previous or current sexual partners to use a condom when you engage in sexual intercourse

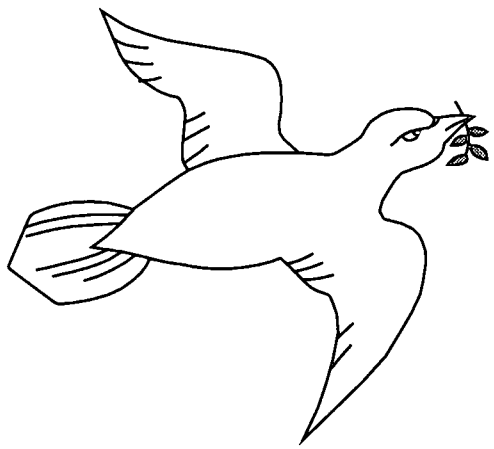
SUBJECTIVE NORMS

Perceptions of behavioural expectations of significant others

1. Who are the people that influence your behaviour the most (Rank)(**ask each individual in group**)
2. How do these people expect you to behave towards your sexual partners (or potential sexual partners)
3. How do you know that they expect you to behave in this manner. Give me a few examples to illustrate what you mean
4. How do these people expect your sexual partners (or potential sexual partners) to behave towards you.
5. How do you know that they expect your sexual partners to behave in this manner. Give me a few examples to illustrate what you mean.
6. What do you do when the expectations of these people that influence your sexual behaviour are conflicting (e.g. one person expects you to behave in a specific way whilst another person expects you to behave in the opposite way).Give examples.
7. What do you usually do when these people that influence your sexual behaviour expect you to behave in a way that you do not want to behave in. Give examples.
8. How do you think your sexual partners expect you to behave towards them as partners.

APPENDIX III:

Individual interview questionnaire



HIV/AIDS/THABONG PROJECT

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Data Collection Instrument 3:
Personal Interview

PERSONAL INTERVIEW

Fieldworker: _____ **Date:** _____

Language of interview: _____

Home language of respondent: _____

Gender of respondent: _____

Age of respondent: _____

Employment status of respondent: _____

Contact details(Tel or address):_____

1. Before you found out that you were HIV-positive, what were your views (perceptions) and knowledge about AIDS?

2. Did your knowledge about the transmission and prevention of HIV/AIDS influence your sexual behaviour before you were infected? Explain.

3. What, would you say, prevented you from practising safe sex before you were infected?

Interviewer: You should now make the respondent aware that questions about men and women will be dealt with separately.

4. In your opinion, how can men in your community, of all ages, protect themselves from being infected with HIV/AIDS in their sexual relations?

5. In your mind, what do you think prevents men in your community, of all ages, from protecting themselves from HIV-infection in their sexual relations?

6. In your opinion, how can women in your community, of all ages, protect themselves from being infected with HIV/AIDS in their sexual relations?

7. What do you think prevents women in your community, of all ages, from protecting themselves from HIV-infection in their sexual relations?

8. Looking back on your sexual relationships before you were diagnosed as HIV-positive, are there any decisions you would have made differently regarding your sexual behaviour? Explain.

9. What would have helped you in making these decisions about your sexual behaviour?

10. What are your views on using condoms to protect oneself from HIV-infection? (advantages, disadvantages, acceptability, etc.)

11. In your opinion, what makes it difficult for men in your community to use condoms in their sexual relations?

12. In your opinion, what makes it difficult for women in your community to use condoms in their sexual relations?

13. Now that you are living with HIV/AIDS, what advice would you give women in your community to help them protect themselves from HIV-infection in their sexual relationships?

14. What advice would you give men in your community to help them protect themselves from HIV-infection in their sexual relationships?

15. Is there anything that the community can do to help women make decisions to protect themselves against the sexual transmission of HIV/AIDS?

16. Is there anything that the community can do to help men make decisions to protect themselves against the sexual transmission of HIV/AIDS?

17. What are organisations in the community doing to help women protect themselves from HIV-infection in their sexual relations?

18. What more can organisations in the community do to help women protect themselves against HIV-infection in their sexual relations?

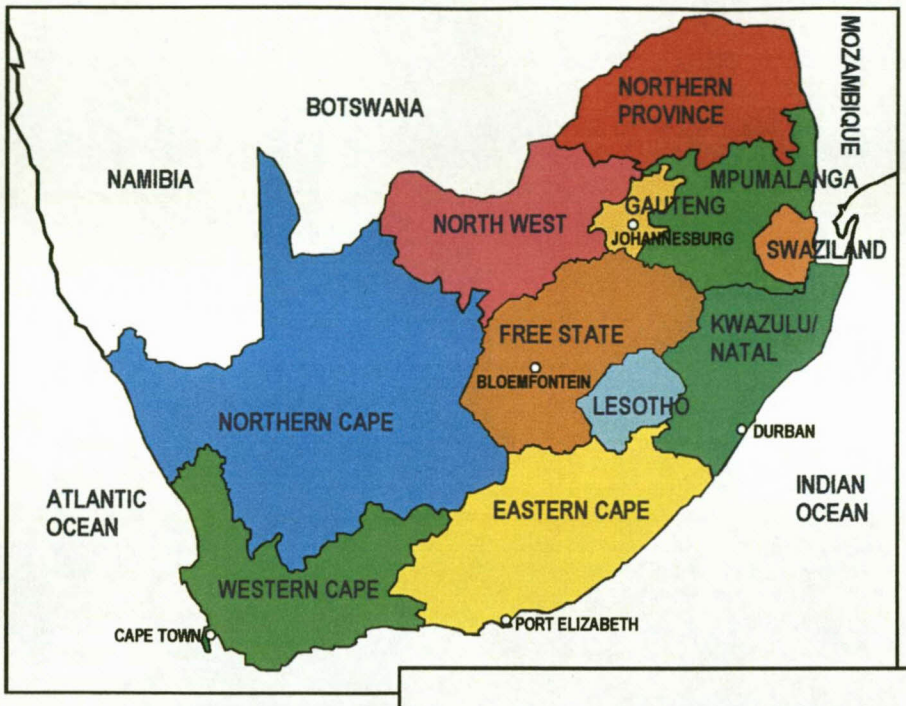
19. What are organisations in the community doing to help men protect themselves from HIV-infection in their sexual relations?

20. What more can organisations in the community do to help men protect themselves from HIV-infection in their sexual relations?

APPENDIX IV:

Maps of Free State Province and study sites

South Africa



Free State

01

Welkom / Thabong