STUDENTS' PERCEPTIONS OF THE IMPACT OF AIDS EDUCATION PROGRAMMES ON SEXUAL NEGOTIATION AND CONDOM USE

by

Lameze Abrahams

Student no.: 9319024

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Psychology

University of the Western Cape,
Bellville

February 2001

Supervisor: Tamara Shefer

ABSTRACT

As we embark on a new millennium, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remains one of the most dangerous threats to the well-being and health of communities all over the world. In Africa (as in other developing nations) this threat is of even more concern as people on this continent are grappling with other complex problems such as famine, disease and civil war. Although AIDS was initially identified as a homosexual male disease, its consequent spread to the heterosexual population and the incidence of HIV infection among this population is rapidly increasing. In Africa, heterosexual intercourse has become the major mode of transmission, as infection by other means are minimal. Since this disease also increasingly reflects the social inequalities evident in our society, it has ensured that especially young black South Africans (and black women in particular), are vulnerable to this disease.

The present research has as its primary aim an exploration of students' perceptions of the impact of AIDS education programmes on sexual negotiation and condom use among this population. A qualitative research design was utilised to explore participants' experiences of how living in the AIDS era has impacted on their sexual behaviour. Data was primarily gathered through three semi-structured focus groups and a thematic analysis was carried out on the transcriptions of the data. Three major themes, including a number of subthemes, emerged, suggesting that most students do not practice safe sex in any form. Although many students argued that safe sex was important,

their response suggests that despite the AIDS campaigns, many still do not utilise safe sex practices. Introducing safe sex options was regarded as impacting negatively on a relationship, with a resultant lack of trust and issues of fidelity being raised. In addition, condoms were reportedly disliked, as they were perceived to decrease sexual pleasure. Safe sex was also more likely to be abandoned in longer-term relationships, especially among the women in the study, as the partner was regarded as trustworthy the longer he was known. For the men in the study sexual history was more important than relationship length. This study also confirmed that many of the myths surrounding AIDS was still prevalent, and used as barriers to safe sex and condom use. These included a denial of the disease altogether as well as a denial of the seriousness of HIV. Underlying all of these barriers to safe sex was the relative powerlessness for many women to demand safe sex from their partners, women's role within these relationships, and the values and norms which further disempower women.

Further research would need to evaluate AIDS education campaigns and investigate in more detail the barriers that emerged as themes in this study. AIDS education programmes designed for the youth should note the cultural values and relationship norms which prevent safe sex from being practised.

DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own work.

L. Abrahams

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude and appreciation to the following people:

Thank you to my supervisor, Tamara Shefer, of the University of the Western Cape.

I also wish to thank Keith Ruiters, of the University of the Western Cape, for his time and energy in helping me gather my data.

Thank you to all the students at the University of the Western Cape who participated in the study.

Many thanks to all my friends and colleagues for helping me through the difficult times and providing a listening ear. Thank you especially to Nikki, who I know will always be a part of my life. A special thank you to Ismail, for your understanding, support and love during the "last days".

Thank you to the DAAD Scholarship and HSRC for their financial support.

Lastly, I wish to thank my parents, Feroza and Abubakar, for all their support and encouragement. Thank you especially to my mother, who has always believed in me.

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Chapter 1

INTRODUCTION

As we enter the new millennium, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) still remains a threat to the well-being and health of communities all over the world. No-where is the threat more evident and a growing concern than on the continent of Africa.

AIDS, which has been described as a pandemic (Schoepf, 1991), has resulted in a whole range of disciplines becoming involved and reflecting on the disease and its consequences. It has been viewed as one of the most serious infectious diseases in contemporary history. The existence of AIDS, which was initially denied by many people, has become a reality for everyone and represents one of the potentially most dangerous threats to public health world-wide (Perkel, 1992).

Even though it was first identified as a homosexual male disease (Strebel, 1995), its spread to the heterosexual population and the subsequent incidence of HIV infection and AIDS among this population is increasing rapidly. HIV and AIDS is as much, if not more, a heterosexual disease in Africa. The epidemiology of AIDS in Africa was, therefore, seen to be different to that of the West (Packard & Epstein, 1991), since heterosexual intercourse has been the main mode of transmission, and infection by other means are minimal (Abdool Karim, 1998; Perkel, Strebel & Joubert, 1991; Strebel & Perkel, 1991; Strebel, 1991).

The complexities of the disease are increased once we take into account the fact that Africa is a continent four times the size of the United States of America (USA), with a multitude of ethnic groups, language families and countries, many of whom are grappling with other complex problems (such as famine and civil war) (Miller & Rockwell, 1988). This disease also increasingly reflects social inequalities, evidenced by the improvement of the situation in several industrialised nations, while the developing world struggles to deal with the dismal situation that AIDS presents.

Even though the rate of HIV infection in South Africa was initially not as high as other countries on the continent, the rapid increase in the rate of HIV infection is cause for major concern. South Africa has the highest number of people living with HIV and AIDS in Africa, and is globally second only to India (Tallis, 1998). Of the 29 million adults living with HIV and AIDS (UNAIDS/WHO, 1998), it is estimated that the seroprevalence amongst adults in South Africa was 12.91% or 2.8 million people at the end of 1997 (Tallis, 1998). This places sexually transmitted diseases (STD's) as well as HIV and AIDS high on the agenda.

STD's spread more rapidly in marginalised and disrupted communities, thus placing these socio-economically disadvantaged groups (who are also the politically most powerless) at greater risk for HIV infection (Tallis, 1998). The result is that blacks, who represent the marginalised communities in South Africa, have a higher rate of transmission than other groups (Crookes & Heynes, 1992).

These and other factors (including poverty, unemployment and limited resources) have ensured that especially black South Africans (and black women in particular) are particularly vulnerable to the epidemic (Evian, 1994). With a vaccine or cure for AIDS not close at hand, the spread of the virus can only effectively be controlled through AIDS education programmes designed to reduce risk behaviours associated with the spread of the virus (Venier, Ross & Akande, 1998).

AIDS education programmes coupled with a willingness to change sexual behaviour can play a significant role in preventing the spread of the disease, as has been illustrated in the gay communities of the USA (e.g. San Francisco), where there has been a decline of new HIV infections (van Niekerk, 1991). However, it has been widely illustrated that in spite of the rapid spread of HIV among young heterosexuals, there is still much resistance to change and people do not readily want to examine their risk behaviours. Qualitative understandings of sexual negotiations are, therefore, important in creating a body of knowledge examining the reasons for the resistance to change within the local context as many 'western' responses and strategies may be ineffective or even irrelevant for the South African population. The present study attempts to shed light on the reasons for the denial of vulnerability to infection among the young heterosexual population. The study investigates students' perceptions of how living in the AIDS era has impacted on sexual behaviour, in particular negotiations around condom use.

Chapter 2

THEORETICAL MODEL

2.1. INTRODUCTION

The study locates itself within a social constructionist framework in which gender and sexuality are viewed as constructed in a particular moment and place, and not stable and fixed over time. There is the recognition that constructing is a social process which has as its base language. What is termed 'sexual' is considered to be as much a product of language as it is a product of culture and nature (Weeks, 1986). It is for this reason that the chosen research method was focused discussions and not a quantitative study, as the research process itself socially constructs a reality or realities (Steier, 1991).

2.2. THE SOCIAL CONSTRUCTION OF SEXUALITY

When examining a disease (such as AIDS), in which issues of sexuality and gender are centred, it becomes important to note the different ways in which men and women perceive of and experience the disease (Landau-Stanton, Clements & Associates, 1993). For example, a woman who may suspect her husband of having sexual relations with other women may, because of her gender socialisation and lack of personal authority, be reluctant to ask her partner to use a condom. Thus, in most cases the unequal status of women in society renders them

vulnerable to social and psychological discrimination (Landau-Stanton *et al.*, 1993), and places them at a disadvantage of protecting themselves against illness.

Prevention programmes that are aimed at the heterosexual population tend to ignore the socio-political and cultural contexts in which they operate. These programmes have tended to focus on women and encourage them to change their and their partner's sexual behaviours. For the majority of women in South Africa this is an impossible task. These programmes have ignored the difficulties of using condoms in conditions of overcrowding and poverty, the position of women in the broader society and the relationships that exist between men and women (Barnett & Blaikie, 1992).

Sexual intercourse necessarily implies a social activity that includes negotiating sexual practices with a partner (Holland, Ramazanoglu, Scott & Thompson, 1994). These negotiations are, however, informed and constrained by the more general institutionalisation of gendered power relations that occur within a patriarchal structure. Thus, it is necessary to examine both the micro and macro levels that impact on sexual behaviour in order to better understand how these might influence each other.

The present study locates itself within a feminist social constructionist understanding of behaviour since individual sexual behaviour is seen as embedded in the social and political context of a patriarchal culture, which while

present in different forms, globally involves unequal power relations between men and women. This framework is informed by a feminist understanding of women's position in society, whereby gender is seen as one of the socially structured foundations of every existing social order (Lorber & Farrell, 1991), which is examined in its relation to sexuality. Within this patriarchal construct men possess the power to control over women. Historically men exercised control over women's bodies through restrictions on contraception and abortion, where this authority symbolised an extension of male power but also served to reproduce the unequal power relations between the sexes.

'Power is both the source of oppression in its abuse and the source of emancipation in its use' (Radtke & Stam, 1994, p.1). Power, therefore, can serve both to maintain the existing unequal gender relations, as well as provide women and men with the tools to challenge the status quo. Even though some writers have ignored specifically looking at gender in their discussions of power (Radtke & Stam, 1994), the position of women in society in relation to men requires special attention when examining power as a construct. The three major axes when examining structures of domination and subordination in relation to sexuality include class, race and gender (Weeks, 1986). Within the South African context all these constructs need to be considered when looking at sexuality and the meanings which people give to them.

In terms of the impact of discourses of race, the study of sexuality has presented the black person as lower down the evolutionary scale and closer to nature (Weeks, 1986). The insatiable nature of the sexual needs of black people is often emphasised in the literature and reinforced in AIDS literature and research, as black people are presented as a population that is unable to change their sexual behaviour or adopt safer sex practices (Schoepf, 1991). This, ultimately, represents a threat to the purity of the western world (Weeks, 1986). Even though these assumptions have been challenged, these myths are still widely held to be true, which serves as additional barriers to HIV prevention.

As mentioned previously, the marginalised communities are those most vulnerable to disease. Within Capitalist societies, the 'working class' are those most at risk to disease. With the advent of the AIDS epidemic, the working class are again those most at risk of infection, due to their position in society as well as their limited access to resources.

Even though class may be regarded as an undifferentiated category between men and women, the crucial divide between men and women is gender (Weeks, 1986). It could be argued that as a class men are more privileged and possess more power and status than women. Since it is usually those with the least power in society who are the most exploited and vulnerable, black women in South Africa are the ones most vulnerable to HIV infection.

Power, (and who possesses that power within society), influences the epidemiology of disease, with AIDS being no exception. The epidemiology of HIV infection and AIDS in South Africa proves that power plays a crucial role in the spread of the disease.

Gender roles are often restrictive and construct very particular sexual roles in intimate heterosexual relationships (Shefer & Ruiters, 1997; Shefer, 1999). Male sexuality is often constructed as biologically driven and assumed to be spontaneous. Men are perceived of and excused for being reckless and irresponsible in sexual encounters (Kelly & Kalichman, 1995). Women's sexuality, on the other hand, is seen as frigid and repressed, with the expectation that women are and should be better able to control themselves than men are. These double standards have a major impact on the way in which men and women relate to each other, and inevitably influences negotiations about condom use.

This construction of women's sexuality often requires women to take responsibility for behaviour change in an area where their power is limited (Strebel, 1993). The proponents of condom-promotion strategies have failed to consider the gender-based power relationships and the way in which this influences a woman's ability to demand that her partner uses a condom. Men might use violence (both implicitly and explicitly) against their partners, and use it within a sexual context as a way of exercising power over women (Kitzinger, 1994), making it almost impossible for the woman to successfully demand condom use in this context.

Holland *et al.* (1994) emphasise that it is important for prevention programmes to especially understand young women's realities and the ways in which they experience themselves (including their body and their sexuality). They argue that young women's limited sexual knowledge, their alienation from their own desires and their concomitant lack of control in sexual encounters places them at particular risk to HIV infection.

Women's understanding of their bodies and their sexuality are socially constructed by definition of their gender which provide particular avenues which women are supposed to follow. When women do not follow this route they are often labelled and discriminated against (Shefer, 1999; Holland *et al.*, 1994).

Young women are taught to approach sexual encounters in a particular way, which are shaped by their sex education, their understanding of male and female desires and their construction of their self-image (Holland *et al.*, 1994). Thus the social representations of women and the particular roles they are ascribed greatly influence the realities of many young women and provides the ideal against which they measure themselves.

Many young women remain dependent on the way in which men define the sexual encounter, with many of their own needs remaining unrecognised and consequently unsatisfied. However, Holland *et al.* (1994) found that women tend to find it difficult to conceive of their own contributions to the perpetuation of this

male power as well. This could be due to the construction of sex under heteropatriarchy, which eroticises power and powerlessness, dominance and subordination (Kitzinger, 1994), or simply because of an acceptance of the norm. This in turn serves to reinforce the partriarchal system of inequality between men and women, as well as the men within this system, as they exercise dominance and control over women.

Mackinnon (1979, 1989), amongst others, argues that sex is constructed of eroticised power differences. Heterosex is defined in terms of domination and submission, and sexual desire is constructed as the eroticisation of subordination. This argument goes beyond simply perceiving this power as prohibiting sexual activities or shaping social representations of sexuality. Seen from this perspective, power does not only act on women's sexuality, but is involved in the way a woman experiences her sexuality, as it forms part of the sexual experience for women. Subordinating herself to her man is precisely what makes the experience erotic. This dynamic is involved in the broader social control of women by men (Shefer, 1999) and serves as an ideology of male dominance (Schacht & Atchison, 1993 in Shefer, 1999).

For many years women were expected to contain and control male sexuality (Bland, 1982), which has been reinforced in the age of AIDS and HIV. Many of the AIDS prevention programmes have focused on the need for women to take control in sexual encounters. However, these programmes ignore the gendered power

relations embedded in sexual encounters and assumes a degree of control on the part of the woman, which is beyond the experience of many women, especially in sexual encounters. There appears to be a lack of understanding of the complexity of heterosexual power relations within the local context, with research only recently focusing on this much neglected area (see e.g. Shefer, 1999).

Thus in order for prevention programmes to have any degree of success, the gendered power relations as well as the experiences and realities of women need to be taken into account. Therefore, these interventions cannot succeed without the political and economic empowerment of women as well (Cochran, 1989).

It is also important not to assume that sexual encounters occur in isolation from the broader socio-political and cultural contexts, or that changes at a macro level will necessarily lead to changes in interpersonal contexts. It is probably safer to assume that the two exist in a reciprocal relationship, but that change would need to occur on both levels in order for it to be effective.

Even though one cannot easily change the social construction of gender, it is imperative that challenges to the status quo, as well as practical changes (such as constitutional and political changes) be implemented with regard to women's status within the broader society.

2.3. THE SOCIAL CONSTRUCTION OF AIDS

'The history of society's response to the problem of sexually transmitted diseases is colored by our social construction of these diseases' (Brandt, in Cochran, 1989). The history of AIDS reflected and reproduced the dominant social constructions of sexuality (Miles, 1992; Shefer, 1999). Qualitative studies in South Africa have illustrated the pervasiveness of such social constructions (e.g. Miles, 1992; Strebel, 1993; Wood & Foster, 1995).

Initially AIDS was linked with high-risk groups (such as homosexual men and prostitutes), which occurred as a result of initial responses to the disease as well as early prevention programmes. The social construction of AIDS as a homosexual male disease was based on the factual prevalence of AIDS among homosexuals in places like San Francisco. People thus tended to avoid high-risk groups rather than high risk behaviour, and denied their own vulnerability by displacing the disease onto an 'other' who did not belong to 'their' group (Miles, 1992; Lear, 1997; Perkel, 1992). Scheiman (1998) suggests that the initial ideas and impressions about AIDS is still prevalent in societal perceptions of the disease, i.e. that it is a disease of gay men, prostitutes and IV drug users, which remains in the social construction of AIDS.

South Africa provides rich ground for the displacement of HIV infection onto an other, with its legacy of Apartheid, which encouraged segregation and a projection of 'badness' onto an other. This displacement transcends even continents as

people in the West claim that it originated in Africa and those in Africa claim that it is a Western disease (Miles, 1992). As Joffe (1996) asserts, the reason for this could be that people tend to integrate and interpret unfamiliar or new phenomena in the light of that which is already understood. Since previous mass incurable illnesses (such as 'the plague' and syphilis) were displaced onto an "other", the same has occurred with HIV and AIDS (Joffe, 1996).

Furthermore, because AIDS is predominantly spread through sexual transmission, it carries with it the stigma of a sexually transmitted disease (STD). It is generally perceived of as affecting promiscuous people, homosexual men and prostitutes (or 'deviant' groups). Thus it is not the behaviour that is regarded as problematic but the particular group that is identified as high-risk.

Schoepf (1991) warns that AIDS, like many earlier epidemics, is shaped and directed by social forces and events. From this perspective disease is regarded as socially produced. This is illustrated by a comparison of the spread of AIDS in developed and developing countries. In most of Africa, for example, AIDS is spread mostly through heterosexual contact, whereas in the West AIDS was initially spread largely through intravenous drug use and homosexual contact.

The social constructions that people hold could influence their perception of risk and play a significant role in their protecting themselves, such as through condom use. It is necessary to understand the constructions of AIDS within the South

African context in order to design more effective prevention programmes which will be relevant within this particular context.

Chapter 3

LITERATURE REVIEW

3.1. AIDS WITHIN THE AFRICAN CONTEXT

Throughout the literature which critically examines prevention programmes, cultural factors are considered to be extremely important in determining the types of sexual behaviour which takes place (King, 1993). Therefore, prevention programmes aimed at a particular population would have to investigate the types of sexual behaviour that takes place and the meaning that these might have for people. Green (1988) argues for an understanding of the patterns of heterosexual behaviour in their socio-cultural contexts. However, very few prevention programmes have as yet included this in their intervention and specified it in terms of the AIDS epidemic. Prevention campaigns generally ignored the complexities of a disease, which by its very nature involves cultural, social and psychological factors.

Prevention programmes in Africa, as in other countries, have been confronted with many difficulties. One of the major factors influencing prevention programmes is the natural history of HIV infection and AIDS in Africa contextualised within current health issues on the continent (Venier, Ross & Akande, 1998). Many communities do not as yet have access to basic needs (such as food and clean water) and adequate health facilities. These factors places HIV and AIDS prevention second

on the agenda for these communities, who may perceive the threat from starvation and other diseases as greater to the threat of AIDS. The general level of education (with low literacy levels) and understanding, and development of the population in Africa have also hampered prevention programmes. The majority of Africans might not comprehend or understand the media messages about the disease (which is often contradictory).

This was recently highlighted when the president of South Africa, Mr. Thabo Mbeki, gave an interview to Time magazine, in which he responded 'no' when asked whether HIV causes AIDS (The Argus, September 2000: see appendix 2). Despite the claims from his office that Time magazine 'conflated his remarks' and that 'he was prepared to accept that HIV might 'very well' be a causal factor', the fact that the president's office was not prepared to take a stand on this matter might leave the public even more confused about the disease.

Other important factors highlighted by Venier *et al.* (1998) are the current beliefs about HIV and AIDS and the social and cultural context of HIV and AIDS in Africa. It is not only important to understand sexual and other risk practices within a particular culture, but it is also necessary to have an understanding of the beliefs and taboos resulting in these practices, as these may present barriers to HIV prevention.

Evian (1994) contextualises the epidemic within the country's social, economic and political situation by citing the following examples:

- By October 1993, nearly 5.5% of pregnant black South Africans were HIV positive, whereas the figure was less than 1% in other race groups;
- Women in the 20-24 age groups have the highest prevalence, whereas the peak for men is ten years later;
- Many teenage girls and older women in socio-economically stressed communities are vulnerable to sexual exploitation and may resort to selling sex for money in order to survive;
- Women in poor economic circumstances have even less social and economic power, predisposing them to sexual and other exploitation and making them vulnerable to HIV infection;
- There is a powerful association between the risk of acquiring HIV and family/community dislocation
- Poor access to health care and treatment of STD's, and availability of condoms have important determining influences on the spread of HIV;
- Low literacy and educational levels makes access to information and HIV prevention means difficult.

These factors points to the vulnerability of especially black women to the disease, as many women currently do not possess the skills and/or resources needed to protect themselves or their partners against the risk of HIV and AIDS.

AIDS has not only been described as a social disease, but a political disease as well. The migrant labour system, which was introduced by the Apartheid regime, is one such example. In South Africa, two of the most important variables that contribute towards the increase in the risk of infection are migrant labour and the presence of high rates of other STD's (Williams & Campbell, 1998). Despite HIV prevention programmes for miners, condom provision and good quality STD services in the mining community, the rates of HIV infection is increasing rapidly (Campbell, Mzaidume & Williams, 1998). Factual knowledge appears to be a weak determinant of sexual behaviour in this community, as miners possess adequate knowledge about AIDS, yet continue to practice unsafe sex.

Miners usually come from poor rural areas where working on the mines is one of the few options for economic gain. It seems that miners tend to perceive HIV as just one of the many risks they face daily on the mines. They fear being killed or injured by a mine accident as greater than being killed by AIDS (Williams & Campbell, 1998). The miners generally work long hours, under stressful and physically exhausting conditions in humidity, heat and confined spaces. They are housed in single-sex hostels and have few opportunities to form intimate relationships. In this context, where death, illness and injury are everyday occurrences, HIV is perceived to merely be one additional health threat.

Many poor rural women go to the mines, hoping to find a boyfriend who will support them or otherwise to make a living selling sex. These women generally

have little or no control over the sexual encounter as they rely on their customers to provide them with income. Interviews with sex workers revealed that many have never used a condom because their customers are not willing to pay for protected sex (Campbell, Mzaidume & Williams, 1998; Williams & Campbell, 1998).

The high levels of STD's already present in the mining communities also increases the risk of HIV infection in these communities (Williams & Campbell, 1998). It is for the above reasons that Williams & Campbell (1998, p.13) describe the conditions of miners lives as 'almost perfectly designed to spread HIV both at the mines and in their rural homes'. Thus, social as well as personal behavioural factors ensures the rapid spread of this disease and increases vulnerability to HIV in populations where they exist (Lachman, 1998).

South Africa has one of the fastest growing rates of HIV-1 infection in the world with an estimated 1500 people infected each day (Tallis, 1998). Epidemiological studies have shown that the greatest HIV prevalence is among the 15-30 age group (Abdool Karim, 1998). In the next five to ten years about 400 000 South Africans, many of whom are young adults, will die because of AIDS and AIDS-related disease (Williams & Campbell, 1998).

The young black population are at greatest risk of HIV infection, therefore, it is imperative that emphasis be placed on this population. If we are to have any hope

of curtailing the epidemic more emphasis should be placed on prevention, and understanding why the young heterosexual population do not practice safer sex.

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~~3.2.~~ AIDS AND THE YOUNG HETEROSEXUAL POPULATION

Despite repeated calls for a focus on adolescence and young adults in AIDS prevention programmes, only recently has this high-risk group received some attention. Even though changing this population's risk behaviours is difficult, the serious consequences that the AIDS epidemic poses demands that this high-risk group become a primary focus of HIV prevention programmes.

The behaviours most likely to place persons at highest risk for contracting HIV are unprotected sexual intercourse, IV drug use and the use of drugs and alcohol that disinhibit sexual behaviour or lead to IV drug use (Rotheram-Borus & Koopman, 1991). All of these behaviours are typically initiated during the adolescent phase. The risk is increased once these young people enter tertiary education or start working, since they now encounter new independence, self-determination and strong peer pressure in the campus environment (Sanderson & Jemmott III, 1996).

However, despite their risk of HIV infection, there has been little research focusing on ways to reduce their HIV risk associated sexual behaviour. Much of the research has been positivistic in nature, focusing on the knowledge, attitudes, beliefs and practice (KABP) of individuals' AIDS related behaviours (Joffe, 1996). There has been criticism of the conventional approaches to studying health related

behaviours which draws mostly from the Health Belief Model (HBM), explaining behaviour in terms of individuals' KABP system. This model is insufficient in explaining sexual risk behaviours or exploring sexual meanings, and tends to overlook situational factors that might influence sexual behaviour.

Much of the KABP studies have concluded that knowledge regarding AIDS and STD's has no significant correlation with AIDS risk behaviour (Akande, 1994; DiClemente & Peterson, 1994; Du Plessis, Meyer-Weitz & Steyn, 1993; Reddy, Meyer-Weitz, Van den Borne & Kok, in press; Strebel & Perkel, 1991). Therefore, even though people may possess adequate knowledge about AIDS and HIV, this does not result in a corresponding behaviour change. Recently there has been a shift from KABP research to examining issues around decisions and negotiations regarding condom use and safe sex in general.

Certain studies have examined other factors in attempting to understand lack of behaviour change strategies in heterosexual populations. In a survey of young people in Germany, Reinecke, Schmidt and Ajzen (1997) found the difficulties of using condoms in long-term relationships to be an important consideration for lack of behaviour change, as the primary concern for this group was birth control rather than AIDS prevention. Wight (1993), in their study of fifty-eight 19 year old men, similarly found that for most contraception rather than HIV was of greater concern. Students may, therefore, abandon the condom if other birth control methods were employed.

Similarly, Finkelstein and Brannick (1997) found that the duration of a relationship was one of the variables which served as a prerequisite for sex. Among women, primarily, this variable outweighed condom availability. Another cue identified in this study as a prerequisite for sex was knowledge of the partner's sexual history. Thus these factors may prevent young heterosexuals from practising safer sex, despite their knowledge of risk factors, as they might tend to evaluate risk according to their own perceptions of the disease.

Hein, Blair, Ratzan & Dyson (1993) explain the reasons for inconsistent condom use as a consequence of health campaign strategies and popular media. These campaigns have stressed abstinence, monogamy, limiting the number of partners one has and using a condom as effective means of preventing HIV. However, these campaigns have been problematic within the South African context, as they do not consider the context of multi-partner behaviour and attitudes towards condoms in their interventions (Meyer-Weitz, Reddy, Weijts, Van den Borne, Kok & Petersen, 1999).

Most young adults do not abstain from sexual intercourse and *do* consider themselves to be monogamous (Hein, *et al.*, 1993), despite the fact that they might practise what is termed 'serial monogamy'. Secondly, limiting the number of sexual partners does not secure the protection of individual adolescents.

10%-20% of the South African population use condoms inconsistently, while condom use is generally very low (Abdool Karim, Abdool Karim, Soldan & Zondi, 1995; Colvin, 1997; Du Plessis, Meyer-Weitz & Steyn, 1993). The popular media campaigns which advocates condom use to prevent HIV can be interpreted and linked together in such a manner that safer sex is actually avoided. For example, condoms are so strongly associated with HIV that to introduce one into the sexual encounter may receive a negative or undesirable response. Many people fear that introducing a condom into the encounter may imply that they have HIV or are HIV positive (Hein, *et al.*, 1993; Meyer-Weitz, Reddy, Weijts, Van den Borne & Kok, 1998).

This was clearly illustrated by adolescents with HIV in the Adolescent AIDS Programme in the United States of America, who do not practice safer sex because they are afraid that either by using a condom or asking for one to be used might imply that they need one (Hein, *et al.*, 1993). As one adolescent in the AIDS Programme remarked about using a condom, "if I do my partner will somehow know or suspect that I have HIV" (Hein, *et al.*, 1993, p. 220).

In the Meyer-Weitz *et al.* (1998, p. 32) study a female respondent commented that a man who uses condoms 'is someone with loose conduct, because if you have sexual conduct you are not expected to have a disease. If you are too promiscuous you are obliged to use a condom because you don't want to have a disease or spread it to many others...I criticise it because most men do not use

condoms for the prevention of pregnancy. They use it for their sexual immorality with many sexual partners.'

Other studies within the South African context also indicate several barriers to condom use, viz. that condoms are viewed negatively; that it is primarily used as a form of birth control and not protection against the HIV virus; that it indicates distrust or infidelity; and that it creates a barrier for the partners, who will be unable to love each other (Abdool Karim, Abdool Karim, Preston-Whyte & Sankar, 1992; Colvin, 1997; Meyer-Weitz, *et al.*, 1998; Shefer, 1999; Strebel, 1993; Wood & Foster, 1995).

Thus AIDS education programmes should not only focus on providing information, but also confront these barriers to safer sex behaviours. These barriers include the anxieties and lack of social competence needed to apply their knowledge in sexual situations (Venier, Ross & Akande, 1998).

The current emphasis on condom use ignores the fact that it is difficult for women to force their male partners to use condoms. The image of the condom as the exclusively safer sexual behaviour places emphasis on penile-vaginal intercourse, thereby ignoring other non-penetrative sexual pleasures (Strebel, 1999).

Behaviour change strategies are, therefore, even more difficult to implement because of patriarchal ideology, as penile-vaginal intercourse '...is deeply

ingrained in a culture which is dominated by a heterosexual male social construction of sexuality that privileges penetration; modification of this construction would require major changes in women's and men's own expectations of sex, as well as in the education of young people, and in representations of sexuality in the arts and popular media' (Hart, 1993, pgs. 79-80).

An additional critique levelled against the advertising campaigns are that they are concerned exclusively with male desire, that it ignores gendered power imbalances, and that women are expected to take responsibility in sexual encounters (Hart, 1993; Holland, *et al.*, 1994). The AIDS campaigns have been concerned with penetrative sexual intercourse, encouraging condom use in sexual encounters. However, these campaigns have not considered non-penetrative sex as another option for young heterosexuals (Hart, 1993). These are merely regarded as foreplay or an adjunct to penetrative sexual intercourse. Sex would, therefore, mainly refer to male sexual desire (penis in vagina), as evidenced by the Holland, *et al.* (1991) study. These women perceived sex as being exclusively penetrative sex, with women as passive recipients of the penis, as illustrated by the following quote:

When anyone ever said sex before, all I ever thought was sexual intercourse. That's what it is isn't it? (p. 8)

In the Strebel (1993) study, constructions of sexuality were also based on the perception of penetration as 'proper sex'. This perception of sex as exclusively male penetration was evidenced from other studies done locally as well:

> But it would be very difficult to say 'I don't want penetration' to a man. If one [the man] didn't enjoy it, how would you negotiate that? (Miles, 1992, p. 24).

There is also the criticism that media campaigns fail to take into account the gendered power imbalances, whereby women are less able to control sexual encounters, despite the evidence that gender relations are crucial in the spread of HIV (Amaro, 1995; Holland, Ramazanoglu & Scott, 1995; Meyer-Weitz, *et al.*, 1998; Strebel, 1993; Shefer, 1999). Women may be at threat of violence from their partners, or simply do not possess the skills needed to assert their sexual needs (Hart, 1993). These campaigns tend to focus on the use of condoms which is the prerogative of the male, and yet women are targeted in campaigns to ensure safer sex through condom use.

The factors that serve as barriers to safer sex behaviour needs to be understood and challenged, both on an individual as well as a political level. AIDS education and interventions cannot succeed without the political and economic empowerment of women as well (Cochran, 1989).

3.3. WOMEN AND AIDS

Although HIV is primarily a biological disease, the transmission of the HIV virus from one person to another occurs within the social context of interpersonal relationships (Cochran, 1989). For most of the women at risk of contracting the virus, these relationships occur within a heterosexual context. Since the identification of the HIV virus, there has been an increase in research on heterosexuality and the contribution of gender relations to the spread of HIV and AIDS (for example, Amaro, 1995; Holland, Ramazanoglu & Scott, 1995; Meyer-Weitz, *et al.*, 1998; Shefer, 1999; Strebel, 1993).

For marginalised black women in South Africa, there are behaviours which may facilitate a relatively more efficient transmission of the virus. Some of these behaviours are socio-culturally based and include engaging in behaviours where HIV is more likely to be present, instability of relationships, health problems, unemployment and underemployment (Tallis, 1998). As a result, black women are at greater risk to the epidemic by virtue of their position in society (economic, political and social) and the limited opportunities available to them (Piot & Aggleton, 1998).

3.3.1. WOMEN'S BIOLOGICAL VULNERABILITY

Generally, frequent and sufficient contact with HIV is needed for infection to occur (Cochran, 1989). However, because a woman's body would generally retain

semen within, this would increase her contact with the virus, and the risk for transmission would be increased as well (Banda-Beer 1994/95).

Secondly, a woman who has contracted an STD is more likely to have hidden lesions inside the vagina, increasing her risk for HIV infection even when precautionary measures are employed (Lamond, 1996). The woman's vulnerability to infection is increased further if the vaginal walls are lacerated or if there is cervical erosion, pelvic inflammation disease or an intrauterine device is used (Banda-Beer, 1994/95; Lamond, 1996).

The transmission of the HIV virus from male to female therefore, occurs more frequently than female to male transmission (Alexander, 1990; Jewell & Shiboski, 1993, cited in Gômez & Van Oss Marín, 1996), placing women at greater risk for infection. Women are therefore more vulnerable to the disease by virtue of their biology, yet despite this knowledge, women may remain in high-risk relationships.

3.3.2. WOMEN'S VULNERABILITY IN RELATIONSHIPS

Power is at the foundation of unequal gender relations, with powerlessness being the strongest in sexual relations (Banda-Beer, 1994/95). As a result of this unequal power relation, it is women who suffer the consequences of being disadvantaged from protecting either themselves or their partners against HIV infection. Women's low social and economic position in society increases their

dependency on men and influences their ability to negotiate or request safer sex practices.

Even though research has been conducted investigating individual factors associated with condom use such as peer norms, perceived vulnerability to HIV, self-efficacy, etc., these studies do not consider the cultural and social settings in which sexual interactions occur.

Sexual behaviour often occurs within the context of unequal power relations and one which dictates that women should be passive sexually and otherwise (Amaro, 1995; Holland, *et al.*, 1990).

Women's powerlessness in African societies is most noticeable in sexual relations where decision making of women's sexuality is made by men. Within Xhosa and Zulu marriages, the groom and his family takes ownership of the bride and all children born to the couple. Both the in-laws and husband dominates the control of reproduction, thus making it difficult for the woman to control her own fertility (Meyer-Weitz, *et al.*, 1998).

In one study on women and AIDS, gendered power relations was one of the main themes to emerge. Women reported that men defined the relationship and determined what was acceptable behaviour within that relationship (Strebel, 1993). The women reported that men would define having more than one sexual partner

as normal within heterosexual relationships. The women in this study reinforced beliefs which are held by the broader community as well, viz. that men are unable to control their sexual urges, and that men need to boost their self-esteem via sexual prowess. The difficulty of negotiating condom use for these women were complicated by lack of communication between partners regarding safe sex, refusal by men to utilise 'safe sex' practices and the dynamics of mistrust that is created when condoms are requested.

For adolescent women in another study, men defined a relationship as one in which sexual intercourse occurred (Wood, Maforah & Jewkes, 1996). The constructions of love were defined by the male partner with sex being the purpose of being in love. For these women this definition was the major reason for them starting and continuing the sexual activity. The Women, Risk and AIDS Project (WRAP) research also highlighted the coercive nature of heterosexual relationships, where sexual coercion of women by men was considered to be 'normal' practice in sexual relationships (Holland, *et al.*, 1991). The low levels of condom use in Africa is a direct consequence of women's lack of power both within the private and public spheres (Banda-Beer, 1994/95).

Many women experience violence or the threat thereof if they refuse sex (Wood, *et al.*, 1996). In a study examining sexual relationships of Xhosa speaking adolescents, many of the women reported to have been assaulted and abused by their partners when they refused sex as it signified to the men that they had other

sexual partners (Wood, *et al.*, 1996). However, men were 'entitled' to several partners at the same time, when one of the partners was not available.

In another study investigating contraceptive use patterns and predictors of condom use with steady male partners among a sample of women, many women reported that their partners would be angry or possibly even violent if the woman suggested that they use a condom (Gómez & Van Oss Marín, 1996). The perception of a sexual power imbalance seems to be an important predictor of less frequent condom use with steady partners. Sexual coercion, therefore, becomes a significant factor in power-imbalanced relationships in which the dominant partner is resistant to using a condom (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1991; Kelly & Kalichman, 1995).

The women in the above studies had little or no control over sexual decision-making, with sexual violence or the threat thereof occurring in many of their relationships. This would occur when the women asserted themselves in the situation by refusing sexual intercourse or insisting on a condom being used. However, it is just as important to note that women often accept and perpetuate men's dominant roles within heterosexual relationships, as evidenced by the following:

> He has power in everything, yes in everything. I like it. I don't have a problem with it. (Meyer-Weitz, *et al.*, 1998, p. 25),

Gender roles are important in determining how sexual encounters are negotiated and who dictates the encounter (Amaro, 1995). The influence of gender roles on communication regarding safer sex practices and the negotiation of condom use has been, to a large extent ignored, yet this may be one of the most important factors in predicting condom use among heterosexual men and women (Amaro, 1995).

African men's socialised roles are characterised by 'male dominance and prowess' while the women are expected to subordinate and submit themselves to the male (Meyer-Weitz, *et al.*, 1998, p. 23).

Amaro (1995) suggests that HIV prevention strategies must address larger social conditions and contexts that include gender roles, sexual power imbalances and the disempowerment of women. All these factors, including gender, culture and power may affect a woman's ability to negotiate and maintain safer sex practices with a primary partner.

Thus, even though both sexually active men and women are vulnerable to AIDS, women are at higher risk of infection due to their reproductive roles and gender oppression (Haysom, 1998). It is, however, often impossible for women to negotiate safe sex or claim monogamy from their partners due to their subordinate status.

3.3.3. WOMEN'S ECONOMIC VULNERABILITY

It is important to recognise that the majority of women in African countries are economically dependent on men (Banda-Beer, 1994/95). Globally, women are considered to form the majority of the poor people.

Lack of education and training in work-related skills results in many women having limited access to resources (such as health care and sexual education) and often with their only access via husbands, fathers or boyfriends (Banda- Beer, 1994/95; Piot & Aggleton, 1998). Economic dependence of women on men plays a significant role in women's ability to protect themselves and may also limit their ability to place demands on their partners to use condoms in sexual encounters.

In addition, economic poverty and insecurity has resulted in women selling sexual favours for money in order to provide for themselves and their children (Banda-Beer, 1994/95; Williams & Campbell, 1998). However, many of these sex workers do not use condoms as their customers do not want to pay for protected sex (Williams & Campbell, 1998). This increases the risks for women and men of contracting the HIV virus, yet many women are willing to take the risk in order to provide for the immediate economic needs of themselves and their children.

Women may also form relationships with older men (NPPHCN, 1995) or form sexual relationships with a number of partners for economic gain or material rewards (Meyer-Weitz, *et al.*, 1998; Shefer, 1999). Women are placed in

particularly vulnerable positions to HIV infection due to economic and gender power inequalities (Shefer, 1999), and, therefore, may find it difficult to insist on condom use.

3.3.4. HETEROSEXUAL MEN AND AIDS

To date there have been few studies addressing heterosexual men specifically or targeting heterosexual men in prevention strategies. Men often resist campaign messages advocating condom usage for various reasons. Among these is a denial of vulnerability with the belief that AIDS does not exist or that STD's are diseases afflicting women only (Banda-Beer, 1994/95; Meyer-Weitz, 1998).

South African studies on male sexual identities indicate that they generally support patriarchal constructs of the world (Harris, Lea & Foster, 1995). In the Xhosa and Zulu cultures custom and tradition dictate that men are the dominant partner, and wives are expected to be submissive and yield to the sexual demands of their partners. Manhood is defined in terms of the number of children produced, with the belief that it is the man's right to seek other relationships (Meyer-Weitz, *et al.*, 1998; Wood, *et al.*, 1996; Banda-Beer, 1994/95).

The Meyer-Weitz, *et al.* (1998) study suggests that within a sociocultural perspective, multi-partners were the norm, and promotion of monogamy as a strategy for HIV/AIDS prevention in South Africa might not be a viable option.

Shefer and Ruiters describe a 'male sex drive discourse' (Hollway, 1984), a central feature of which is that men need sex and are controlled by their sex drive as in this quote from one of their participant's:

> Sex and love have nothing to do with each other beyond that...that's what I believe in. And I also say...I am a guy. I have biological needs. I need...to be satisfied. If a woman...comes walking past here now. And just by the look of it she arouses me and I want to be satisfied by her, then I'll go for her...and I'll go for her...to satisfy me. Now I don't really love her... (p. 5).

This is clearly illustrated in the Wood, *et al.* (1996) sample where men would explain to their partners that 'people in love must have sex as often as possible' (p.3).

The above factors need serious consideration in any programme designed to prevent the spread of the HIV virus. These factors may serve to impede prevention campaigns as the messages relayed in these campaigns tend to contradict existing beliefs and values. What emerges most strongly throughout the literature is the vulnerability of particularly young, black, poor women in the South African context. Therefore, this population as well as an understanding of behavioural norms, beliefs and values needs to be incorporated into any education drive geared at stemming the spread of the disease.

Chapter 4

METHODOLOGY OF THE RESEARCH

This chapter deals with the methodological framework and details how the study was conducted and analysed.

4.1. INTRODUCTION TO METHODOLOGY

> If the dominant paradigms reflect limited perspectives, then the policy conclusions they suggest or legitimate may be ineffective or even counterproductive (Schoepf, 1991, p. 749).

There are limitations within various paradigms of research. It is thus necessary to explore issues and topics from various perspectives in order for the research to be effective in its aims

Qualitative research methods have a long history in the social sciences and have made an increasingly important contribution to research in these fields. Historically, only quantitative methods were regarded as valid and there was an imperative on social scientists to conduct research in this way (Guba & Lincoln, 1994).

Within social science research, and especially research on AIDS, most of the policy conclusions and official AIDS campaigns have been based on quantitative studies. It has, however, been recognised that qualitative research methods

enable the researcher in the area of AIDS to note and explore the impact of this power imbalance on sexual relations.

For a long time there has been a call for methodological and epistemological reform in the sciences, and especially within the social sciences. While there is still much debate about which techniques are most suitable for particular inquiries, there have been arguments for the re-examining of the research process and the epistemological underpinnings of research, i.e. "that we as researchers construct that which we claim to find" (Steier, 1991, p. 1).

4.2. RATIONALE FOR THE QUALITATIVE FRAMEWORK

Much of the social science research on AIDS is conducted using quantitative surveys investigating the knowledge-attitudes-beliefs-practice (KABP) of participants (Joffe, 1996). These studies rest on the assumption that changes in the knowledge, attitudes and beliefs of people leads to behavioural changes. However, there have been challenges to the assumptions of the KABP paradigm of AIDS research, as these surveys have often concluded that changes in knowledge do not necessarily lead to corresponding behaviour changes (see for example, Du Plessis, Meyer-Weitz & Steyn, 1993; Reddy, Meyer-Weitz, Van den Borne & Kok, in press; Strebel & Perkel, 1991). This study locates itself within a qualitative framework in an attempt to understand some of the complexities involved in behaviour change.

Within the social sciences there is an ongoing debate about the nature and essence of research (Mouton & Marais, 1990). Much of this debate (often referred to as a crisis) within social science research has been methodological in nature. The two differing positions within research methodology resulted, partly, from sharply polarised opinions about the epistemological underpinnings of psychology, namely the way in which the relationship between the researcher and the subject is viewed. This polemic has resulted in the emergence of two schools of thought: the 'experimental', 'hypothetico-deductive' or positivist and the 'naturalistic', 'contextual', 'interpretative', or anti-positivist approach (Henwood & Pidgeon, 1993). The positivist school of thought places considerable trust in numbers and statistics to represent opinions or concepts and emphasises a universal law of cause and effect. The qualitative approach, on the other hand, concentrates on words and observations to express reality and attempts to describe people in natural situations (Henwood & Pidgeon, 1993; Krueger, 1994).

Quantitative approaches have always enjoyed greater status and recognition over qualitative approaches, and have established themselves within the social sciences field of study. However, there has been strong criticism levied against mere quantification and the positivist tradition, which has resulted in a serious consideration of the utility of the qualitative approach (Guba & Lincoln, 1994). These critiques will be briefly outlined below.

Firstly, quantitative approaches have been criticised for 'context stripping'. It has been argued that quantitative studies seems to ignore other contextual or social variables which may impact on a particular research question, which might, if examined, greatly alter the research findings (Guba & Lincoln, 1994; Miles & Huberman, 1984). Quantitative research involves a process of reduction and abstraction, which may eventually reach a point where the context in which the research question is posed, completely disappears (Banister, Burman, Parker, Taylor & Tindall, 1994). It therefore, excludes the meaning and purpose that humans attach to their activities. Qualitative researchers attempt to redress the imbalance by focusing on the situational and structural contexts and thereby including differential variables and at the same time providing valuable contextual information and insight into human behaviour. Within the current study, this approach allowed the researcher the opportunity to explore students' perceptions of AIDS and sexuality within their particular context.

Secondly, quantitative data concerns generalisations which may be statistically meaningful, however, these generalisations can often not be applied to the individual case (Guba & Lincoln, 1994). Qualitative research provides the opportunity for individual cases to be presented and analysed and given meaning within a particular context.

Furthermore, quantitative approaches claim "objectivity", yet facts are grounded in a particular theoretical framework and are themselves value statements (Guba &

Lincoln, 1994). Thus the assumption that research and researchers are neutral and objective is fallacious. Even when the research being conducted is descriptive rather than analytical, research within the social sciences is not value-free. Qualitative research approaches on the other hand place considerable emphasis on the subjectivity of the researcher in defining the research question. In this study the researcher was able, through this approach, to reflect on her role and influence on the research process.

Positivist research would like to believe that human behaviour is predictable, and that it is possible to explain, predict and manipulate future social behaviour through knowledge of universally valid causes (Guba & Lincoln, 1994). However, social behaviour lacks the underlying predictability and orderliness that apparently occurs within the physical and biological sciences (Popper in Fielding, 1993). Therefore, it is virtually impossible to shape and control human behaviour. The historical position of science that it can, by its methods ultimately converge on the truth is, at the very least, questionable (Guba & Lincoln, 1994).

Banister, *et al.* (1994, p.3) concluded that:

> Quantification all too often fuels the fantasy of prediction and control, but qualitative research in psychology takes as its starting point an awareness of the gap between an object of study and the way we represent it, and the way interpretation necessarily comes to fill the gap.

Much of the social science research on AIDS in Africa is conducted using quantitative methods, most specifically questionnaire surveys, which reflects a trend towards narrowly-defined problem-oriented research (Schoepf, 1991). While quantitative surveys are useful in identifying statistical trends they cannot adequately predict the potential effects of this pandemic. Research data is lacking on topics which closely examines sexual relationships qualitatively, such as 'the social and emotional meaning of sex, the prevalence of various sexual practices within broad and focused segments of the adolescent and adult populations, and individuals' sexual fantasies and their influence on behavior', which would be needed to concentrate HIV prevention efforts (Kelly & Kalichman, 1995, p.914).

There is still much debate regarding the positivist and anti-positivist paradigms, with little consensus about the way forward, especially with regard to social science research. Each is said to have its own merits and limitations, however, due to the factors outlined above it is suggested that the present study is best located within a qualitative paradigm.

Denzin and Lincoln (1994, p.2) offer the following definition of qualitative research which is that 'Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter'. According to the above definition, qualitative researchers study phenomena in their natural setting, attempting to secure an in-depth understanding of the subject matter and not to capture objective reality, as this can never be achieved. Qualitative research does not only

provide a critique of the politics and methods of positivism, but also provides well-grounded, rich descriptions and explanations of the processes occurring within local contexts (Miles & Huberman, 1984).

Much of the criticism concerning qualitative research centres around its validity and reliability. The methodological problem is concerned with how to collect valid data and the ethical dilemma is doing so without offending those within the research context, participants, colleagues and government (Schoepf, 1991). Lincoln and Guba (1985) point out the inappropriateness of conventional criteria at establishing the trustworthiness of naturalistic inquiry and offer acceptable alternative criteria. They argue that in attempting to establish the 'truth value', conventional positivist terminology such as internal validity, external validity, reliability and objectivity are inappropriate for qualitative research.

Lincoln and Guba (1985) propose four alternative constructs for determining the truth value of qualitative inquiry, viz. credibility, transferability, dependability and confirmability which are explored below:

Since reality is conceived of as a multiple set of cognitive constructions, research should be conducted in such a way that the credibility of the findings is enhanced and approved by the constructors of the multiple realities being studied. Thus the naturalistic inquirer must demonstrate that the multiple constructions were adequately represented, and that the reconstructions are 'credible to the

constructors of the original multiple realities' (Lincoln & Guba, 1985, p. 296). In this study the researcher attempted at all times to ensure that the participant's representations were adequately presented through reflexivity.

The second construct is transferability, rather than generalisability of findings. It implies that the burden of demonstrating that the findings are applicable in another context lies with the person seeking to make the application and less with the original investigator.

However, making any kind of generalisability or transferability regarding qualitative inquiry is problematic. The inability to generalise to other populations within the qualitative framework (the external validity) is usually regarded as a weakness of the qualitative approach. However, as Lincoln and Guba (1985) correctly points out, within the parameters of that setting, population and theoretical framework, the research will be valid, especially if one considers the multiple realities which exist.

The third construct is dependability, in which the researcher attempts to account for 'factors of instability and factors of phenomenal or design induced changes' (Lincoln & Guba, 1985, p. 299). It differs from the positivist view in that it accounts for everything normally included in the concept of reliability as well as additional factors. Whereas the positivist paradigm regards the world as stable, consistent and predictable, the qualitative researcher notes that reality is a dynamic process.

The final construct is confirmability as opposed to the traditional concept of objectivity. The qualitative researcher would investigate whether the findings could be confirmed by another and so remove the emphasis from the researcher and place it on the data itself. Strebel (1994) also makes the point that validity and reliability can be addressed through linking the findings to other similar research.

Since research does not occur in a social vacuum, qualitative researchers emphasise the socially constructed nature of reality, the relationship between the researcher and the subject matter, as well as the contextual framework of inquiry. This point is emphasised by Kelly and Kalichman (1995, p.911) who argue that within the realm of AIDS research, 'research on situational antecedents of high-risk sex underscores the fact that sexual behavior does not occur in isolation from other events in people's lives, and that these other events can serve as important risk co-factors'. Schoepf (1991) emphasises that research on sexuality has to be culturally appropriate particularly when it is conducted outside clinical settings.

Qualitative research demands a high degree of reflexivity on the part of the researcher. Within the qualitative framework the researcher is central to the analysis as her interpretation is shaped by her personal history, gender, social class, ethnicity and race, as well as those of the people in the setting. Reflexivity provides insight into one's own behaviour and interpretations, as well as an understanding of issues which may be central to the research process (Banister, *et al.*, 1994; Olesen, 1994). This necessarily enhances insight into one's own

perspectives. According to Fielding (1993), closure can only be achieved at the point where there is a balance between the researcher as an outsider (or observer) and as an insider (part of the research process).

Henwood & Pidgeon (1993, p.16) concluded that:

> Qualitative methods are privileged within the naturalistic approach because they are thought to meet a number of reservations about the uncritical use of quantification in social science practice: in particular, the problem of inappropriately fixing meaning where these are variable and renegotiable in relation to their context of use; the neglect of the uniqueness and particularity of human experience (cf. nomothetic-ideographic debate in psychology); and because of concern with the overwriting of internally structured subjectivities by externally imposed 'objective' systems of meaning.

AIDS research represents both challenges and problems for the social sciences, since it involves talking about issues that are almost always avoided. Creating a database for AIDS risk prevention necessarily involves talking about sexual intimacy and the bedroom. Topics focusing on sexuality are generally regarded as sensitive and private and shielded from others. Therefore, it becomes necessary for AIDS researchers to acknowledge and use their own subjectivity when formulating hypotheses or theories. As a result, research on AIDS is often regarded as "sensitive" which can itself be problematic. However, the qualitative framework would provide the opportunity for participants to discuss these sensitive

topics which are almost always avoided. In addition the researcher is able, via this framework, to use her own subjectivity in formulating hypotheses.

Lee and Renzetti (1993, p.5) define a sensitive topic as 'one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or researched the collection, holding and/or dissemination of research data'.

It is not necessarily the topic itself that is sensitive, but rather the relationship between the topic and the social context within which the research is conducted. At times research may also be seen as threatening and sensitive when it intrudes on the personal sphere or delves into deeply personal experience. However, topics and activities which are regarded as private vary according to the particular cultural and situational context (Lee & Renzetti, 1993).

Present studies around AIDS and condom use have shifted their focus from providing quantitative data to qualitative information about sexuality, since qualitative methods allow for the exploration of more complex issues and increase the depth of understanding needed for research in this sphere (Schoepf, 1991). The effectiveness of AIDS and HIV prevention efforts can be greatly improved by linking HIV prevention to research on human sexuality (Kelly & Kalichman, 1995). All research is value-laden (Denzin & Lincoln, 1994), however, qualitative research recognises that reality is socially constructed and attempts to make sense of and

interpret phenomena in terms of the meanings which people bring to them. This framework will allow for rich descriptions of the social world, thus providing detail and subjectivity to a field of study which by its very nature involves intimate social relationships.

4.3. AIMS OF THE PRESENT STUDY

The central aim of the study was to obtain qualitative data concerning students' perceptions of the impact of AIDS on sexual practises and particularly negotiations around condom use. The study examines themes which emerge as the young student population discuss AIDS and the negotiation of condom use.

4.4. DESCRIPTION OF PARTICIPANTS

A sample of 25 undergraduate male and female students from the University of the Western Cape was randomly selected. Two of the groups (mixed and female only groups) were randomly selected from psychology tutorial groups. The male only group were randomly selected from the general campus, as it was difficult to organise a male group from the psychology tutorials. Given that UWC is an historically black university, all of the participants were black (or in Apartheid categories, 'Coloured' and 'African'). Participants were third year students, as it was felt that they may be more willing to discuss issues of a sexual nature, than their younger fellow students.

Demographic variables such as gender, age, religious affinity, marital status, home language, place of origin and AIDS education exposure are reflected in Table 1 (see Appendix).

The majority of participants who partook in the study were female with the average age being 23.08. The majority of participants were Christian or affiliated with a Christian denomination. 80% of the participants were single with the rest in relationships or married. The majority of participants were urban and spoke an African language as a home language. Most of them reported having been exposed to some form of AIDS education. However, an alarming 28% reported not having had any AIDS education exposure. Where participants were exposed to AIDS education, it was mostly in the form of television and magazines.

4.5. INSTRUMENTS

The instruments utilised in this study were focus groups, vignettes and biographical questionnaires.

4.5.1. FOCUS GROUPS

Focus groups, located within the qualitative paradigm, was the chosen method of data collection for the research topic.

Focus groups were first used in market research but have become an increasingly valuable tool for social scientists more broadly. Focus groups have been defined

as involving a group of individuals who interact with each other and seek information that is more profound than is usually accessible at the level of interpersonal relationships (Goldman, cited in Stewart & Shamdasani, 1990). The focus group is usually conducted in a series of groups with persons who possess particular characteristics which are needed for the research topic (Krueger, 1994) and involves a mediator who elicits information from the group.

The number of participants varies and there is no agreed upon ideal amount, but the literature suggests using a minimum of 6 up to 12 individuals (Krueger, 1994; Morgan & Spanish, 1984; Stewart & Shamdasani, 1990). The group needs to be large enough to provide for a diversity of ideas, yet small enough to give everyone in the group an opportunity to respond and share their insights.

Focus groups are usually conducted in a series with a similar profile of participants in order to detect trends and patterns across groups. Ideally, the participants are unfamiliar with each other as the responses given might be related to the groups' past, present or future interactions and not necessarily to the subject being discussed (Krueger, 1994). However, it is not a prerequisite that the subjects should be unfamiliar with each other, since focus groups provide naturalistic data and group members influence and are influenced by others in the group, as would be the case in reality. With regards to the current study the researcher decided to recruit participants who were somewhat familiar with each other, and had interacted and exchanged views in past tutorial groups. This would make

discussion about the topic less threatening than if it was discussed among strangers.

The purpose of the focus group is usually to determine the perceptions, feelings and way of thinking of the participants rather than to reach consensus on a particular topic. Therefore, the focus group is specifically conducted to produce data of interest to the researcher. A number of researchers have highlighted the value of group approaches in AIDS and sexuality research (Leviton, 1989; Shefer, 1999; Strebel, 1995; Valdiserri, 1989). Even though focus groups are regarded as especially useful when dealing with sensitive topics, and offer the opportunity to study attitudes and opinions of people in a qualitative fashion, there are both advantages and disadvantages associated with this method (Morgan & Spanish, 1984; Pugsley, 1996).

One of the major advantages of using focus groups is that it allows the researcher the opportunity to observe participants engaging and interacting and is concentrated on the attitudes and experiences that are of interest to the researcher (Morgan & Spanish, 1984). In addition, the focus group method allows for the exchange of knowledge, which generates rapport and makes investigation into sensitive areas of sexuality less offensive and therefore the researcher's task is made easier. This method allowed the researcher access to discussions about sexuality which would have been difficult to obtain by other means. The information obtained in this manner would appear to yield more reliable information

than other methods such as questionnaire surveys, individual interviews or participant observation. The focus group method facilitated the examining of the influence of gender in terms of how the different gender groups discussed the topic.

However, in the use of focus groups the group can vary considerably and there may be different levels of disclosure. In addition, the researcher has less control over group discussion, which can result in detours in the discussion and the raising of irrelevant issues (Krueger, 1994; Morgan & Spanish, 1984; Stewart & Shamdasani, 1990). Focus groups have been criticised for failing to provide hard data and that the data elicited may not be representative of a larger population. They also tend to rely heavily on the group dynamic as this influences the success or failure of a group in providing data. This may have been a limitation of the current study, in that it relied on the group to be able to discuss the topic, despite its sensitive nature.

One of the major criticisms levied against the focus group method is that it does not provide valid data. However, the same criteria used to assess the validity of qualitative research would be used to assess the validity of focus groups. Additional criteria for assessing focus group validity are discussed below. The validity of focus groups are determined by face validity and predictive or convergent validity (Krueger, 1994). Face validity is concerned with whether the results look valid. Focus groups tend to have a high degree of face validity, as

explanations are obtained directly from participants and their comments appear very reasonable and believable. Predictive or convergent validity is the degree to which the results are confirmed by future actions, events, experiences or behaviours. However, as Pugsley (1996, p. 117) asserts 'there is no *a priori* reason to assume that they need validation'.

The researcher serves a number of functions in the focus group. Krueger (1994) identifies listening, moderating, observing and analysing using an inductive process as some of the tasks of the researcher in the focus group. The researcher in her/his role as a moderator assures that the group discussion flows naturally but that the subject remains on the research topic and that the group members do not divert from the topic.

With regard to the present study, a number of questions relating to general topic areas were compiled in order to have some degree of comparison between groups, and ensure that the conversation flowed and group members did not divert from the topic. The moderator is very influential in the role that they assume within the focus group setting, and can influence and direct the discussion (Stewart & Shamdasani, 1990). Within the focus groups, the facilitator was very active in directing the discussion as participants would often deviate from the question or discuss issues not directly relevant to the research topic. It is, therefore, important that the researcher is observant of group dynamics and possesses the necessary skills to moderate or facilitate the discussion.

An important component of focus group research is reflexivity, as 'the analysis would include an in-depth study of the event, experience or topic in order to describe the context of the experience and the ingredients or components of the experience' (Krueger, 1994, p. 20). This is discussed in greater detail under the heading "Self-reflexive issues of the researcher".

4.5.2. VIGNETTES

In order to facilitate the discussion within groups, Stewart and Shamdasani (1990) recommend the use of various aids. This study employed the use of vignettes (see appendix 3) in order to facilitate discussion and allow subjects to explore relatively threatening material. The subjects may use the vignettes to project their anxiety to those of the characters in the stories (Strebel, 1994). The vignettes were developed based on previous research conducted in the area in the South African context (Shefer, 1999; Strebel, 1994; Wood & Foster, 1995).

Two vignettes were constructed which highlighted relationships and condom use within those relationships. The women in the stories were confronted by safe sex situations and needed to make decisions based on this. The first vignette involved a married couple where the woman wants to use a condom and the second vignette involved a couple at university who have been having a relationship for three months, and the woman wants to use a condom. Each vignette was followed by the question: What do you think will happen next?

4.5.3. BIOGRAPHICAL INFORMATION QUESTIONNAIRE

A questionnaire (see appendix 4) was designed by the researcher to obtain biographical information about each participant including age, gender, home language, marital status, religious affinity and place of origin (whether rural or urban). In order to better understand their AIDS-related educational experiences, the questionnaire also included questions asking the participants what exposure they have had to AIDS education, for example, workshops, courses, reading, media or lectures. The completion of the questionnaire was compulsory for all participants.

As this study compared the ways in which the different gender groups discussed the topic, the combination of qualitative methods and questionnaire was especially useful.

4.6. PROCEDURE

Permission for the study was obtained from the Psychology Department (UWC) as well as the university authorities. Participation in the research was entirely voluntary, with anonymity and confidentiality of the participants ensured. The copy of the completed thesis will be available for participants to review if they so desire.

Three focus groups were held and the participants were selected from third year psychology tutorial groups as well as from the general campus student population. One group was a male-only group (selected from general campus), another a

woman only group and the third consisted of both men and women (selected from psychology tutorial groups). The tutors informed the tutorial groups a week before that they would be involved in a research project and the male only group were informed a few days prior to the focus group. Participants were offered a choice of English or Afrikaans, as these are the only languages understood by the researcher and apologies were made to students who were not speaking their mother tongue. However, most participants preferred to speak English as English was usually the common language among diverse language speakers and all focus groups were conducted mainly in English. The focus groups were audio recorded, as this allowed the researcher to more fully be a part of the process. The tape recordings also allowed the researcher the opportunity to listen accurately and observe the non-verbal behaviours of the participants.

Participants were welcomed and thanked for their participation. The biographical questionnaire was handed to participants and completed before the focus group discussion.

The same vignettes were presented to all three of the groups and the participants were asked to discuss what they thought would happen in each instance. Thereafter other questions were introduced in order to elicit specific information about the research topic. In particular, their feelings about the difficulty of negotiating sexuality and the impact of AIDS on sexual negotiation and condom use were elicited.

The focus groups lasted approximately 50 minutes. The mixed gender group were facilitated by the researcher and a male facilitator, the women-only group by the researcher and the male-only group by a trained male facilitator. It was felt that in the same sex groups participants might discuss the topic more openly with a same sex facilitator.

Participants were assured of confidentiality and no names were obtained. The data were handled and completed by the researcher.

4.7. ANALYSIS

The tape recordings were transcribed verbatim by the researcher herself with pauses, hesitations, unclear speech and noises indicated. This enabled the researcher to obtain a clearer understanding of what had been communicated. The focus groups and transcriptions were both done in English.

There were, however, problems encountered with the transcription process. At times it was difficult to hear what participants had said as some of the participants spoke very softly, and thus that information was lost. In addition, the process of transcription does not capture the non-verbal communications of the process (Stewart & Shamdasani, 1990). However, documentary material itself is data in their own right that captures a distinctive version of social reality (Silverman, 1992).

The data obtained from the focus groups was analysed qualitatively by thematic analysis. The participants' transcripts were coded according to specific and general themes, which had been identified from the data. Some of the categories which were identified overlapped with one another, and therefore certain quotations were applicable to more than one theme.

Miles and Huberman (1984) cautions the researcher against including too many topics, as they might lose sight of the research topic, and thus much of the quality is lost in the process.

After the similarities and themes were identified, the researcher identified the central themes and utilised quotations from the transcripts to illustrate these themes. The researcher then classified all the thematic categories which emerged.

4.8. SELF-REFLEXIVE ISSUES OF THE RESEARCHER

The researcher was aware of her own interests and needs within the focus groups, as she needed particular information for the research project. The researcher had a particular agenda and would therefore, direct the discussion accordingly. This was necessary in order to elicit particular information that was needed for the research topic.

The researcher was also aware of the group dynamics involved in the focus group discussions. In the mixed focus group there appeared to be more responsiveness from the participants. Even though women in the group were generally not as active as the men in the group, they were able to assert themselves and would often challenge the dominant ideologies. The researcher was aware of the power issues between men and women in the mixed group, with the two genders opposed to each other.

In the same sex group there was greater difficulty discussing the topic and the participants often had to be prompted for answers. The researcher noted that in this group there were significant age differences, as well as differences between women adhering to more 'traditional' values and those women who have taken on 'modern' values. The group displayed disagreement and resentment towards women in the group who admitted not being assertive in sexual encounters. The researcher frequently felt like an outsider and untrusted by the group, however, they did elaborate and provide valuable input with regard to the topic. Participants displayed their discomfort with the topic by laughing at times. At times the researcher also felt discomfort with the sensitivity of the subject and discussing issues of such an intimate nature.

The participants may have felt reluctant to participate because of the sensitivity of the subject. It also appeared that the participants would talk about the 'correct' things to do and knew what to do in terms of safer sex. Later participants (as they

became more comfortable) would admit that they know 'what to say' (the correct response) and that maybe it is for the researcher's benefit that they are saying those things, but that that is not what happens in reality, as emerges in the analysis.

Chapter 5

DISCUSSION OF RESULTS

5.1. INTRODUCTION

This chapter represents the results of the study in the form of a qualitative thematic analysis. The discussion includes the participants' experiences and perceptions in relation to the influence of AIDS education campaigns on sexual practices, 'safe sex' practices and particularly condom use. This involves factors which may influence students' abilities to practice safe sex. Sections of the field data or transcriptions have been highlighted where they are appropriate to the discussion. The discussion focuses primarily on three thematic areas, namely:

1. Relationship factors influencing condom use,
2. A denial of vulnerability to infection and
3. Constructions of gender that impact on and may impede condom use.

The implications for AIDS intervention campaigns and educational programmes will be discussed, as well as the application to relevant literature. The thematic categories are not exclusive, and overlap may occur, as the participants' experiences may have been reflected in more than one category. [1]

[1] The quotes do not indicate which participant has spoken in order to ensure confidentiality. 'M' indicates male, 'F' indicates female, 'FF' indicates female facilitator and 'MF' indicates male facilitator. 'M1' and 'M2' and 'F1' and 'F2' have been used to represent different participants where a dialogue is quoted.

5.2. RELATIONSHIP FACTORS

The most dominant theme that arose out of the data was the impact that practising 'safe sex' using a condom could have on a relationship[2]. Most of the participants related that using a condom or even suggesting using a condom would have negative consequences on a relationship.

Despite the fact that they were aware of the risks involved with not using a condom, it was suggested that many students still do not use protective measures for practising 'safe sex'. In all of the focus groups the negative impact that the condom would have on a relationship was discussed at length.

Most of the students felt that condoms were not used in relationships because it could lead to mistrust between partners, poor communication and possible loss of the partner. There was also the perception that sex with a condom was less pleasurable for both men and women.

Even though the participants' recognised the need for self-protection (even within relationships), they admitted that the negotiation of safer sex methods within relationships could have dire consequences for all parties involved.

Relationships are highly valued within society as they do not only provide intimacy and care but often serve more pragmatic needs such as food and housing.

[2] In much of the emerging data 'safe sex' is equated with condom use.

Women feel more protected within relationships, even though these relationships may themselves be characterised by abuse and unequal power dynamics. It, therefore, becomes extremely difficult to negotiate the use of condoms within these relationships, as it is seen as violating the sanctity of what a relationship represents.

The above findings are in agreement with previous research which has found that condoms are often not used, especially within longer-term relationships and are abandoned in favour of other methods of contraception (Finkelstein & Brannick, 1997; Reinecke, Schmidt & Ajzen, 1997; Wight, 1993). It is clear from the data that the condom does not only represent a means of protection, but is seen as involving moral issues of trust and fidelity as well.

5.2.1 LACK OF TRUST

The most significant subtheme that emerged from the data was the lack of trust or mistrust that would result if one partner requested another to use a condom. Most of the students felt that a relationship is based on mutual trust and that asking a partner to wear a condom necessarily implies mistrust in that person, which would have a negative impact on that relationship.

M: because we are socialised in such a way as to be faithful to each other so I should say that they must trust each other (unclear).

The negotiation of condoms in longer-term relationships or in a marriage was felt to be especially problematic, and at times inconceivable, as illustrated by the following:

M: because it's intolerable for married (people to use condoms). But it's not the way people think things to be done in terms of marriage - using a condom - it's unbelievable.

W: (It will result in) arguments between husband and wife and because he will obviously ask her 'Don't you trust me? Why should I use a condom, we haven't before', if that's the case, if they haven't used a condom before or something like that.

This illustrates one of the difficulties women face in negotiating condoms in a long-term relationship, since trust forms part of the decision-making regarding the use of condoms. Her partner might regard her request as a betrayal of the relationship, indicating that she does not trust him or the relationship.

Women are often powerless to confront their partners about suspected infidelities and are thus faced with a dilemma in these contexts. Some of the participants felt that women *should* confront their partners about alleged affairs rather than simply request that he uses a condom. However, the partner could simply deny his infidelity if confronted, leaving the woman with even fewer alternatives. The following dialogue illustrates this:

W: If she asks him if he's having affairs with womens he'll say, 'No, I'm faithful to you', ya, something like that but the truth won't come out.

W: I think she doesn't ask him because maybe she's afraid of the answers she'll get from him. Maybe he will tell her 'Ok I *am* having an affair' and just imagine what would happen further.

MF:Now sorry did you want to say something?

M: Ya, I think that she's afraid to confront him because maybe that will show that she doesn't trust him. And even if he had no affair, that might have an effect that ok while he takes another trip he will feel that ok my wife doesn't trust me so why do I not use these prostitutes, just because she doesn't trust me. So I must carry on, even if he had no affair.

M: But for the mere fact that she asked him to use a condom is a indirect way of confronting him - a guy that she suspects that he is having an affair.

The above participant appears to justify the male's affairs by implying that it is the woman's action or confrontation that will lead her husband to have an affair. This response is indicative of the popular perception that women are responsible for the action or inaction of men. Women might, thus, be afraid of confronting their partners for fear of losing the relationship or have doubts that he would admit to the infidelity.

Within shorter-term relationships when a woman requests her partner to use a condom, it is not regarded as responsible decision-making, but a reflection that she perceives the partner as untrustworthy. The implication for the man would be that the woman regards him as someone who "sleeps around", thereby insulting his integrity, which is regarded as unacceptable.

As a consequence of the media campaigns condoms are commonly associated with AIDS. AIDS is loaded with negative connotations and an implication of deviance and contamination is implied (Hein, *et al.*, 1993). Therefore, for a woman to ask her partner to use a condom carries with it the implication that she thinks that he has AIDS.

Trustworthiness implies authority and control as the man has gained the trust and devotion of his partner (Miles, 1992). Men must necessarily be seen as trustworthy and trusted by their partners. When his trustworthiness is brought into question, it represents a challenge to his masculinity. This contradicts other popular discourses of masculinity which regards sexual prowess as a rite of passage (Shefer & Ruiters, 1997; Shefer & Ruiters, 1998).

M: For me it will go firstly beyond asking saying that I will think about trust and devotion and so on, because (if she) ask me to wear a condom because we are seeing that she must think that I am the kind of guy who sleeps around secondly ...

MF:Would you like that?

M: No, I think not.

MF:Ok so the implication is she might ask you to wear a condom. The implication is that I think you're sleeping around so already I don't trust you.

Another reason raised for not using condoms is that the partner who requests using the condom might be implicated as the one who is "contaminated" and possibly having affairs. The condom is a symbol of a casual relationship and sex without a condom defines the relationship as serious. Thus, when women request their partners to wear a condom, the implication is that she is immoral and possibly sleeping around.

M: Has she confronted him about having this kind of frustration or having affair or she just keeping it to herself, trying to protect herself. Because if she don't confront him and he also can (*have*) the same kind of suspicion cause why (*is she*) asking (*him to use*) a condom. She might have an affair. She try to protect him (but) maybe she might be infected also.

FF:It will make a difference whether she confronts him or not?

M: I think if she confronts him then things will get clearer but if she don't then the two of them will, the one will have a suspicion of the other.

W: Some they feel that if you say you must use a condom then you are cheating on them (*while*) some are able to use it.

Again the request by the woman to use a condom is not regarded as being part of a safer sex practice but rather the perception is that the woman is "contaminated" in some way. The implication being that women would not ask their partners to wear a condom otherwise. Whichever way it is interpreted, women are defined as deviant, whatever they do. They are either untrusting of their partner or immoral.

Miles (1992) similarly found that the negative connotations associated with AIDS often prevented women suggesting the use of condoms to their lovers. Miles's findings also reflects the woman being in a 'double-bind' where women are constructed as the 'other' and are placed in negative light when requesting that the man use a condom.

The respondents felt that asking a partner to wear a condom does eventually lead to problems within that relationship and might result in the break-up of the relationship, as 'the very fact of being in a steady relationship implied the existence of trust' (Holland *et al.*, 1990, p. 20).

One respondent felt that it was a matter of who was "clean" and "not clean" and not an issue of trust. As the respondent said

M: But what is the point of ... what is the question. The question that the condom tried to solve, the problem of who's clean who's not. It's not a matter of moral issues here of having an affair with (*someone*).

This might be what the condom represents - those who are 'unclean' (Waldby, Kippax & Crawford, 1993) and within the context of a relationship this would symbolise the disintegration of the assumptions of trust and fidelity inherent in the relationship, and make it difficult for condom use to be negotiated.

5.2.2. STEADY RELATIONSHIPS vs. THE ONE NIGHT STAND

Most relationships are defined by the time that the couple has been together. The longer the relationship the more serious and trusting the partners are supposed to be.

For most of the female participants time was a factor when considering using a condom with a sexual partner or not. It appears that condoms are used less in longer-term relationships, although what is thought of as longer-term varied between participants and appeared to be an arbitrary classification. Many respondents felt that three months was too short a time in which to get to know a person and consequently trust him/her. Thus, these respondents felt that a longer relationship period was needed before having unprotected sex.

W: Not that I don't trust him (but I think you don't trust him) but we've only met for three months, so maybe before that he could have contaminated somewhere or something like that so (women have to be careful), just to protect themselves.

W: Three months is a short time (laughter) knowing the person and having him. You know how long it takes for the HIV to show up on a blood (*test*), so I mean three months...

Therefore, in order to feel safe with someone, one should get to know the person as knowing someone implies that they are safe to have sex with, without using protection. AIDS is usually linked to a stigmatised 'other' (Miles, 1992), but if the other is known, it makes them safe.

W: I don't know, I mean three months is a shorter time than one and a half years but maybe (unclear) she wouldn't even ask him to use a condom unless something happened that motivated her to ask (*him*) to use a condom. But in three and half months ... I think the time period itself must motivate the person.

However, others felt that time was not as much a factor as knowing your partner's sexual history. However, inquiring about someone's sexual history can be a difficult task, as well as deciding whether to believe him or her.

M: I think time means nothing because maybe the partner that you have, I mean it was not the first. But I think that what is important is if it was the first partner.

MF:But you guys don't do that. People don't do that. I'm going to give you an opportunity to respond. Two things what you've said now, what I've mentioned. So if he didn't, why is the use of the condoms immediately associated with

issues of trust. Suddenly it's about an issue of trust. That's the first thing. And the second thing is and I mean I asked all of them to respond and I'm going to ask all of you guys to respond, do you actually ask the woman that you're interested in having sex with, do we actually ask her am I the first one or have you slept with other guys before? Do we or don't we.

M: Ok when you've just met someone, when you've just fallen in love what is happening you don't just go to make sex. You do meet at times, you have conversations, you know how has been life before. And this person, when you are proposing her she's telling you that 'no you have someone in your life now' then maybe I declared myself 'no I've never been in love before' or ok, I was having someone in love maybe with but we've just broken up because of this or that. What I'm showing in all is that she is aware that I was in love before.

Knowing a partner's sexual history was therefore regarded as important in making the decision to use condoms or not. It seems that the longer the relationship, the more someone is known (and no longer the 'other') and trusted, the less the perceived risk involved in having unprotected sex.

The majority of participants felt that going for a blood test would solve many of the difficulties associated with negotiating the use of condoms. This seemed to be the answer to many of the students.

M: People must trust each other. Whether she ... if she is going to confront him with the question now wear a condom then I think what he must respond is that you expect me to maybe have an affair. And because of it the two of them must go to a doctor and tell him and gain some certainty about (their HIV status). (*The*) problem must be solved, that's the only way

M: I mean you know that you are you are clean you are clear so maybe that you know it, you don't sleep around. And if she, if my wife (*confronts me*) and I confront (*her and ask*) 'do you expect that I am having an affair?', and she say yes, and I I'll tell her that the two of us must go to the doctor so that the two of us can be tested for HIV and our whole problem will be solved. Then I know that she's clean and I know and she knows that I'm clean.

M: I'm sure if I met her for the first time I'd like it and I'll ask her to both of us to go for a blood test just because even myself I don't trust it. And I'm going to ask whether it's her first relation or ... she has slept around before, but I know that she might lie. So I know that it's important for me to go for a blood test.

However, even though the students mentioned this as a precautionary measure to take, they admitted that this was not what was done in reality and that people usually went for a blood test only if they were at risk.

M: Now it depends whether we had gone for a blood test if we had gone for a blood test I'm sure obviously I will not accept a condom.

FF:Do you think people do that? Do you think people in relationships go for blood tests before they have sex?

M & W:No (unclear)

W: I wanted to make a comment about that because if I said a blood test and whatever what, but people don't do that. Or at least the people I know don't do that. So I don't know, maybe we're saying it for your benefit or something.

W: I mean usually people go for blood tests if something happens that's the only time. When couples and obviously maybe the guy don't like to go for (the blood test), the girl has to go and then the sister asks the girl, 'do you have a relationship?' and she says 'yes', 'for how long?' then you say, 'maybe two or three years', the sister would say, 'no bring your guy, your boyfriend'. And then it takes some nerves (*and*) a heck of a struggle just to get the guy there and let them do the blood test. I'm not saying all guys, but I know most guys, they don't want to go.

Condom use does not seem to be employed within longer-term relationships as the person is known and, therefore, trusted. Thus, once someone is known, they no longer represent a threat and therefore, within these contexts condom-use will be abandoned.

5.2.3. CONDOMS DISLIKED

Another reason for condoms not being used is the perception among students (men and women) that it decreases sexual pleasure for the partner. For a relationship to be successful it would need to be sexually satisfying. Since condoms represent a decrease of sexual pleasure and a control of sexuality, it might not be used, even within casual sexual relationships.

W: So you mean sex is the only important thing in the relationship. (Noise & laughter from participants)

M1:Ya, if the relationship with sex you see (it is about) mutual satisfaction through sex you see.

M2:At the same time when you are going to sleep (with someone) for the first time you can see (or) you feel it's like going to test. Because if you fail test (unclear), she may not want you again.

There was a strong emphasis in the mixed group about satisfying your partner through sexual intercourse. The condom was regarded as prohibiting full sexual pleasure from occurring, as one participant stated:

M: I mean I've used condoms several times really (unclear) some of the ladies you see they don't enjoy it if you don't sperm inside. (If) you sperm in the condom they say 'No, it's not enjoyable'. They want to feel those sperm (unclear). We

always have that fear, if maybe it's your first time to sleep with her, so I must try to satisfy her. She must feel it so it's there.

It seems that there has also been difficulty in adapting to safe sex in the era of AIDS as some participants reported that people would not use condoms as this had not been the case before and they, therefore, felt that it was unnecessary. The condom does not only challenge our perceptions of sexuality and what it should be, but also our traditions and customs.

W: They want flesh to flesh. Their fathers have been having more than five wives and they never catch that disease. That disease was never there. So why now, where does it come from, (*so they don't use condoms*).

There is the need to satisfy the man sexually as the focus of sexual relationships is perceived of as centred around the male and his needs. Condoms are seen as artificial and thus "real" satisfaction does not occur. Since it was important for the woman to satisfy her partner completely the condom would not be used.

W1:Well, there are some women who don't want to use condoms.

FF:What's the reason for that?

W1:(unclear) They think that you must go all out. (*The women*) don't want to use any(*thing*) artificial.

W1:I know girls who say they want personal pleasure not rubber pleasure.

W2:And then there's some guys that ask the woman if they should use a condom and then the women

W1:...Say no (W: ya) they don't want to use a condom so I mean if they - the woman - doesn't want to (unclear)...

This quote illustrates how women have assumed the responsibility for HIV prevention in the same way that they have assumed responsibility for preventing pregnancy. Thus when the woman does not insist on using a condom, the man does not initiate condom use. Furthermore, the respondents accepted the dominant discourses that what both men and women want from sex is penetration and male orgasm (Holland, *et al*, 1990). Thus avoidance of the use of condoms would be understandable in this context, as it is assumed that the condom would limit the sexual pleasure of both parties and particularly male pleasure which women feel responsible for.

5.2.4. CONDOMS AS SELF-PROTECTION

All of the participants saw the need for women to protect themselves in sexual encounters, as women were not without agency in protecting themselves when safe sex is made a priority.

W: I think she should use a condom and she should insist they use a condom because she doesn't know his sexual background. And then she doesn't know

with who he has slept with. Unless they are gonna take a test first because before they can but before if they're going to take a test she should insist on that ... on using a condom.

The participants argued that the woman has "a right to save herself". It does appear that even though the woman might have this right that it becomes difficult for her to exercise this right in the context of the relationship. And so this right exists outside of the realm of what is possible for the woman to do.

W: I think she has a right to not to continue having sex with him because, I mean, she has a right to save herself. If she doesn't want to continue with him (*or*) if that guy doesn't want to (*use a condom*) then she has a right to save herself.

Even though this right exists, many women do not possess the means to exercise this right.

W: We women, we like to give in (*and*) don't want to use a condom because you love him so much. And you see that if I won't do what he's asking me (he will have an affair). You don't at that moment think of yourself. You just do that to keep him you know.

Thus, even though women may understand the seriousness of HIV and AIDS, and recognise the need for self-protection, there are variables which may impact on their ability carry through this need.

5.3. DENIAL OF VULNERABILITY

Another prominent theme that emerged from the data was a denial of vulnerability to HIV and AIDS.

Some of the participants related that there is the perception among sexually active students that they will not contract the disease. This could possibly be due to the discourse that places AIDS and HIV as belonging to the 'other' (Joffe, 1996; Miles, 1992).

From the discussion it was evident that a large body of students still deny the existence of AIDS. The students argued that AIDS is an attempt by Westerners to prevent African people from reproducing. This ideology is evidenced in research done elsewhere as well (Miles, 1992).

It appears that it is easier for students to deny the existence of AIDS and HIV rather than be faced with the challenges that a disease such as this poses. It challenges the basic beliefs and value systems which have been entrenched for so long. Thus our views about sexuality and relationships and culture need to be re-examined.

From the discussions it emerged that women tended to take responsibility for safe sex in sexual encounters. Women also appeared to be more aware of the dangers and risks involved in unprotected sexual intercourse.

For men to practice safe sex they would first need to acknowledge that they, as heterosexual men are at risk. As AIDS is perceived as belonging to 'outgroups' (prostitutes and gays), practising safe sex would represent a challenge to their manhood.

5.3.1. "NOT AN AFRICAN DISEASE"

A popular belief among the student population seems to be that AIDS does not exist. This emerged strongly in group one (mixed gender group). It might be that the anxiety and fear resulting from the acknowledgement of the risk of AIDS becomes too difficult for students to deal with, and therefore, it is easier to deny the existence of AIDS altogether.

Aids was first identified as a white homosexual male disease, and it seems that the perception among the black student population is that this is not an African disease but something which affects certain population groups only. Here the risk of infection and vulnerability to AIDS is projected and displaced onto another continent, and so would not form part of the South African context.

M: Some people do not believe it.

MF:Some people don't believe it?

M: They say 'no there's no such (*thing*), it's just an American idea to destroy sex.

FF:Is this a very popular belief?

M: ya I know of some, many people who say 'no there's no such (*thing*)'. They say it's like cancer. I mean you cannot just get it. That's what they say. Because you can get even through blood even if you never had sex so (I don't know why they say so).

Joffe (1996), found within her sample of the South African and British populations, that AIDS was projected onto a continent with which the respondents did not identify. For example, in her sample, the majority of the white[3] respondents in the British and South African samples thought that AIDS originated in Africa, while a greater proportion of black respondents in both samples thought that it originated in the West.

For someone to practice safe sex s/he would have to acknowledge the disease and the fact that they are at risk. This would place the disease in a space where the person would have to acknowledge their feelings and fears concerning the disease.

[3] 'white' referring to Apartheid categories of White

MF:Lets ask them. Why are you guys reluctant to take protective measures? As for example blood tests.

M: Because some of the guys are thinking that maybe he could find out that he is having this … this disease.

Condoms may not be used because of the difficulty adapting to living with the threat of HIV and AIDS. AIDS was not present before, and many cannot understand that this is a new disease which has only recently been identified.

W: They want flesh to flesh and that their fathers have been having more than five wives, and they never catch that disease. That disease was never there so why now where does it come from …

In addition to the argument of retaining African traditions, there is also a strong religious argument against the use of condoms. It is argued that contraceptives are against the will of God, and if a person were to contract AIDS that it is God's will. These arguments seem to serve as defences against dealing with the reality of AIDS.

M: You see some of the guys who don't believe in AIDS, they say … most of them are Christian … they say, 'ya God created us and he knows how all of us are going to die. If he had created me to die with AIDS, I die with AIDS. So I can't avoid it. If I meet someone with AIDS, it will be on God's way.

W: And condoms ... have... if contraceptives are man-made things, (then AIDS is man-made) ... that's true.

M: That's why (most people do not use condoms). So it's basically blaming God for creating this disease.

Thus, there appears to be a displacement of the disease, and a denial of both HIV and AIDS as well as a denial of the seriousness of the disease.

5.3.2. "IF I GET IT, I GET IT"

In addition to a denial of the illness, there is also denial of the seriousness of the illness and the implications that this could have for them and their families. This was linked to the fact that not many students personally knew of someone who is HIV positive or has AIDS and therefore there is a perceived lower risk.

W1:I think it's carelessness among us because we don't think about it is going to happen to me.

W2:If you never ever met somebody who is HIV positive ... (if a person who is not infected) ... if a person ever met a person with AIDS ... maybe that person is a relative or what ... then that, you are going to be careful. Then you'll do anything like use condoms.

There was the belief that one could tell when a person is HIV positive and can therefore, avoid infection in this way. It also seems easier for women to deny their

risk of infection than to confront their husbands and partners despite the fact that they were aware of their partner's infidelities.

W1:I would say that because we used to use condoms I will then ... (unclear) if I am supposed to get it I must get it (laughter) ... because I can't force my man to be that, because if he wanted to ... so if I just keep on saying that.

FF:So it's the fear of losing someone. But why are the men not wanting to use condoms?

W2:Some are sick. Because men ... they're just sleeping with some girls outside ... I don't know what's on their minds, if they don't care ...

W3:I'd like to ask her something. So you say 'I would rather die than using this condom' because at the end of the day you sit with the disease so I will look at that.

W1:I will look at that time we'll both die together

FF:what do you mean

W1:I will just at that time (*have*) that frustration now. I don't have any signs outward or inward. So we always have it like that because your mother says that you must go to the clinic first then you sleep with the man, but then you see that oh the clinic is just too much. But then you fall pregnant and it's oh I'm pregnant, why she told me long ago so now we have that problem because we ... it happened so that similar the same with the AIDS when we got that when we hear that uh you HIV positive, (then you think) I made a mistake, but we didn't think before.

It seems that men would rather deny their HIV status than accept responsibility and initiate safer sex practices. Women are left with the responsibility of ensuring that their partners practice safer sex and use condoms. However, this is complicated as it is the man who has to put the condom on.

W: And he'll go on as well ... infecting other people, because that's what they're doing. They don't want to accept (*responsibility*). They just go to start new relationships and that's why you must stand ... you must be bold ... you mustn't be off using them and all that because these things are being said. Everything (unclear) ... are the man if there is perhaps a topic of this nature they just decided to go or they don't want to listen to this things you see

It would seem that people only begin taking precautionary measures after they have been at risk or they perceive an immediate risk to themselves.

M: I ask her what is important first if you fell in love with someone I mean you reached that agreement your first thing is to have sexual so then everything will fall (into place). Then you might go for the blood test and (unclear) (laughter) what is important...

MF:This is this is the thing.

W: I mean usually people go for blood tests if something happens. That's the only time when couples and obviously maybe the guy don't like to go to (*the clinic*). The girl has to go and then the sister ask the girl 'do you have a relationship?'

and she say 'yes'. 'For how long?' then you say, 'maybe two or three years'. The sister would say 'no bring your guy your boyfriend'. And then it takes some nerves a heck of a struggle just to get the guy there and let them do the blood test. I'm not saying all guys but I know most guys they don't want to go or ...

5.4. CONSTRUCTION OF GENDER

The third major theme to emerge was the way in which the role of men and women in society is perceived.

The question of gender differences was another obstacle to practising safer sex. The women reported feeling powerless to negotiate condom use because of the constraints placed on them as women within heterosexual relationships. The women also reported that they would be "discriminated" against if they asked a man to use a condom. When asked what this meant, the woman reported that she would be emasculating the man. Gender role construction also appears to prevent the men from initiating condom use as this is perceived of as "unmanly" and would decrease sexual pleasure for the woman.

Thus for both genders there was constraints when attempting to use a condom in sexual encounters.

5.4.1. CONSTRUCTION OF FEMININITY

The lack of safe sex measures was often blamed on the passivity of women within relationships. Both men and women felt that women were not assertive enough in insisting that their partners wear condoms.

Women's identities are often enmeshed within the relationship and they view their self-worth in terms of how successful their relationships are (Holland, *et al*, 1990). There is pressure for the woman not to 'fail' in the relationship - with failure being defined as the break-up of the relationship.

Women need to please the man at the expense of their own needs as this is what the popular patriarchal discourse demands.

FF: We've been talking a lot about the right things to do and like you say in the one case, where they're married, that the woman ... they should go for blood tests and so on but just in reality hat really happens out there?

W: We women we like to give in (we) don't want to use a condom because you love him so much and you see that ... if I won't do what he's asking me (he will have an affair). You don't at that moment ... you don't think of yourself you just do that to keep him you know.

W: Because this thing of using condoms is real to us. Because really ... we always compromise for the man. Though they insist that they can use these

things because of these possible diseases but most of the time we do compromise.

FF:Why is it that?

W: I'm sure one did mention that because we don't want to lose the relationship.

M: I think women are having sex for because they need to love and they want to be ... they feel more protected if they have some other man ... (unclear)

Thus the woman would not persist if her partner refuses to wear a condom and would compromise her own needs rather than risk ridicule. There is the fear that without the relationship the woman would no longer possess an identity. The woman, especially within marriage is required to sacrifice her needs and commit herself to the relationship by adapting a passive role.

M: If we can go back that ... we see that the two of them are married, so they, she committed herself to him so no matter what kind of religion they are, she's committed to him. So she must trust for whatever reason I don't know what the traditions of marriage (*are*) or what they promised each other. She's willing to say to herself that she will be faithful to this man ...

Women also feel powerless within relationships as men yield the control, which merely reflects the societal values and norms of gender roles.

W: Ya the women, even men can because what he's saying is right (he can) never be wrong.

FF: So it sound as if a lot of the time the men are a lot in control of what happens.

W: It's because in society men are being seen as the dominant one …

Women are therefore not asked for their consent regarding the use of condoms, and condoms are not a negotiable issue in the relationship.

However, the fear of confronting a partner is not always because of some underlying threat, as the woman might genuinely fear abuse and be vulnerable to abuse if she confronts her partner.

W: Ya sometimes men do abuse … the fact that they are dominant and maybe women might feel inferior, or they might have fear from him that's why they're submissive.

The woman who challenges her partner might make herself vulnerable to ridicule by her community, as the man would perceive the challenge as an insult to his masculinity and would want to degrade the woman in order to maintain his sense of power.

W1:It's because of this thing that this lady said ... maybe some men will say (things about the woman), that's what I'm afraid of ... such things ... or else some men go and talk bad things about you.

FF:so you're scared of their reaction

W1:yes

W2:I think the easiest way to come out of that situation if you are infected and you're afraid to talk to the man or the guy, I mean ... I'm not saying you are not married ... even think that this one if I tell you, you will talk bad about me ... why not keep a distance from him.

In South Africa women have equal rights under the constitution and discrimination is not tolerated. However, these rights have not been translated into equality in heterosexual relationships, where the unequal balance of power makes it increasingly difficult for women to insist that their partner practices safe sex.

W: That men are ... and men I think I read an article ... by them saying that women should be treated like low class they should be treated like animals ... and there are so many issues around that ... but culturally it's our culture in terms of ... us as women I'm sure there is so many commonalities around.

There was a number of reasons given for the passivity of women in relationships, viz. culture, religion and patriarchy, but what all the participants agreed on was that women were submissive in relationships. Women were therefore once again

placed in a no-win situation, as they were regarded in a negative light whether they insisted on the use of condoms or not. Those who insisted would make themselves vulnerable to ridicule and abuse and those who do not are blamed for being submissive in the relationship.

MF:so why are the guys so reluctant to take responsibility for that

M: No I think women are too submissive and ... (Unclear)

5.4.2. CONSTRUCTION OF MASCULINITY

Many of the stereotypes and constructions of men and masculinity as the realm of power and control may also impede the employment of 'safe sex' measures within relationships. Many women are reluctant to ask their male partners to use a condom as this is seen as emasculating the man. The woman is regarded as wanting to control the sexual encounter, and this is unacceptable.

FF:Discriminated ... in what way.

W: You feel so that you are lowering their (egos) as men.

FF:So it's a sort of ... it hurts their ego. (It seems) that some men are like that and some men are quite accepting of it.

Women are supposed to surrender within sexual encounters, and therefore, any attempt at controlling the situation is regarded as threatening by the man. Within marriage women are also supposed to surrender and obey her husband. For a

woman in a marriage to request that her husband use a condom would be regarded as punishing the man. The focus is on the man's needs with the woman's needs largely ignored and seen as the same as the man's.

M: Tell me what if these people are not yet having children what is going to be done are we going to condemn him as a father?

The woman is blamed for requesting the condom and insulting the man. Using a condom in a long-term relationship is regarded as unacceptable and difficult to conceive of.

M: And accept the fact that they're trying to protect themselves is that maybe for which the lady might feel very ... trying to insult the man for this suspicions you know ... in a way that ... knowing that she's suspecting she might be wrong, she might be right. So she try to insult the guy by saying ... using a (condom) because it's intolerable for married ... not impossible but it's not in the way people think things to be done in terms of marriage using a condom it's unbelievable.

From the discussions it is clear that there are many barriers towards safe sex and condom use within sexual relationships, including perceptions of AIDS, relationships and sexual encounters. It appears that the majority of students do not practice safe sex, which has major implications for AIDS prevention

programmes as well as for South Africa, as these students are supposedly the more literate and educated sector of the population.

Chapter 6

CONCLUSION AND RECOMMENDATIONS

6.1. INTRODUCTION

This study aimed to explore students' perceptions of the impact of AIDS education programmes on sexual negotiation, and specifically condom use. Health education programmes aimed at increasing condom use are "often poorly developed and practised without a research foundation." (Reddy, P., Meyer-Weitz, A., Kok, G., & Van den Borne, B., 1999., p. 139).

This study is intended to provide information for the development of health education interventions that will focus on the young adult population, with the aim of promoting behaviours that minimise their risk of contracting and transmitting HIV.

This chapter provides a synopsis of the results explored in the previous chapter. The most prominent themes which emerged are summarised and discussed and the limitations of the study as well as recommendations for future research in the area are explored.

6.2. REFLECTIONS ON THE RESULTS

The study aimed to explore issues relating to safe sex practices and condom use among a group of young adults. Their perception of whether AIDS education campaigns was successful were largely negative, as they explored the reasons for the negativity surrounding safe sex and condom use. Despite their understanding that safe sex is important in the prevention of HIV, many students affirmed that safe sex is often not practised.

One of the most dominant themes to emerge from the data was the negative impact that requesting safe sex would have on a relationship. Many participants reported that it would result in mistrust between the parties and questions of fidelity would form a major part of the relationship. In addition, the condom in particular appears to represent promiscuity, casuality of a relationship and a decrease in sexual pleasure which would, in turn, represent a betrayal of that relationship. Condoms may therefore, not be introduced into a sexual encounter as they may raise issues that many students apparently do not want to deal with.

Another reason given for safe sex not being employed relates to the length of a relationship. Some participants (particularly women) reported that the length of a relationship would determine whether condoms would be employed as a safe sex option. For the women in the study, the longer a relationship, the more the partner is trusted, and therefore, safe sex methods would be abandoned or not be employed entirely. For the majority of men in the study, however, it appeared to be

more a matter of sexual history, than length of relationship. The number of previous partners the woman had would determine whether safe sex methods were employed or not.

Another dominant theme to emerge from the data was the role that denial plays in many students not practising safe sex as they do not perceive themselves to be at risk. In addition to the denial of the disease itself, there also appeared to be a denial of the seriousness of the disease. Many seemed to perceive of HIV as just another risk that they face in everyday life. Many women, especially, would apparently rather face this risk than lose the relationship, given that the relationship provides emotional and economic security.

However, within this discussion there were also many voices of resistance to this role of women as submissive, and some women reported being very assertive with regard to safe sex. However, they reported facing an 'upward battle' as other women reinforced the stereotypes and myths surrounding women's roles within relationships.

The discussions once again highlighted that knowledge regarding HIV and AIDS does not necessarily lead to behavioural changes. Despite their knowledge regarding sexual risk factors and their awareness of condom use in the prevention of HIV, many students do not practice safe sex. There appears to be additional factors involved in the decision to practice safe sex, including myths surrounding

the disease, cultural norms, perceptions of intimate relationships and gender relations. These factors all seem to play a role in the final decision regarding safe sex and condom use and applied to both men and women within the study. Certain factors may have been more significant for men than for women while others may have applied more to the women in the study.

The findings suggest that although participants seemed to have a general understanding of HIV and AIDS, their perceptions of the seriousness of the disease are inadequate. There appeared to be an apathy and sense of powerlessness to affect change in an area which is sensitive and private.

Throughout the discussions regarding the barriers to safe sex, was the consistent way in which these barriers were embedded in the politics of gender relations. Thus, for intervention programmes to have any degree of success, they would need to address the larger issues of women's roles both within the public and private sphere. This would seem to be a great task as it would require altering the perceptions of women and men embedded in centuries of tradition and culture. Prevention programmes would need the involvement and assistance of both government and the private sector in addressing these issues on a broader level.

6.3. LIMITATIONS OF THE STUDY

The research study had as its broad objective to explore students' perceptions of safe sex methods and condom use in relation to AIDS campaign strategies. The specific aim was to examine barriers to safe sex methods and under which circumstances these methods would not be used. The main objectives of the study have been met, although the exploration in this area is by no means exhausted. The qualitative methodology, with its emphasis on description rather than measurement of social phenomenon, was appropriate for eliciting participants' perceptions and experiences regarding HIV and AIDS prevention.

The focus group method has inherent limitations, as the dominant group members may have influenced others within the group. This may have resulted in responses that were not entirely spontaneous and were influenced by considerations of social desirability. However, there was debate and disagreement among group members indicating that group participants did voice their opinions freely.

The results of the study were influenced by the relative ability of the researcher to elicit information from the participants, interpret the data collected, and determine what is important and relevant for the study. My lack of extensive experience in group facilitation and knowledge in the area of HIV and AIDS may have impacted on the process of accessing and examining the relevant data.

The issue of language differences between the researcher and the participants was addressed at the outset of the study but may have influenced the ability of the participants to express their views accurately.

6.4. RECOMMENDATIONS FOR FUTURE RESEARCH

It has been documented in the literature review that the pandemic that the HIV virus represents to world health warrants special and specific attention. Further research is needed on the influence of environmental determinants of sexual behaviour such as condom availability and pricing of condoms, the role of tradition and culture, the influence of religious establishments with regard to condom use and specific attention is needed on gender politics influencing condom use.

Research examining those factors which do lead to condom use needs to be explored and findings incorporated into AIDS education programmes.

6.5. CONCLUSIONS OF THE STUDY

This research dealt with the exploration of students' perceptions of whether AIDS education programmes influenced condom use among this population. This was done via focus group discussions exploring specific issues relevant to safe sex practises and condom use. It is hoped that this study will contribute further to the body of knowledge on HIV and AIDS and deepen our understanding of sexual practices among the student population. The findings of this study highlighted that

many of the young adult population do not practice safe sex and continually place themselves and others at risk of contracting and transmitting the HIV virus.

Designing effective HIV and AIDS programmes for the South African population is imperative if we are to have any hope of curtailing the disease.

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Appendix 1

Table 1: Demographic variables

Demographic variable		Number of participants	Percentage of participants
Gender	Male	9	36
	Female	16	64
Age	19	1	4
	20	1	4
	21	2	8
	22	3	12
	23	1	4
	24	1	4
	25	4	16
	26	1	4
	27	3	12
	28	2	8
	29	2	8
	30	1	4
	32	1	4
	Missing cases	2	8
Religious Affinity	Moslem	1	4
	Christian	7	28
	Catholic	1	4
	Presbetarian	2	8
	Reformed Church	2	8
	AIE church	1	4
	Assembly of God	3	12
	Methodist	4	16
	Church of Christ	1	4

	Anglican	1	4
	United Congretional Church	1	4
	Maranatha Morning Star Penticostal Mission	1	4
Marital Status	Married	2	8
	Single	20	80
	Divorced	0	0
	Co-habiting	0	0
	In relationship	1	4
	Missing cases	2	8
Home Language	English	1	4
	Afrikaans	5	20
	Other	17	68
	Xhosa	15	60
	Tswana	2	8
	Missing cases	2	8
Place of Origin	Rural	9	36
	Urban	16	64
I have been exposed to AIDS education	Yes	18	72
	No	7	28
In what form	Workshop	7	28
	Training Course	0	0
	Books	12	48
	Academic Literature	5	20
	Other	1	4
	Television	13	52
	Radio	9	36
	Newspaper	10	40
	Magazine	13	52

	Lecture	3	12
	Other	2	8

APPENDIX 2

Rings of fire – a firework display lights up the Sydney skyline as the Olympic rings were lit up on the Sydney Harbour Bridge last night

What I really think about HIV – Mbeki

KHATHU MAMAILA AND ROBERT BRAND
Staff Reporters

Amid the growing clamour joined even by members of his own party, President Mbeki has been forced to state unequivocally his views on the link between HIV and AIDS.

Advertisements seeking to clarify the views of the president and Health Minister Manto Tshabalala-Msimang on whether HIV causes AIDS have been placed in newspapers today.

This follows the leaking on Wednesday of a confidential document written by leaders of the African National Congress national health committee, calling on Mr Mbeki and Dr Tshabalala-Msimang to acknowledge that HIV causes AIDS. Dr Tshabalala-Msimang last week clashed with Radio 702 host John Robbie when Robbie insisted that she explain whether she believes HIV causes AIDS.

The adverts (see page 10) also follow the admission earlier this week by Essop Pahad, the Minister in the President's Office and the political head of the Government Communication and Information System (GCIS), that he had failed to communicate Mr Mbeki's stance on the link between HIV and AIDS effectively.

The ANC's parliamentary whips have also written to Mr Mbeki asking him to brief the party's parliamentary caucus in an effort to clear up misunderstandings about the Government's policy on HIV/AIDS.

The adverts, an attempt to "put the issue beyond doubt in the public mind", were placed by the GCIS. They say "neither the president nor his cabinet colleagues have ever denied a link between HIV and AIDS".

This is made clear if one refers to the full transcript of the president's interview last week with Time magazine, the advert asserts.

The published edited version in Time on which many critics now depend, conflated his [illegible]

"In fact, the president went on to say: 'You cannot attribute immune deficiency solely [illegible] The context of the full transcript makes it expressly clear he was prepared to accept that HIV might very well be a causal factor.

"The president went on to say: 'AIDS is a syndrome, a whole variety of diseases which affect a person because something negative has happened to the immune system. If the scientists come back and say this virus is part of the variety of things from which people acquire immune deficiency, I have no problem with that. But to say this is the sole cause, therefore the only response to it is antiretroviral drugs... I am saying we will never be able to solve the AIDS problem.'"

The ANC also moved yesterday to reverse [illegible] perception of discord in its ranks over the issue. The party said the confidential document by leaders of its health committee did not reflect the ANC's official view. But policy on HIV/AIDS would continually be debated within the organisation.

The document, part of which was leaked this week, reflects concern among ANC members about Mr Mbeki's ambiguous statements on the disease.

Neither his office nor Dr Tshabalala-Msimang would comment on the developments, saying they were internal ANC matters.

ANC spokesman Smuts Ngonyama did not deny the authenticity of the health committee document, but said it did not reflect the views or policies of the ANC, its leadership structures, committees or organs. "It was an internal discussion document that reflects the views of its author."

The document's author is the deputy chair of the ANC's national health committee, Confidence Moloko.

Pagad man guilty of killing girl

Appendix 3

FOCUS GROUPS

STORY 1

Kanyi and John, both students at university, have been going out for 3 months. They both feel that they are ready to start a sexual relationship. Kanyi is taking the pill, but wants to use condoms as well. However, John feels that condoms are unnecessary... Discuss what you think will happen and why.

STORY 2

Mogammat and Shahieda have been married for seven years. Mogammat is a long-distance driver and is sometimes gone for 2 weeks at a time. Shahieda suspects that he is having an affair. So one night when he wants to have sex with her she asks him to use a condom... what do you think will happen and why. Discuss.

QUESTIONS

1. In both stories - would it have made a difference if it was the man who wanted to use a condom?
2. Who do you think should take responsibility in sexual encounters?
3. How do you think men see the use of condoms?
4. How do you think women see the use of condoms?
5. How are women and men who carry around condoms viewed by men and women?
6. Does using a condom impact on masculinity or femininity in any way?
7. How is AIDS education impacting on sexual behaviour?

Appendix 4

DEMOGRAPHIC QUESTIONNAIRE

1. **GENDER**	MALE	☐
	FEMALE	☐
2. **AGE**	.....	
3. **RELIGIOUS AFFINITY**	.....	
4. **MARITAL STATUS**	MARRIED	☐
	SINGLE	☐
	DIVORCED	☐
	CO-HABITING	☐
	IN RELATIONSHIP	☐
5. **HOME LANGUAGE**	ENGLISH	☐
	AFRIKAANS	☐
	OTHER	☐
	SPECIFY IF OTHER	
6. **PLACE OF ORIGIN**	RURAL	☐
	URBAN	☐

7. **I HAVE BEEN EXPOSED TO AIDS EDUCATION:** YES ☐

NO ☐

Appendix 4

IF YES, IN WHAT FORM (CAN BE MORE THAN ONE)

ALSO STATE WHERE THIS TOOK PLACE:

WORKSHOP _____

TRAINING COURSE ☐_____

READING - BOOKS ☐_____

ACADEMIC LITERATURE ☐_____

IF OTHER, PLEASE SPECIFY.....:_____

MEDIA - TELEVISION ☐_____

RADIO ☐_____

NEWSPAPER ☐_____

MAGAZINE ☐_____

LECTURE ☐_____

OTHER ☐_____

SPECIFY IF OTHER ..... ☐_____

THANK YOU FOR YOUR CO-OPERATION