A QUALITATIVE INVESTIGATION ON THE SEXUAL PRACTICES OF ADOLESCENTS IN RELATION TO SEXUALLY TRANSMITTED DISEASES AND ACQUIRED IMMUNO - DEFICIENCY SYNDROME

by

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ABSTRACT

Research shows that prevention campaigns have been successful in raising awareness about AIDS and even in teaching people how to protect themselves, i.e. "Abstain, Be Faithful, Condomise" where they have failed dismally is in convincing people especially the youth of today as to how to apply it.

The aim of the study was to investigate qualitatively the sexual practices of adolescents in relation to sexually transmitted diseases and acquired immuno-deficiency syndrome.

The study investigated the determinants of condom using behaviour amongst school going adolescents, in the Durban and Verulam metropolitan region of Kwa-Zulu Natal. The motivation for the study was contexualised within the preventative health model which views the consistent and correct use of condoms as a primary strategy in preventing the spread of STD's and HIV/AIDS. In South Africa the health promotion campaigns focusing on safe sex practices and condom use have met with limited success as evidenced in this study.

The sexual behaviour of adolescents is a key factor in influencing HIV transmission and sexually transmitted diseases. The reason for this behaviour is that most youths are inconsistent condom users and those who become sexually active at an early stage, run a greater risk to being exposed to HIV and STD's, both because of multiple partners and increased episodes of unprotected sex.

The results indicate that on a very superficial level, South African adolescents possess good knowledge about transmission and prevention. The reason for this is that in order to produce behavioural changes, education programmes on sex and AIDS should include cognitive and behavioural skills training, addressing interpersonal problem solving, planning and assertive communication. Furthermore the under-resourced health sector, inaccessible health facilities, poor education and preventative measures do not empower the youth to make health choices responsibly

It is envisaged that the recommendations from the research would ensure that existing health facilities are accessible to the youth today. Family planning clinics which are decentralised and offer a youth day programme in respect of sexuality education and proper use of contraceptives and condoms, ensuring full confidentiality. It is further hoped that this research would show that prevention and education messages are more effectively conveyed to the youth in South Africa, emphasising cognitive and behavioural skills training, with the co-operation and co-ordinated efforts of all departments and non governmental organisation, as well as by those infected themselves.

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DECLARATION

I hereby declare that this is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

Ms A.K. Razak
January 2004
Durban

CHAPTER ONE - INTRODUCTION

Introduction and Rationale for the Study

The domain of sexual behaviour lies at the core of social structure to the extent that it is related to the nature of gender politics and is thus a major determinant of the type of society in which we live. The subtleties of this highly personal area are difficult to quantify or even define. It fulfils our basic need for love, care and intimacy and fuels the desire to procreate. It is an area that pitches our private needs against outside pressures. It is undoubtedly one of the hardest areas of human interaction to navigate and, where difficulties arise, these are most often not confronted until there is a consequence that cannot be avoided (Reddy & Meyer-Weitz, 1999). The extent of sexually transmitted diseases (STDs) makes unsafe sexual behaviour an issue that must be examined closely. Adolescents in this regard are of interest in STDS/HIV (Human immuno-deficiency virus) studies as they are a group whose behaviour places them at increased risk of STDS/HIV infection (Hein, 1992). Research has shown that knowledge of STDS/HIV does not change behaviour and that despite knowing that condoms prevent STDS/HIV transmission, condom use has remained disappointingly low (Di Clemente, 1992) especially in developing countries (Oostergaard, 1997).

In addition, there has been the realisation that much of the risk behaviour associated with adolescence has its roots in the way in which adolescents construct their identities within the context of heterosexual society (Buysse & Van Oost, 1997). Adolescents are particularly vulnerable to HIV/STDs because this is a period characterised by the development and formation of sexuality, a process which frequently involves a high turn over of sexual partners. Normative social influences of their peers (Di Clemente, 1992), perceptions of invulnerability to HIV infection and non-personalisation of the threat of AIDS combine to make this particular group a high risk one to HIV/STDS. The factors, which place adolescents at risk of HIV, tend to stereotype adolescence as a period of traumatic social behaviour.

This emerging knowledge has provided an impetus for a new body of research into adolescent sexuality and the ways in which sexuality most commonly influences behaviour. This is consistent with the objectives of the Ottawa Charter (1986) which views health promotion as a process of enabling people to increase control over, and to improve their health. The key components of such health promotion actions include, *inter alia,* building health policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Research imperatives in the developing world regarding adolescent sexuality has a two -fold importance in relation to interventions. First, the impact of norms, values and entrenched social beliefs provide some answers for the failure of existing STD/HIV interventions. Second, future interventions will benefit from an understanding of the complexities facing adolescents in the decisions, which govern their sexual lives

MOTIVATION

The proposed study accordingly intends to investigate the determinants of condom using behaviour amongst school going adolescents, in the North Coast and Durban Metropolitan region of Kwa/Zulu Natal. The motivation for the proposed study is contexualised within the preventative health model, which views the consistent and correct use of condoms as a primary strategy in preventing the spread of STD's and HIV/AIDS.

The impetus for my thinking in undertaking such a study is evidenced by the recent data showing that the majority of HIV infected people in South Africa are between 15 and 45 years of age and because of the lack of research undertaken in the South African context in respect of knowledge, attitudes and beliefs of adolescents in respect of AIDS/HIV/STD's and condom use.

AIMS AND OBJECTIVES

1. To investigate the knowledge, attitudes, treatment and prevention influences of adolescents towards STD's, HIV and AIDS.

2. To examine the determinants of condom using behaviour in terms of enabling and reinforcing factors such as skill and access with regard to condom use.

3. To explore self-efficacy expectations, effective and social influence components in relation to condom using behaviour.

4. To examine if developmental periods could serve as a predictor of condom usage among adolescents (i.e. children between ages 15 to 18 years).

STATEMENT OF THE PROBLEM

The research that will be presented in this study will demonstrate that the prevalence of AIDS (acquired immuno-deficiency syndrome)/HIV is highest in young people in this country. The sexual behaviour of adolescents is a key factor in influencing the HIV transmission and other sexually transmitted diseases. The reasons for this behaviour is that most youths are inconsistent condom users, at best, those who become sexually active at an early stage, run a greater risk to being exposed to acquired immuno-deficiency syndrome and sexually transmitted diseases, both because of multiple partners and increased episodes of unprotected sex. Psycho social, cultural, environmental and economic factors such as adolescent's perception of a future with little hope, high rate of unemployment, illiteracy, peer pressure, autocratic and inconsistent parenting, poor education, poverty and a lack of access to health care facilities, has led to increasing numbers of street youth, who appear to exchange sex as a survival strategy, encourages high-risk behaviour amongst young people. (Perkel and Strebel, 1991).

RESEARCH METHODOLOGY

Data collection will be through the use of focus groups and in-depth interviews. This methodology will allow for research participants themselves to provide answers to open-ended questions that would generate insights towards condom using behaviour. A detailed open-ended interview schedule which probes to generate in-depth information will be utilised with adolescents at schools in the North Coast and Durban metropolitan region. The interviews will be conducted in the language of the respondents and tape recorded with their informed consent. Females and males will be interviewed separately as a result of the sensitive nature of the topic. These interviews will take two hours and an interview schedule will be used to explore questions in an open and flexible manner.

Focus groups with two groups of adolescents male and females will focus on their understanding, attitude, knowledge and beliefs in respect of sexually transmitted diseases, Acquired immuno-deficiency syndrome and the practice of condom use. Discussions will take place for two hours and these discussions will be tape recorded with the consent of the group. The advantage of utilising a focus group in research is that it is socially orientated, it places people in natural, real life social situations rather than imposing impersonal control, quantitative conditions. It also allows the researcher to probe high content validity, it is easily understood, and the results are accessible and believable. It is cost effective and can provide quick results to inform interventions. (Breakwell & Hammond, 1995).

DATA ANALYSIS

Data will be processed by analysing focus group discussions of adolescents and responses to in-depth interviews as well as to open ended questions. Findings therefore will be expressed mainly qualitatively.

VALUE OF THE STUDY

It is hoped that insights gained from this research could contribute in providing information about the attitudes, knowledge and beliefs of adolescents towards condom use and HIV/AIDS and STD's in the school environment. It can modify, enhance, educate, prevent and develop intervention strategies to decrease high-risk behaviour in adolescents by encouraging safe sex methods and it would encourage policy makers to adopt an intersectoral approach and develop social policies to effectively implement the appropriate strategies.

CHAPTER 2: LITERARY CONTEXT

2.1 Background Information

Africa continues to dwarf the rest of the world on the aids balance sheet. According to the UNAIDS (United Nations Acquired immuno-deficiency syndrome) and WHO (World Health Organisation) estimates, 7 out of 10 people who were newly infected with HIV in 1998 live in Sub Saharan Africa. Among children under 15, the proportion is 9 out of 10, of all aids death.

Since the epidemic started 83% of the infected population have been in the region, at least 95% of all aids orphans have been African, yet only one tenth of the world's population lives in Africa south of Sahara. The sheer number of Africans affected by the epidemic is overwhelming. Since the start of the epidemic, an estimated 34 million people living in Sub Saharan Africa have been infected with HIV. Some 11.5 million of these people have already died, a quarter of them are children. In the course of 1998, aids will have been responsible for an estimated two million funerals in Africa. It was estimated that by the end of 1998, 21.5 million men and women will be living with HIV in Africa plus another one million children. Some four million of these people will have contracted the infection in 1998 alone. South Africa trailed behind some of its neighbours in HIV infection levels at the start of 1990's. Unfortunately, it is catching up fast. In 1999, just over 50% of all new infections in Southern Africa occurred in this one country. In South Africa as Malawi, Mozambique, Rwanda and Zambia between one in seven and one in nine adults live with HIV infection.

People continue to be at risk for HIV throughout their sexually active lives and all should benefit from services and information that allow them to reduce their risk of infection. However, efforts to promote

safer behaviour are especially critical for young people who in mature epidemics are those at greatest risks. (Schaalma, 1995).

In 1982 the number of AIDS cases diagnosed in the United States was approximately 250, by 1993, nearly 300 000 cases have been diagnosed. It took eight years for the first 100 000 AIDS cases in the United States to be diagnosed, whereas a further 100 000 cases were diagnosed in just a two year period. AIDS is now the second leading cause of death among American men between the ages of 18 and 44 years, and the sixth leading causes of death among women in this age group. The most critical difference between HIV and most other life threatening diseases (i.e. cancer and cardiovascular conditions), is that the HIV infection is communicable and in some cases can be contracted through relatively low rates of risk taking behaviour. However, a focus only on who has AIDS is now counterproductive to HIV prevention efforts because AIDS defining illness occur ten years after initial HIV infection. (Macphail, 1998).

Recent studies also show growing HIV infection levels among heterosexual adolescents and adults, particularly in American inner cities and especially in populations with high rates of STD's and drug abuse. American perspective on AIDS often underestimates the enormity of the HIV epidemic, prevalent in other areas of the world.

In contrast to the epidemiology of HIV disease, familiar in the United States and many developed countries with gay men and injection drug users most affected to date, HIV contracted through heterosexual contact is predominant in most developing countries: (Kelly, Murphy, Sikkema and Kalichman, 1993).

The number of AID'S cases continues to double in South Africa every eight and a half months: (Bless & Achola, 1992). Unless the doubling time of HIV transmission can be lengthened, the expected personal social and economic consequences of the disease will be enormous. Universally, adolescents have been identified as a group at high risk for HIV infection. In South Africa, as in the United States, persons 20-29 years of age account for a significant proportion, i.e. (24,5% and 20%) of all known AIDS cases, given the median latency period of 8-10 years between HIV infection and the development of AIDS, many young adults with AIDS must have acquired the infection during their teenage years. In addition, adolescents in the USA currently have the highest rate of other sexually transmitted diseases, a factor, which increases susceptibility to HIV infection. (Richter and Kruger, 1995).

Sexually transmitted infections, although preventable, are a major public health problem in South Africa, both in terms of quality of life as well as economic costs. Their widespread occurrence is evidenced by the approximately 11 million episodes of sexually transmitted infections treated annually. (Reddy, and Meyer-Weitz, 1999).

The magnitude of the epidemic in many areas of the world is grave with HIV prevalence exceeding 20% of the rural populations and 30% of adult urban populations in regions of Sub-Saharan Africa. Within the past two years, HIV prevalence has increased dramatically, especially in heterosexual populations in Africa, India and Asia where up to 110 million HIV infections are expected to occur by the end of the decade.

Driven by the high prevalence of such traditional STD's as syphilis and herpes simplex II which may facilitate HIV transmission between heterosexual partners, as well as by cultural values that do not favour either monogamy or condom use, by the very limited public health resources, the virtually unchecked HIV epidemic will take a great toll in health, economic and social misery in much of the developing world in the coming years. (Kelly, Murphy, Sikkema and Kalichman, 1993).

The HIV virus is one of the most fatal diseases of our century. It is not caused by diet, lack of exercise or environmental pollution, instead it involves the breakdown of the immune system by a virus that is spread largely through sexual contact, unprotected sex, i.e. lack of condom use, drug use and infected blood.

The HIV virus is difficult to identify or control and there are no vaccines or cures that are readily available or effective treatment for it. Sexual contact is currently regarded as the primary transmission mode for HIV amongst adolescents in the country. According to (Richter and Kruger, 1995), a number of behavioural and social characteristics of adolescents have been linked to high risk behaviour, i.e. onset of sexual activity during teenage years, multiple sexual partners by adulthood, inconsistent use of condoms and the tendency of adolescents to perceive themselves to be both psychologically and physiologically invulnerable. Furthermore, our education and health care systems approach sex education with adolescents in a mystified and conservative manner. Thus they perceive existing health education and counselling services as unconventional, inappropriate and unattractive in meeting their developing needs.

Previous research indicates that on a very superficial level, South African adolescents possess good knowledge about transmission and prevention. The reason for this is the under-resourced health sector, inaccessible health facilities and poor education and preventative measures, that do not empower the youth to make health choices responsibly. They continue to display negative attitudes towards condom use and are continuing to engage in a number of inconsistent and high-risk behaviours. The results of these research studies expose the inadequacies of the present health care system and the intervention programmes for the youth in this country. (Abdul Karim and Preston Whyte, 1992).

2.2 Health Promotion and Health Education

Health promotion is the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realise aspirations, to satisfy needs and to change or cope with the environment.

Health is seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources as well as physical capacities. Thus, health promotion is not just the responsibility of the health sector but goes beyond healthy life styles to well being. This should be undertaken by building healthy public policy, (to ensure safer and healthier public services, cleaner and more enjoyable environments); creating supportive environments, (to ensure that living and working conditions that are safe, stimulating, satisfying and enjoyable); strengthening community action, (to ensure community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health); to develop personal skills (health promotion supports personal and social development through providing information, education for health and life enhancing skills and by doing it increases the option available to people to exercise more control over their own and over their environments and to make choices conducive to health); to reorient health services, i.e. (the responsibility for health promotion is shared among individuals, community groups, health professionals, health service institutions and governments who work towards a health care system that supports the needs of individuals and communities for a healthier life and open channels between the health sector and broader social, political, economic and physical environment components). (Ottawa Charter for Health promotion, 1986).

Health Education is a strategy in the service of health promotion, rather than a separate or contradictory approach. Health education may be defined as being the deliberate structuring of planned learning opportunities about health which are aimed at voluntary change, in health related behaviours to give individuals the opportunity of achieving a more favourable position on the health continuum.

By contrast, health promotion is any combination or health education with related organisational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health in individuals, groups or communities. (Reddy and Tobias, 1994).

2.3 The influence of parents and peers in shaping adolescent sexual behaviour

Street youth are more vulnerable to the virus, as they are more susceptible to rape, survival sex and non use of condoms. In addition, they are cut off from customary sources of information about AIDS

such as school and family. Other factors such as family problems and peer influence could also be precipitating causes of high-risk behaviour in adolescents.

Parents exert a powerful influence on their children's lives. Parents of high achievement youth are likely to set high standards for them. They encourage them to be competitive and are concerned with their performances and set up tasks and standards, even when none are inherent in a situation. Parents of low achievement youngsters are highly directive, make decisions for them and react with annoyance and anger when they do not behave appropriately and successfully. (Gardner, 1978).

Thus inconsistent, dominating and autocratic parenting may lead adolescents to disregard any parental influence in respect of exploration of their sexuality and may rely on peers in shaping their sexual behaviours. (Carson and Butcher, 1998). Alienation and rebellion are common to many teenagers from all socio-economic levels. Alienated teenagers may submit passively to their elder's demands or they may openly disobey parental and other adult authority. In either event, alienation from family and from the broader society, exposes them to becoming captives of their peers to whom they turn to, for guidance and approval, thus undesirable peer relations could lead to peer pressure in influencing the adolescent to engage in high risk behaviour so as to gain recognition and be part of the gang.

2.4 The influence of school in shaping adolescent sexual behaviour

On a national level, we know little about the proportion of schools providing education about sex and AIDS, what teachers teach, methods and materials they use. A Dutch study (1988) provides some insight although it has methodological shortcomings. The survey indicated that some education about sex and AIDS was provided by about 85% of Dutch secondary schools, generally by teachers. Topics such as intercourse and sexual desires seem to receive the lowest attention. With regard to AIDS education, the topics covered were chiefly practical guidelines regarding the prevention of infection such as condom use and ways of infection. The ways in which topics were covered and the teaching methods that were used varied widely among teachers of different speciality areas. Most of the teachers dealt with sex and AIDS education at a classical level, although it is frequently argued that health education should be a well planned process, most of these courses and materials have not been developed systematically. Very few were based on analysis of behavioural determinants, pre-tested and/or evaluated. As a result, little is known about the effectiveness of the various courses and materials on sex-related knowledge, attitudes and behaviour of young people. (Schaalma, 1995).

2.5 A disease of attitudes and beliefs

Other factors that, lead to the high prevalence and causes of STD's, HIV and/or AIDS, are that AIDS is a disease of attitudes and behaviours. In the absence of prospects of a cure or vaccine at present, the only effective route to reducing HIV/STD transmission is through changing sexual behaviour.

Experiences in other countries teach us that the inducements to practice safe sex are a complex and difficult process. Sexual practices are notoriously difficult to change. Whilst knowledge of the disease is important, it appears that there is a poor correlation between knowledge and behaviour change. Judson, (1989) as cited in (Perkel and Strebel, 1991) for example, argued that the majority of new cases of HIV infection may occur in individuals who have adequate knowledge to prevent infection, however other variables intrude that reduce the impact of educational programmes.

For intervention to have a positive effect, it is crucial to understand these variables, i.e. legitimacy of the message in social and political terms, awareness of present attitudes that are prevalent in various sectors of the society, as well as psychological variables that mediate between knowledge and behaviour change, are examples of such variables.

In South Africa, the state has little credibility in the broader community. Piecemeal attempts by the state to intervene, have led to alienation from government campaigns, suspicion and an apparent increase in the denial of the problem within various sectors. Shock tactics have led to the rejection of the message. Suspicion around the use of condom persists. Many blacks still view condoms as a platform by the state to limit the size of black families as a result of the history of apartheid and the socio-political dynamics (Perkel and Strebel, 1991).

According to Reddy, Meyer-Weitz, Van Den Borne, Kok, (1998), who undertook a qualitative study of patients perspectives of the social-cultural context of sexually transmitted infections, indicated the following attitudes of the black community, interviewed at primary health care clinics in Kabokweni and Mpumalanga. Persons with STD's perceived themselves as having "bad" or "dirty" blood caused, as a result of delayed ejaculation and with consecutive intercourse with women who are tense. They believed using condoms or oral/injectable contraceptives caused a recurrence of STD symptoms. Both men and women considered condom use to be "unnatural" and very strongly associated with promiscuity, with women perceiving men to use condoms not as a contraceptive but "for sexual immorality with many partners". Both men and women viewed the use of condoms with fear, believing the female partner could die if the condom remained inside the vagina. Partner referral an important STD strategy was thus seriously compromised as an STD is often viewed as proof that one's partner has other sexual partners as well as a strategy to avoid interpersonal conflict.

Attitudes to sexual practices vary in different sectors of the population and this makes general intervention strategies difficult. Of clinical, though neglected significance, is the necessity to account for these psychological variables that play a role in sexual practices and the resistance to behaviour change.

Social factors and intra-psychic elements that impact on the individual, bring to bear on the social environment, need to be carefully examined. It is only in examining and accounting for this interactive process that intervention may be more sophisticated and effective. (Perkel and Strebel, 1991).

According to Baum and Nisselhof, (1988), the contribution of scientific research is central in the prevention of the HIV virus and STD's. We know what causes AIDS and we know how it spreads, so if we can prevent healthy people from having unprotected sex, the epidemic can be controlled. The single most important message for individuals would be to indulge in safe sex methods, i.e. (Use of condoms) and engaging in a monogamous relationship. Physically there are no clear indications that can identify a person as having the HIV virus nor can one depend on their assurance verbally that they are telling the truth about themselves.

In South Africa there appears to be a relatively small number of HIV risk behaviour change outcome studies, repeated to date. A key issue with respect to HIV primary prevention is how to make risk education socially normative within vulnerable populations and how to produce these normative changes before the prevalence of HIV infection rises to high levels. Given the impracticality and cost of face to face intervention for curbing large numbers of people, research evaluating mass interventions in South Africa is critical. (Kelly, Murphy, Sikkema and Kalichman, 1993).

2.6 Gender Stereotypes

Gendered expectations of girls and boys are translated into adulthood. Women are expected to behave in socially acceptable ways. This makes them "good" women. Women must "look after themselves, be obedient, emotionally controlled and well mannered.". They should not talk about sex. They are under pressure to bear children. Those identified as "good" women are also perceived as "low risk". Male partners of "good women" are less likely to use condoms. Men are allowed to have more than one partner. Women are socialised in a context where they must respect men and everybody must respect their elders. In sexual relationships, men are often older than women, so women have to respect them as both men and elders. When women try to address issues with their men, they are accused of being arrogant and disrespectful. As the saying goes, "there is no democracy at home". So women have difficulty negotiating sexual practices with their partners.

There is a prevailing idea that "real" men financially support women and their households. Part of being a man is to do paid work and to have and support a family. Women's expectations in love tend

to be materialistic, they look for a man with "triple Cs" (car, cash and cellphone). The economic context of the day makes it difficult for men to meet such expectations. Men feel inadequate as they think they cannot entice and provide for their women. They may resort to alcohol, drug use and violence. Men end up lingering in the community, with no income, very reluctant to help at home and more than keen to spend the whole day at the shebeen drinking. They return home drunk, frustrated and angry with everyone. Often they are abusive. Various kinds of rape and sexual abuse, occur. Some boys and men report having participated in what they term "isitimela", where a group of men have sex with a women who is known to all or one of them. This woman can be a girlfriend to one of them (the one who organises "isitimele") and they consider it a way of "sorting out" a women who has been unfaithful or who has slept around. Thus although women aspire, as many do, to getting married and having children they often find it difficult to negotiate safer sex with these kinds of men and to protect themselves against infertility, sexually transmitted diseases and HIV/AIDS (Nduna and Jama, 2000) as cited in (Hamilton, 2001).

2.7 A multi sectoral approach to intervention

It is clear that a collaborative approach needs to be undertaken to increase adolescent's knowledge and empower them to have a clear understanding of the nature of the condition and how infection can be prevented.

With concerted and multi sectoral effort involving medical, public health, social sciences, education and social community service, the goal should be to develop and mobilise services in preventing high risk behaviour and condom use in adolescents, i.e. public awareness and education programmes through the media, and through the introduction of drama groups at schools that stimulate high risk behaviour and its implications, appropriate sexuality education at schools, accessible and community based clinics and counselling centres that are user friendly and ensure confidentiality.

According to (Kelly, Murphy, Sikkema and Kalichman, 1993) the key objective of multi sectoral collaboration is to decrease high-risk behaviour and encourage condom use. This approach of prevention and intervention should be integrated into the routine services of schools, health clinics and community organisations.

According to (Richter and Kruger, 1995), there are two types of information distortion amongst South African Youth. Under inclusive errors involves projecting AIDS to outsiders by stereotyping and scapegoating groups like homosexuals and prostitutes, which reduces the potential of the person to identify himself as being at risk and over inclusive errors which install mundane behaviours, like sharing a glass with a person with AIDS could transmit this infection. Furthermore, reviews of sex education and HIV intervention, have revealed a progression from and emphasis on information

transmission to social communication skills training, to theory based programmes including the models used in health promotion.

Psychological services in South Africa have been harshly criticised because of South Africa's health care problems, i.e. these services are accessible only to the wealthy minority. A few mental health practitioners have gone a long way to meeting the needs of urban based and fairly well resourced people with STD's and HIV. The counsellor training programmes, information centres and other AIDS specific programmes are insufficient to meet the needs of the community, especially in rural communities (Kelly, Murphy, Sikkema and Kalichman, 1993).

Presently 65% of South African teenagers are presently HIV positive, who will develop full blown AIDS in adulthood. There should be policy development, preventative educational campaigns, education and training of lay counsellors, psychological counselling for screening of HIV infected people and setting up research projects into various aspects of AIDS, especially in the education of adolescents in safe sex practices. (Abdul Karim and Preston-Whyte, 1992).

2.8 Models of Intervention

Precede - Proceed Model

According to (Green and Kreuter, 1991), the Precede-Proceed Model focuses on planning any intervention that aims to promote health by changing health related behaviour and living conditions. Health promotion has been defined as any combination of educational and environmental support actions and conditions of living conducive to health.

Combination refers to the necessity of matching multiple determinants of health with multiple intervention or sources of support. Education refers to health education, defined by any combination of learning experiences, designed to facilitate health. Environmental refers to the social, political, economic, organizations policy and regulatory actions, bearing on the behaviour or more directly, health. It refers to dynamic social forces operating on the situation, rather that to the physical environment or medical services. Living conditions enable health promotion to expand beyond behavioural, to incorporate the complexity of culture and norms, as well as socio-economic environment. The model is divided into the following phases:-

Phase One: The Social Diagnosis

This phase focuses on factors that affect quality of life, eg poverty, crime or health related problems. It describes the impact these problems have on a population.

Phase Two: The Epidemiological Diagnosis

This phase focuses on the mortality and morbidity caused by health problems.

Phase Three: The Behavioural and Environmental Diagnosis

This phase focuses on the analysis of the social and physical environment, which is linked to the outcome, i.e. health and quality of life. The behavioural diagnosis is directed towards specific behaviours in a target group. However, health problems also have non-behavioural causes considered in any intervention.

Phase Four: Educational and Organizational Diagnosis

This educational phase studies the determinants of the target behaviour and the organizational phase will study the current health education, organization and practice. The model identifies three categories of determinants that influence individuals or collective behaviour, including organization actions in relation to the environment. These categories are useful as they enable the planner to make the transition between perceptions and real skills that are necessary to perform new behaviour.

Pre-disposing factors - are antecedents that provide rationale or motivation for behaviour

Reinforcing factors-are factors subsequent to behaviour that provide continued reward or incentive for the behaviour to continue to be maintained. Enabling factors - are those antecedents to behaviour that enables a motivation to be realized.

Phase Five

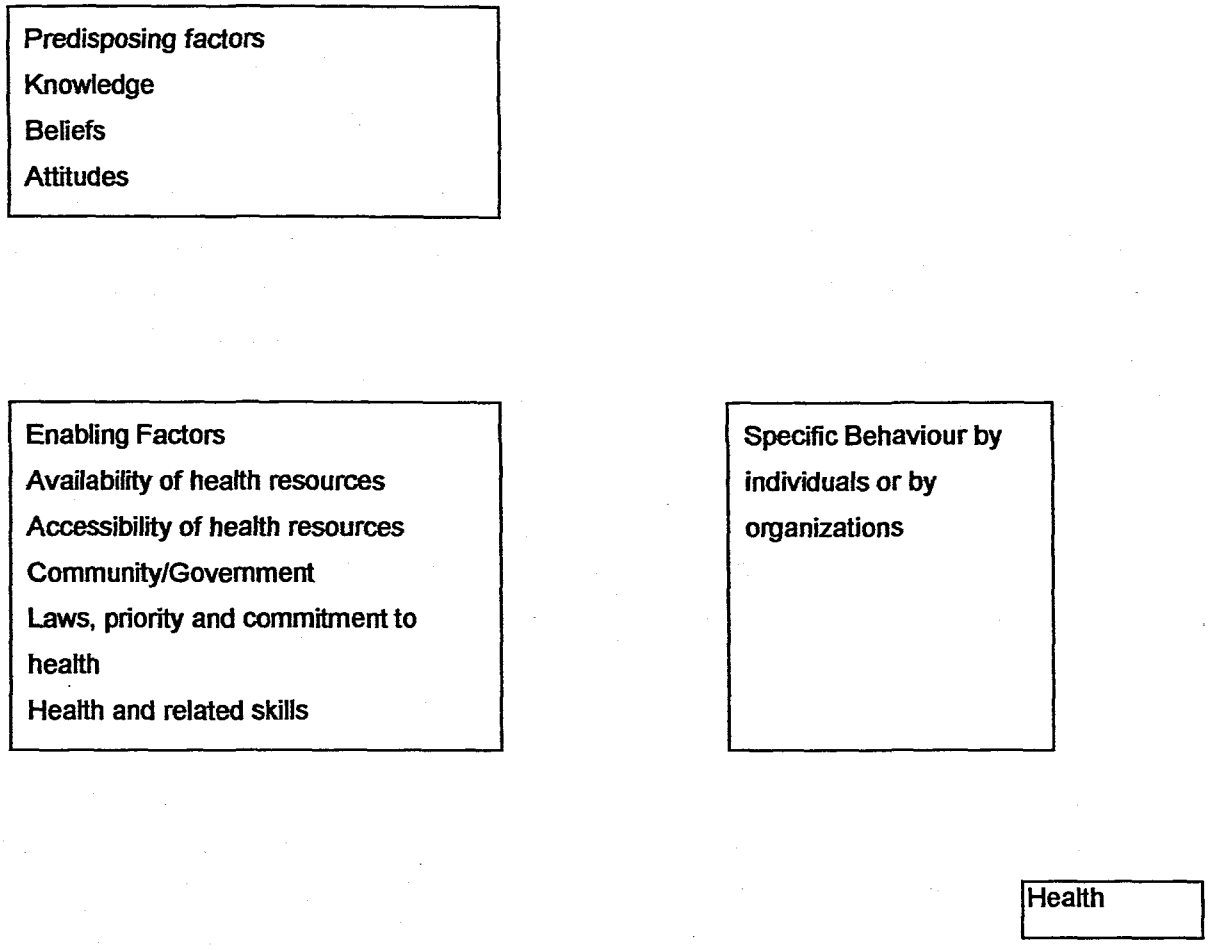
This phase assesses the organizational and administrative capabilities and resources for the development of interventions.

Phase Six, Seven, Eight and Nine

These phases involve the implementation, process, evaluation, impact and outcome evaluation. The evaluation is seen as an integral and continuous part of the entire planning framework.

APPLICATION OF THE MODEL

The following is an example of how a behaviour health action can be explained by using the Precede/Proceed model as a Theoretical guide. (Green and Kreuter, 1991)


Predisposing factors
Knowledge
Beliefs
Attitudes
Enabling Factors
Availability of health resources
Accessibility of health resources
Community/Government
Laws, priority and commitment to health
Health and related skills
Specific Behaviour by individuals or by organizations
Health
Family
Peers
Teachers
Health Providers
Community Leaders
Decision Makers
Reinforcing factors

Health Belief Model

This model focuses on rational decision making as the sole basis for engaging in health promoting behaviour. As (Bandura, 1986) states, effective behavioural control is not solely achieved by will. It requires social and cognitive skills but also a strong belief in one's ability to exercise personal control. According to this view, for health intervention to be effective, it must instill in people the convictions that they have the capacity to alter their behaviour by insisting on the use of condoms and to deal constructively with risk situations to which they are exposed. Intervention must provide instruction and practice in doing so.

The AIDS risk reduction model according to (Coates,1990), was developed specifically for HIV related risk acts, which incorporated all of the above concepts. It encourages motivation to act safely and skills to implement safe acts that must be acquired and practised. This model is based on the premise that to avoid disease, individuals must perceive that their sexual behaviour places them at risk for HIV infection, reach a firm decision to make behavioural changes and to take action. Skills training are needed for behaviour change. Support maybe sought from self-help strategies (pamphlets, reading material and lectures, informal support, family, friends or professional helpers, physicians, mental health professionals and clergy). The increase in funding for research in AIDS needs to be complemented by a structure that co-ordinates work across federal agencies, non-governmental organisations and promotes development of theory based interventions.

Despite the use of the health belief model, some disappointing results have begun to appear in the AIDS literature.

For example, Hingson, Strunin and Berlin, tested the relationship between belief in the H.B.M. and condom use over three years amongst a large sample of 16-19 year olds in Massachusetts. They found that the belief in H.B.M, including perceived susceptibility to HIV infection, perceived severity of HIV and perceived effectiveness of condoms in preventing infection, accounted for 10,5% of condom use.

This led to the authors to conclude that many other factors not specified in the H.B.M. also influence condom use. It becomes clear that to be effective, the approach will have to be extended firstly to street youth, who are able to exercise little control over their sexual partners or the nature of their sexual experiences.

According to (Bandura, 1986), for AIDS prevention programmes to be effective, it must address socio-economic and social cultural realities that impose restraints on the scope of behaviour control amongst individuals in these groups. Interpersonal expectations, social norms and situational survival

pressures, contain the degree to which the threat of the AIDS virus can be salient and the extent to which rational decisions or trained skills can be put into practice.

Secondly, by emphasising cognitive processes, too little emphasis is placed on moral and emotional domains involved in AIDS related issues. As mentioned, current STD campaigns are ineffective as they enhance roles of those elements by inducing high levels of fear and by compounding perception of risk, with immoral behaviour. It is inappropriate when directed to individuals, for whom sexual behaviour is one way of surviving in pressing and personal circumstances.

The Attitude Social Influence Efficacy Model

According to (De Vries and Mudde, 1998), the Attitude Social Influence Efficacy model (A.S.E.), states that behaviour is a function of a person's intention. Intention and behaviour are assumed to be directly determined by three types of proximal cognitive factors, attitudes, social influences and self-efficacy expectations. The A.S.E. model has been used to explain various health behaviours, such as nutrition (Brug, Lechner and De Vries, 1995), exercise (Lechner and De Vries, 1995), alcohol consumption (Oostreen, Knibbe and De Vries, 1996), child safety (Wartel, De Vries and De Gens, 1995), and smoking (De vries and Backbier, 1994, Willemsen and De Vries, 1995, De vries, Mudde, Willemsen, Dykstra and Peters) as cited in (De Vries and Mudde, 1998)

Firstly, the A.S.E. model does not assume that attitudes and social norms should be measured by multiplicative function.

Secondly, the A.S.E. model assesses two indicators for attitude, an effective component operationalised by the evaluative response of an individual towards the behaviour as described by Azjen and Fishbein, (1980) as cited in (De Vries and Mudde, 1998) and a cognitive component determined by both positive (pros) and negative (cons) outcome expectations with respect to a particular behaviour.

This model distinguishes three types of social influences, social norms, perceived behaviours of other and direct pressure or support to perform a particular behaviour, since each of the three constructs have been found to make unique contributions towards explaining behaviour.

Self-efficacy expectations, a construct derived from social learning theory is measured instead of perceived control by measuring the level of difficulty in performing the desired behaviour and/or measuring the confidence a person has in his success in performing this behaviour. (Bandura, 1986).

The A.S.E. model has adapted the notion of the Transtheoretical model indicating that behaviour change should be regarded as a process. (Prochaska, Nocross and Di Clemente, 1994). Therefore

besides measurements of intentions and behaviour, the principle underlying the motivational stages suggested by the Transtheoretical model were integrated into the A.S.E. model.

The impact of the three proximal factors is assumed to be moderated by four types of distal factors, behavioural factors (eg acquisition of skills and previous experience with the same and related behaviours) psychological factors (eg attributes, vicarious learning process), biological factors (eg gender, age, hereditary variables) and social and cultural factors (eg social climate, socio-economic status). It has furthermore been acknowledged that behaviours that have become habitual may have a direct effect on future behaviour as well and may thus prompt the individual to a less elaborate processing of information.

The proximal cognition's of an individual about the behaviour are assumed to be influences by predisposing factors, but can also be changed by an intervention, which may be elaborate but can serve as salient cue to others. (Janz and Becker, 1984).

The effectiveness of a behavioural intervention in motivating an individual to change is considered to be influenced by three types of information factors, and/or message factors (eg level of discrepancy between message and the opinions of the individual); and source viable (eg. reliability and credibility of the source in the eyes of the individual). The theory underlying the A.S.E. model is therefore in line with social cognitive theories and the model could be destined as a model of motivational change, since the assumption of the A.S.E. model is that behaviour change can be realised by motivating individuals to change unhealthy behaviour and to maintain healthy behaviour.

The Transtheoretical Model

The Transtheoretical Model states that the behavioural change process should be considered as a process of five different motivational changes (Prochaska, Nocross and Di Clemente,1994). The T.M. proposes that two interrelated dimensions are needed to assess the behavioural change process. The first dimension is labelled the stages of change. People can move from precontemplation via contemplation and preparation to action and then to maintenance or relapse. The second dimension is called the processes of change, focussing on 10 different styles of coping activities, five of which have a more experiential nature and five, a more behavioural nature. In addition to the stages and processes of change, which are regarded as the independent variables, T.M. also incorporates two sets of dependent variables that mediate stage movement. The first is decisional balance, which measures pros and cons of behaviour change.

Although this concept is not assumed to assess attitude, it does measure the sum of perceived beliefs regarding quitting and thus provides an estimate of the attitudes which is somewhat comparable to that obtained when measuring the sum of beliefs (without multiplying them by evaluations). The

second set assesses self efficacy by measuring a persons situation, dependent and confident in his ability to change and the situational temptations to engage in the problem behaviour. Research suggests that the five experiential processes of change are made important in pre-contemplation, while the behavioural processes are more important in the action and maintenance phases. (Prochaska, Nocross and Di Clemente, 1994).

Earlier Dutch research integrating the A.S.E. model with the stage concepts of T.M. showed that pre-contemplators could be distinguished from contemplators by their less positive perception of the outcomes of quitting, while contemplators could be distinguished from smokers in preparation and actors by their lower levels of self-efficacy. The studies demonstrated that subjects in pre-contemplation had a negative attitude towards quitting and perceived few advantages of the healthy behaviour, whilst those in contemplation were more convinced of the advantages. Moreover, the latter group also reported more social support to engage in the healthy behaviour. Subjects in preparation were more convinced of the advantages of healthy behaviour and reported more support than those in contemplation. However, the greatest difference occurred with regard to self-efficacy. Subjects in preparation reported higher levels of self-efficacy than those in contemplation or in precontemplation.

Early Dutch research integrating the A.S.E. Model with the stage concepts of the T.M. has been applied to smoking cessation. However, with regard to condom using behaviour, there is little research in South Africa employing such behaviour-orientated models. More specifically, little attention has been paid to the determinants of condom use within the context of different relationships, i.e. condom-use behaviour within the context of the steady partner relationship and casual partner (outside partner) relationship. (Reddy, Meyer-Weitz, Borne, Kok, 1998).

These authors recent South African study, among Xhosa speaking men and women STD clinic attendees, has demonstrated that condom use among this group is not consistent and that there are different stages of condom-use behaviour. Their data suggests that enhanced communication between partners can help people move from pre-contemplation to contemplation, to action. They conclude that their theory driven interventions suggest that health education messages will therefore have to be tailored to the individual to accommodate the different social and cognitive needs in the relevant stages.

The model explains the sequence as follows:

A person has an initial reason, impulse or motivation (predisposing factor) to pursue a given course of action, (eg a previous STD and that this infection is transmitted sexually). This factor may be sufficient to start the behaviour but will not be enough to complete it unless the person has resources (eg condoms) or skills (eg the correct usage of condoms) needed to carry out the behaviour. The

motivation is followed by the use of resources to enable the action (enabling factor), (eg necessity of condoms and ability to use a condom).

This usually results in a behaviour, (eg using a condom with a casual partner), followed by a reaction to the behaviour, which is emotional, physical or social (reinforcing factor), (eg. possible sexual experience and support from the partner).

Reinforcement strengthens behaviour, future resources and motivation, (eg a community norm that caring couples have protected sex). The ready availability of enabling factors provides cues for further action and heightens other factors, predisposing the behaviour. From the environmental perspective of health promotion, the building of social reinforcement for a behaviour can lead to the enabling of the behaviour in the form of social support and assistance.

Social Development Model:

According to (Catalano, Kasterman, Hawkins, Newcombe and Abbot, 1996), The Social Development Model is a general theory of human behaviour that seeks to explain antisocial behaviours through developmental processes leading to either prosocial or antisocial outcomes. The model takes a development life course perspective , specifying four submodels for specific periods in childhood and adolescence. It is clear empirically, that multiple biological, psychological and social factors at multiple levels in different social domains (i.e. within the individual and in the family, school, peer group and community, all contribute to some degree to the development of problems as delinquency and drug use. On the other hand, some individuals do not become involved in antisocial behaviour despite exposure to high levels of risk factors. Investigators have thus sought to identify factors that protect these individuals from undesirable outcomes.

This model also incorporates protective factors which are hypothesized to mediate or moderate the effects of risk exposure. To acquire a greater explanation of behaviour, this model is consistent with the tradition of integrated theory, in the field of criminology. Control theory was used to identify casual elements in the causes of antisocial behaviour, as well as the causes of conforming behaviour. Social learning theory was used to identify processes by which patterns of conforming and antisocial behaviour are extinguished or maintained. Differential association theory was used to identify parallel but separate casual paths for prosocial and antisocial processes.

It is hypothesized that children learn patterns of behaviour whether prosocial or antisocial from the socialising agents of family, school, religions and other community institutions and their peers. Children are socialised through four constructs:

perceived opportunities for involvement in activities and interaction with others;

the degree of involvement and interaction; the skills to participate in involvement and interaction the reinforcement they perceive and that they will receive from performance in activities and interactions.

When socialising processes are inconsistent, a social bond develops between the individual and the socialising agent. This bond once established, has the power to affect behaviour thus inhibiting deviant behaviours, i.e. individuals tend not to engage in behaviour that is inconsistent with the standards and norms of those to whom they are bonded, because the bond may be threatened if the behaviour is exposed. Research on prosocial bonds has demonstrated an inhibitory effect on antisocial behaviour.

Hypothesized in the social development model that an individual's behaviour will be prosocial or antisocial, depending upon the norms and values held by those to whom the individual is bonded. This approach departs from control theory which asserts that there is no causal role for bonding to antisocial others, in the causes of delinquency, characterising relationships as cold and brittle. (Hirschi, 1969), as cited in (Catalano, Kasterman, Hawkins, Newcombe and Abbot, 1996)

If attachment and commitment depend on the level of perceived reinforcement, for involvement, then factors that enhance reinforcement should indirectly strengthen the development of attachment and commitment. Certain emotional, cognitive and behavioural skills should increase the probability of experiencing rewards for prosocial involvement and interaction. These skills include the ability to identify, express and manage feelings, control impulses, cope with stress, read and interpret social cues, solve problems and make decisions, understand behavioural norms, perform academic tasks and communicate verbally. (Grant,1992) as cited in (Catalano, Kasterman, Hawkins, Newcombe and Abbot, 1996).

Commitment and attachment to prosocial activities and people affect the development or belief on the moral validity of society's rules of conduct. Once internalised, these standards become part of the individual's value system and help to determine which activities the individual views as morally acceptable.

The social development model incorporates a development perspective. It identifies specific behaviour outcomes indicative of antisocial behaviour during different periods of development, and identifies social agents expected to influence behaviour during these development periods.

The developmental submodels have been specified which include preschool, elementary school, middle school and high school. Transitions from home to elementary school and from self contained classrooms of elementary schools to modular environments of middle school are accompanied by shifts in the balance of influence among socialising agents of family, school and peers. These

submodels have been instructed, as recursive models, i.e. prosocial and antisocial influences from one period, affect the levels of the beginning variables in the next phase. This notion of recurring phases allows the construction of models that account for reciprocal effects, i.e. mutual casual influences among antisocial behaviours and hypothesized causes. (Thornberry, 1996) as cited in (Catalano, Kasterman, Hawkins, Newcombe and Abbot, 1996)

The social development model thus hypothesizes the types of events and social contexts that lead to behavioural continuity or change from previous developmental periods. There is substantial evidence that specific life events and adjustment to changing social contexts during adolescence and adulthood, can modify the course of antisocial behaviour over time (Elliot, 1993: Moffit, Rand, 1987) as cited in (Catalano, Kasterman, Hawkins, Newcombe and Abbot, 1996)

For the purposes of this study, the attitudes, behaviours and sexual practices of middle to late adolescents and their development stages will be examined. According to (Piaget, 1972), cognitive development in adolescents influences their self concept by affecting the manner of their cognitive functioning, i.e. regards adolescents as being capable of thinking in a concrete level. Formal thought implies that adolescents are able to think abstractly, to see relationships between various events and to consider their own thought, which makes them more introspective.

Such new insights may introduce new elements to their self-concept, as the young person is now able to evaluate himself not only in terms of his directly observable characteristics but also in terms of abstract ideals.

According to (Erikson, 1973), adolescence is defined as 12 or 13 to 18 years of age. Identity is usually reached in adolescents and the alternatives open to the young person are on one hand identity formation and on the other hand, role confusion. The person is able to think abstractly and to consider not only what he observes in concrete reality but also consider other possibilities. He is able to ponder about his own thought processes and wonders how and why he thinks certain thoughts. His/her body is rapidly taking on the adult form and sexual feelings are beginning to emerge with the result that he/she needs to redefine his/her gender identity and to recognise himself/herself as a sexual being. In addition, he/she is expected to accept more responsibility as he/she is regarded as being almost adult and must assume more adult roles. These changes make it possible and necessary to question attitudes and beliefs he/she has already adapted through identification with others in childhood and to form a clear picture of his own attributes, values, interests and needs. (Gardner, 1978).

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This study is qualitative in approach and this method of data collection is useful when studying condom use and AIDS prevention. It explores in a confidential and personal way, issues related to the subject's sexuality and the understanding of the position he or she finds themselves in. This study is located within the interpretive/constructive paradigm which perceives knowledge as socially constructed by people active in the research process and that researchers should attempt to understand the "Complex world of lived experience from the point of view of those who live it". (Schwandt, 1994).

Qualitative methods such as in-depth interviews, focus groups, observations and document reviews, are predominant in this paradigm and will be used in this research study. These are applied in the assumption about the social construction of reality in that research can be conducted only through interaction between and among investigator and respondents.

This methodological implication of having multiple realities in that research questions cannot be definitely established before the study begins, rather they will evolve and change as the study progresses. (Mertens, 1992). The data collection will be in the form of focus groups and in-depth interviews. This methodology will allow for research participants themselves to provide answers to open-ended questions that will generate insights towards condom using behaviour.

3.2 Methodological Orientation

Qualitative research can be perceived in different ways. One way is to see it as a current approach researchers and therapists have adopted to study psychotherapy and change. Another way is to see qualitative research as a longstanding method, clinical researchers and researching clinicians have used to describe and explain therapeutic processes and outcomes. From the "newly arrived perspective", qualitative research is understood as a group of methods borrowed from social sciences and humanities over the last three decades to provide naturalistic, discovery orientated, interpretive quantitative informing inquiries. From the latter "since the beginning point of view," qualitative research is synonymous with the case by case, way of knowing" central to most therapists everyday practise and understanding of therapy, clients and themselves. (Maione and Chenail, 1999).

According to Polanyi (1958), qualitative research places emphasis on understanding through looking closely at people's words, actions and records. The traditional or quantitative approach to research looks past these words, actions and records to their mathematical significance. This approach quantifies the result of these observations. A major difference between the two approaches is not the

counting or lack of counting of the occurrences of a particular word or behaviour, but rather the meaning given to the words, behaviours or documents as interpreted through quantitative analyses, as opposed to patterns of meaning which emerge from the data and are often presented in the participants own words.

Maykut and Morehouse (1997) argue that philosophic writing in qualitative research provides the same type of orientation that statistics now provide for the quantitative researcher, though these writings have not yet been organised into subdiscipline like statistics. While the qualitative researcher will not have to confront statistics the task of understanding and presenting qualitative research is as demanding as the task of understanding statistics. They further state that qualitative researchers look to understanding a situation as it is constructed by the participants, they attempt to capture what people say and do, that is, the product of how people interpret the world. The task in qualitative research is to capture the process of interpretation. To do this requires an empathic understanding or the ability to reproduce in one's own mind the feelings , motives, and thoughts behind the actions of others.

Bogden and Taylor (1975), state that words are the way that most people come to understand their situations. We create our world with words. We explain ourselves with words. We defend and hide ourselves with words. The task of the qualitative researcher is to find patterns within those words (and actions) and to present those patterns for others to inspect, while at the same time staying as close to the construction of the world as the participants originally experienced it.

Bruner (1986), argues in "actual minds possible world's, that the examination of people's stories captures the particulars of peoples lives and what they mean. While the positivist paradigm with its mathematical approach seeks to transcend the particular by higher and higher reaching for abstraction and in the end disclaims in principle any explanatory values at all where the particular is concerned. In other words from the qualitative perspective, to present this situation mathematically by using statistics would be to strip the experience of its meaning, that is the meaning as the participants experienced it.

The goal of qualitative research is to discover patterns, which emerge after close observation, careful documentation and thoughtful analysis of the research topic. What can be discovered by qualitative research are not sweeping generalizations but contextual findings. This process of discovery is basic to the philosophic underpinning of the qualitative approach. (Hammersley, 1990).

Again, Polanyi (1958) shapes our understanding of this process. Discovery is understood in the relationship between what he calls the subsidiary and the focal. Polanyi, argues that no knowledge is or can be wholly focal or as we might say totally in focus. When trying to discover something or to uncover a problem, the subsidiary looms large because we do not know in a focal sense what we are

looking for and yet we can look because we rely on clues to its nature. It is through these clues that we somehow anticipate what we have not yet plainly understood.

Further, these clues are held in subsidiary, rather than focal awareness. This searching for pattern to help understand a given person, situation or phenomena is an activity for qualitative research as it is based on the fact that reality is multiple and constructed, events are simultaneously and mutually shaped and the goal of this approach to discovery. Whichever perspective is more true, the fact remains that qualitative research has emerged as an influence in contemporary clinical practice and research.

Mahrer (1988) states that qualitative studies are discovery orientated. They are less concerned with quantification, but instead explore the meanings, variations and perceptual experiences of phenomena. Qualitative researchers establish credibility for their work by constantly comparing what they learnt from previous observations on a site, group of people or phenomena with what they subsequently see in later samples from the site, people and phenomenon. Each observation of the phenomenon presents an opportunity for researchers to justify their best story, description, coding or interpretation of that phenomenon. Also, each visit with the data increases the researcher's confidence that their analysis is the best and most fitting account of what they found in the field.

Qualitative researchers do not rely on statistics to show the confidence they have in their representations of their fieldwork. Instead, they build confidence in their findings or constructions by attempting to saturate themselves with observation of the phenomenon in question. Indeed, the heart and soul of qualitative research is displaying the processed data with its accompanying descriptions or interpretation. The validity of these analyses is in the reading and re-reading of the work. Each observer of the interplay between the researcher's words and the phenomenon on focus makes his or her critique on the fit and coherence of the presentation. From a qualitative perspective, generalizability is a two-fold process. Firstly, researchers must be confident that how they describe a phenomenon is the best generalization they can make, that is, the most fitting among the variety of ways to discuss a given phenomenon. Secondly, the consumers of the research must judge whether the work is generalizable to them and consistent with their perceptual reality. In this way, generalizability is an interactional process, it consists of a conversation between the researcher and the researched, as well as the reader and the text. The qualitative approach to research seems to satisfy the needs for psychological research from a phenomenological perspective.

Patton (1991), states that qualitative research is based on a phenomenological position. The phenomenological approach is a focus on understanding the meaning events have for persons being studied. Although it includes qualitative research it also has under its umbrella such areas in enquiry as ethnomethodology, symbolic interactionism, hermeneutic inquiry, grounded theory, naturalist enquiry and ethnography. The phenomenological position sees the individual and his or her world as

co-constituted. In the truest sense, the person is viewed as having no existence apart from the world and the world as having no existence apart from the person.

According to Giorgi (1986), the operative word in phenomenological research is "describe". This notion emphasises the view that the researcher aims to describe as accurately as possible the phenomenon as it appears rather than indulging in attempts to explain it within a given framework. Kruger (1988), states that the investigator needs to remain as true to the facts as they are happening. The phenomenological approach contends that the imprint of the human element in the research situation should be taken into consideration in order to be rigorous. The researcher should identify the confine to which he or she is present in relation to what he or she is studying by making the position from which he or she advances clear.

Participants or subjects suitable for this type of research must have had experiences relating to the phenomenon that is being researched, they must be fluent and able to articulate their feelings, thoughts and perceptions with regard to the phenomenon in question. They also must have the same vernacular language as the researcher so that subtle semantic nuances will not be lost in translation and finally, they must communicate a willingness to be open to the researcher. Heppner (1992) states that phenomenological research is similar to naturalistic-ethnographic research, but focuses in gaining participants' understandings of their environments, involvements and experiences. Thus, for example, phenomenological researchers in counselling typically collect data by interviewing group members and facilitators to try and make sense of how they experience the group process. He further states that "bracketing" and "horizontalisation" are important in order to minimise researcher bias. Bracketing is the deferment of the researcher's personal prejudices and biases so as not to impose structure in the interview. Horizontalisation involves treating all data as if it were equally important, thus avoiding the tendency to over-emphasise data consistent with the researchers preconceived notions.

This study is structured within the naturalistic ethnographic framework. According to Maykut and Morehouse (1997) famous cultural anthropologist such as Margaret Mead and Ruth Benedict have sought to understand the lives of people in their own terms by spending time with people in their natural settings they inhabit. Anthropologists efforts at describing culture is called ethnography and there are numerous ethnographic accounts of the lives of people in diverse settings, climates and stages of development. It is from these early ethnographers that we have learned about being a participant observer. The participant observer attempts to enter the lives of others, suspending as much as possible his or own ways of viewing the world.

In the broadest sense, the participant observer asks the questions, what is happening here? What is important in the lives of people here? How would they describe their lives and what is the language they would use to do it?. Relying on emergent research design, the participant observer begins with a

broad focus of enquiry and through the ongoing process of observing and participating in the setting, recording what he or she sees and hears and analysing the data, salient aspects of the setting emerge. Using participant observation for qualitative research is for many the method of choice. It is also the method of data collection which draws most heavily upon the various skills of the qualitative researcher. As Patton (1990) notes, participant observation simultaneously combines document analysis, interviewing of respondents and informants, direct participation, observation and introspection.

Maykut and Morehouse (1997) state that **in-depth interviewing** is a conversation with a purpose. In qualitative studies interviews often take place while one is a participant observer, although people in the setting may not realise that the informal conversations they have been engaged in are interviews. In the field it is sometimes possible to arrange interviews with people whom the researcher believes may add to his or her understanding of the phenomenon. Formal arrangements such as this also take place when interviews are the primary means of enquiry about some phenomenon. Participants agree to be interviewed to help the researcher pursue his or her focus of inquiry.

Mishler (1986), highlights the difference between a qualitative research interview and other standard forms of interviewing and proposes a reformulation of the process. He states that at its heart, is the proposition that an interview is a form of discourse. Its particular features reflect the distinctive structure and aims of interviewing, namely, that it is discourse shaped and organised by asking and answering questions. An interview is a joint product of what interviewees and interviewers talk about together and how they talk with each other. The record of an interview that we researchers make and then use in our work of analysis and interpretation is a representation of that talk. What characterises the interviews presented in the research reports is the depth of the conversation which moves beyond surface talk to a rich discussion of thoughts and feelings.

Mishler further states that these interviews average one and a half to two hours in length, following prolonged engagement with the interviewee. This time frame establishes rapport with the interviewee and fosters a climate of trust. The interviewee is interviewed more than once, which allows the researcher to understand their perception at a deeper level.

Three main formats for an interview provide a useful beginning to a discussion on interviewing, the unstructured interview, the interview guide and the interview schedule. Each interview format differs in the level of skill required of the researcher to maintain the conversation around the purpose. Each format, however shares a critical commonality. The questions are open ended and designed to reveal what is important about the phenomenon under study. A detailed open-ended interview schedule with probes to generate in-depth information was utilised with adolescents in the North Coast and Durban Central region of KZN for the purposes of this study.

The reason for these personal interviews was to explore in a sensitive and confidential way, issues related to the subject of sexuality, STD's/HIV, condom use and the position he or she finds him/herself in and can be used as an intervention strategy for health education and to reduce the prevalence of STD/HIV in KwaZulu-Natal. These interviews were conducted in the language of the respondents and tape recorded with the informed consent of the respondents. Females and males were interviewed separately as a result of the sensitive nature of the topic as mentioned above. These interviews took two hours and an interview schedule was used to explore questions in an open and flexible manner.

David Morgan (1988) emphasises the purpose of doing group interviews is to bring several different perspectives into contact. **Group interviews** are utilised to understand that people experience and perceive about the focus of inquiry that is open and emergent. The researcher is able to find out what participants think, feel or know about the researcher's focus of inquiry, explore a topic that is new to him or her and participants have an opportunity to listen to each other's contribution, which may spark new insights or help them develop ideas more clearly. Used alone or in combination with other methods, the aim of **focus groups** is to get closer to participant's understanding of and perspectives on certain issues. The focus group can be used either as a self-contained means of data collection or as a supplement to other methods, depending on how it fits into the overall research plan.

Maykut and Morehouse (1997) state that a group interview is defined as a group conversation with a purpose. The qualitative researcher brings together relatively small group of people, typically six to eight to find out what they think, feel or know about the researcher's focus of inquiry. The most important of the group interview is using the dynamics of group interaction to gain information and insights that are less likely to be gained through individual interviews of participant observation. However, it occupies an important place in qualitative research combining some of the features of individual interviewing and participant observation. In a well conducted group interview, participants have an opportunity to listen to each other's contributions, which may spark new insights or help them develop their ideas more clearly. Information that may be thought of or shared in the individual interview may emerge in the group process. People have an opportunity to think aloud about their private perceptions of issues or events, sometimes coming to new understanding through interaction with others in the group. Researchers are sometimes able to "see" people thinking through these interactions and can gain fresh insight with how people construct their worlds. Some researchers have preferred to use the term focus group to refer to the group interview that emphasises dynamic group interactions.

Morgan (1988), believes, that group interviews are especially useful for investigating what people think and for uncovering why people think as they do which is relevant to understanding risk reduction behaviour amongst adolescents in this study.

In order to understand this focus of inquiry further, it is important to explore the unprecedented emergence of sexual violence against children. It has created a psychological disaster for victims, parents and professionals alike. It is a nightmare of exposure, fear, confusion, helplessness and paralyses. Anyone touched by the reality of child sexual abuse moves into a New World from which there is no deliverance. Old comforts like justice, fairness, decency, self worth, power, autonomy and free will take on a new meaning. To effect any change in the conflicts that surround the subject, the researcher must learn to be both comfortable in dealing and knowledgeable about sexual and psychological abuse of children. (Macfarlane and Waterman, 1989).

Even in the twentieth century, reason and scientific enlightment is a neglected relic and there is considerable confusion that dominates contemporary ideas about sexual violence against children. Traditional psychology continues to focus on positivistic experimental psychology, modeled on natural science or biological studies which has led to over simplification and narrowly focused research on child sexual violence. The tendency in psychology has been to research human functioning in terms of emotional states, cognitive processes, learning and perception. These systems and the individual are commonly separated from the historical contexts of social groups and socio cultural processes, as they are universal and apply to all population groups irrespective of socio-linguistic and cultural conventions. (Levette, 1989).

In relation to HIV prevention, women's autonomy is often crippled. Lacking economic resources of their own and fearful of abandonment or violence on the part of their male partners they have little or no control over how and when they have sex and hence over their risk of becoming infected with HIV. Male predominance often comes with a tolerance for predatory, violent sexuality. Prostitution constitutes another setting in which women have little power to protect themselves from HIV. Young girls are forced or sold into sex work even before puberty, are generally unaware of the AIDS risk and unable to run away or take protective action. Girl children including babies are at much greater risk as men target them for sexual assault in the belief that such children are HIV virus free. (Butegwa, 1993).

South African research has disadvantaged a large number of children in this country as it supports western standards, which have been skewed from examining the developmental consequences of living under disadvantaged circumstances. The study of the child in and as part of the social context is crucial to our understanding of children's function and development. This includes physical elements of the environment such as the sort of house the person inhabits, the conventional social practices, the system of economy, government and other elements which regulate society. (Clegg, 1994).

The classical empiricist strategy which rests on a reductive account of explanation which owes more to survey logic and the spurious desire for prediction, than the scientific attempt of a qualitative nature

that identifies real issues surrounding child sexual abuse, renders their status as scientific findings dubious. Furthermore, it is short circuited in the interests of prevalence of statistics and its most crucial feature is that for purposes of research and theoretical conceptualisation, the child is seen as ontologically separate from its social context. (Dawes and Donald, 1994).

Thus, advantages of utilising focus groups in this research study are, according to Breakwell and Hammond (1995):-

- It is socially orientated, it places people in natural, real life social situations rather than imposing impersonal controlled quantitative conditions.

- It allows the researcher to probe the high content validity and is easily understood.

- The results are accessible and believable, it is cost effective and can provide quick results to inform interventions.

Further advantages of utilising focus groups in this research study are, according to Krueger 1993:

- Insights are needed in explanatory or preliminary studies. This could occur at the beginning of a larger scale research effort or when the study has limited resources. The goal might be to gain reactions to areas needing improvement or general guidelines on how an intervention might operate.

- There is a communication or understanding gap between groups or categories of people. This gap has a tendency to occur between groups who have power and others who do not. Professional groups (medical, educational, scientific, technical, legal) are facing a crisis due to communication gaps caused by language and logic. Professionals have developed unique ways of thinking that are substantially different from the very people they are trying to teach.

- The purpose is to uncover factors relating to complex behaviour or motivation. Focus groups can provide insight into complicated topics where opinions or attitudes are conditional or where the area of concern relates to multifaceted behaviour or motivation.

- The researcher desires ideas to emerge from the group. Focus groups possess the capacity to become more than the sum of their participants, to exhibit a synergy that individuals alone cannot achieve.

- The researcher needs additional information to prepare for a large scale study. Focus groups have provided researchers with valuable insights into conducting complicated and often quantifiable investigations.

- The clients or intended audience place high value on capturing open ended comments of the targets audience.

- Human behaviour should be studied as an act of communication. Within this it is essential to understand the relationship between the behaviour and context, as the context is understood by the subjects.

3.3 Defining the Context

There is an increasing need in society to understand social and economic factors, cultural factors and political factors to develop effective prevention programmes, in relation to risk reduction behaviour, amongst South African, youth and adults. There has been very little research about any of these issues, especially in the context of behaviour change intervention trials.

In relation to social and economic factors, for many people in South Africa health services are inaccessible or unavailable and many of the messages irrelevant or inapplicable. Access to health care, family planning services, education and employment is especially difficult for women. More girls than boys have dropped out of school, as the cost of education soars. Maternal mortality is steadily rising as health and medical services become out of reach for women, already disadvantaged by the socio-economic system.

Tradition and culture continue to be manipulated and used by society to deny women the enjoyment of fundamental human rights. In almost all countries of the sub region, discrimination in law and practice in marriage, divorce and inheritance are rampant, as these areas are still governed by so called customary law. The concern was that only aspects of custom in these areas, perpetuating the subordination of women have been retained. Some traditional practices and rituals in certain societies may increase womens vulnerability to HIV infection. These include genital circumcision and customs such as ritual intercourse with a male relative in the event of the death of the husband. Women are seen as minors and women can be forced to marry against their will as long as their father or other male guardian consent to the marriage. Women are often younger than their male partners who have been sexually active for a longer period and who are more likely to have been infected themselves and to transmit this to their partners. As descion-making and power in such society lies with men, women are often not in a position to resist or change cultural and traditional practices (Pauw and Brener, 1997).

In relation to political factors, the apartheid legacy, migrant labour, gross deficiencies in education opportunities, medical services, widespread poverty, civil conflict and political violence has exacerbated the spread of HIV infection. The high rates of sexually transmitted diseases, a high rate of teenage pregnancy, widespread mistrust of family planning services adds to the formidable list of problems facing HIV/AIDS control programme in South Africa. It was unlikely that the National Party (NP) government could establish an effective AIDS awareness campaign because it lacked credibility with the majority of the population. The ANC government committed itself to effective AIDS prevention. Unfortunately despite their intentions, the Department of Health is a source of controversy and the overall message in many educational programmes is still that condom promotion encourages promiscuity. (Macphail, 1998).

Psychological intervention alone cannot take the lead in advancing HIV prevention intervention and research objectives. Interdisciplinary collaboration with community organizations including consultation with local chiefs and traditional healers public health and social scientists should rapidly integrate successful evaluated interventions into the routine service of schools, health clinics, neighbourhood organizations and community programmes. Although psychology has long been called upon to improve the quality of human life, the HIV epidemic challenges us to quickly develop better approaches that are culturally, socially and economially relevant that can save lives. An important criterion of intervention utility in the real world, is understanding the reasons interventions work and the behaviour change mechanisms responsible for their effects should lead to more focused and efficient interventions (Kelly, Murphy, Sikkema and Kalichman, 1993).

3.4 Design and Data Collection

3.4.1 Sample Selection

12 Respondents comprising of two groups from a low to middle socio-economic status of adolescents, both males and females between the ages of 15-18 years, from the North Coast and Durban region sufficed for this study.

The results were analysed through the use of Thematic Content Analysis as outlined in Qualitative Research. The data was coded into phenomena and then into concepts and broader categories. The process of careful listening and then reflecting statements back at the respondents during the interviews was to ensure validity of the information. During the analysis, the process of reconsideration and rechecking themes was used to ensure further validity. The interviews and discussions were recorded and subjected to rechecks during the transcribing process.

3.4.2 Focus Groups

Focus groups with two groups of adolescents male and females focused their understanding, attitude, knowledge and beliefs in respect of sexually transmitted diseased, Acquired-Immuno-deficiency syndrome and the practice of condom use. Discussions took place for two hours and these discussions were tape recorded with the consent of the group.

Research Instrument 1:

The questions that appear here are based on the categories of determinants that influence individual or collective behaviour, including organisational actions in relation to the environment actions as laid out in the Precede/Proceed model. Each of these categories is believed to have a different type of influence on the behaviour.

These categories are useful as they enable the researcher to make the transition between perceptions and real skills that are necessary to perform the new behaviour.

Predisposing Factors - are the antecedent to behaviour that provide the rationale or motivation for the behaviour. It focuses on knowledge, attitudes and beliefs of adolescents towards STD's/AIDS and condom use.

LAY KNOWLEDGE

Themes:

The meaning of STD's/AIDS
Explanation of cause and symptoms
Ideas of how it spreads
Ideas of how it could be prevented
Knowledge of condom use

Questions:

What do you think is the meaning of STD's/AIDS?
What do you think causes this disease?
How do you think this disease spreads?
Any ideas of how it can be treated?
What do you think can be done about this disease?
Are you aware of any place where you can acquire condoms?
Do you think condoms are safe and are you aware of how to use one?

ATTITUDES

THEMES

Nature of sexual interactions and conditions under which it takes place (eg pleasure, experience, and social status)

Moral judgements, i.e. religious influences, (eg AIDS is a punishment)

Fear based prejudices - AIDS/STD's, persons should be avoided at all times?

Rights of AIDS sufferers - informed consent should be essential before testing.

QUESTIONS

Are you afraid of contracting STD's/HIV?

What is your relationship with the person/s you have sex with like?

Is it important to use a condom during sexual activities and why?

Does your religion influence you to have sex only after marriage? Would you adhere to this?

Would you socialise with a person who has STD's/AIDS

Do you think it is important to get permission from a person before testing for HIV/AIDS and why?

BELIEFS

Misconceptions: I cannot get AIDS/STD's because I am Indian, Black, young.
I cannot get AIDS/STD's if I sleep with someone once.
If I leave AIDS/STD's untreated, it will disappear on its own
Effectiveness of condoms

QUESTIONS

1. Do you think you can contact AIDS/STD's?
   Is it possible to contact AIDS after one sexual contact?
   Is it important to use a condom?
   How are condoms viewed by men and women?
   Is it safe to use a condom?
   What are some of the difficulties you may find in using a condom?

Enabling Factors - are those antecedents to behaviour that enable a motivation to be realised. It focuses on skills, policy and health resources.

THEMES

1. Satisfaction with communication at local health and preference for type of communication
   Resources
   Trust
   Fears/Power/Style
   Reasons for possible delay
   Stigmas associated with seeking help at the clinic
   Health campaigns and their effectiveness

QUESTIONS

If you had STD/AIDS where would you seek treatment?

What do you think of the treatment you would get at the local clinic/hospital in your area?

Would you trust people that work there?

What would you like to see different about this clinic?

Do you think they would ensure you of confidentiality of your condition?

What do you think the government should do to reduce AIDS or STD's in this country?

Do you think the present health campaigns are effective (Pamphlets, media, television and radio coverage of these conditions).

Reinforcing factors - are those factors subsequent to behaviour that provide continued reward or incentive for the behaviour and contribute to its maintenance or repetition. It focuses on peer group support, parents, teachers, employers, decision-makers and community leaders.

THEMES

1. Openness of communication with peers, parents and teachers, including own participation
   Trust
   Fear/Power
   Social meanings/social influences
   Barriers

QUESTIONS

1. Who would you trust most with information about your sexual behaviour?
   Who was the first person to talk to you about sex?
   What do your friends think about AIDS/STD's?
   What do your friends think about condom use?
   Would you approach your parents and teachers about sexuality education?
   Would your friends encourage you to engage in high-risk behaviour?

Transcript of In-depth Interviews

In-depth interviews was undertaken with 12 respondents i.e. (Six males and six females at schools in the North Coast and Durban Metropolitan regions.

RESEARCH INSTRUMENT II

Discussion guide for the in-depth interviews was as following:

THEME: Knowledge, attitude and beliefs

What is your understanding of STD's/HIV?
How do you think it is caused?
When should you use a condom and do you think it is necessary?
What do you know about condom use, is it safe?. Do you know how to use one and when to use one?

THEME: Enabling Factors

Who is the most effective person/community resource where you can receive information about AIDS/STD's.

Do you think government is doing enough to educate young people about AIDS/STD's

How is the media i.e. television, radio and posters effective in educating young people in practising safe sex behaviour?

C. THEME: Reinforcing Factors

3. Who influences you most about your sexuality and how?
4. What is your relationship with your parents and can you talk to them about sex?
5. What is your relationship with your teachers and can you talk to them about sex?
6. How are condoms viewed by your friends and other important persons in your life

CHAPTER 4 - DATA ANALYSIS

This chapter focuses on presentation of the data collected from research participants. To gain an understanding of knowledge, attitudes and beliefs of adolescents in respect of STD's and HIV/AIDS and the determinants of condom use, a qualitative study was undertaken. This phase of the study is located within the interpretive/ constructivist paradigm which conceptualizes knowledge as socially constructed by people active in the research process. The objective is an attempt to understand the "complex world of lived experience from the point of view of those who live it" (Schwandt, 1994).

The data collection techniques were in the form of focus groups and in-depth interviews. This methodology allowed for research participants to provide answers to open-ended questions that generated insights into the subject. From a social-psychological perspective, the focus group is "by definition an exercise in group dynamics and the conduct of the group, as well as the interpretation of results obtained must be understood within the context of group interaction". Two interrelated forms of evidence are therefore derived from focus groups, the group process, (the way in which people interact and communicate with each other) and the content around which the group process is organized (the focal stimulus and the issues arising from it). The group process can be understood on two different levels first, interpersonal, that is, thoughts , feelings, attitudes and values of the individual and second, intragroup, that is, how people communicate and interact with each other within the group. Consideration of the group process are integral to the role of the researcher who requires very different skills to those of one to one interviewing.

Focus groups thus afford rich insights into the realities defined in a group context and in particular the dynamic effects of interaction on expressed beliefs, attitudes, opinions and feelings. One advantage of using the group as opposed to the individual medium of investigation is its emphasis on the process of opinion formation and propagation in everyday life insofar as "opinions about a variety of issues are generally determined, not by individual information gathering and deliberation but through communication with others". Focus groups are thus communication events in which the interplay of the persons and the social can be systematically explored. (Breakwell and Hamond, 1995). While the study of group processes has a rich and substantial research history the focus group challenges the epistemological assumptions underlying much research in psychology today. Thus I hope to demonstrate in this chapter that focus groups not only enhance the ability of psychologists to answer research questions but that more importantly they can generate questions from new angles and perspectives.

Following the approach as originally outlined by Mertens (1992) adolescent experiences were coded into phenomena and then into concepts and broader categories and documented in the form of emerging themes. Focus was on emerging themes as these reflected the authentic experiences of the research participants.

4.1 Qualitative Data Analysis

4.1.1 Adolescent Vignettes

The task of the adolescents was to discuss their knowledge, attitude and beliefs in respect of STDS, HIV/AIDS and the practice of condom use. The results were then interpreted and analyzed.

Predisposing factors. It focuses on knowledge, attitudes and beliefs of adolescents towards STD's/AIDS and the practice of condom use.

Vignettes of female participants

Aids is spread when .... eh a person with aids gives blood to someone else.

Ma'am you need to abstain completely from sex to prevent getting AIDS or STD's.

Both HIV and AIDS are very alike and along with STD's they are transmitted from one body to another by sex. Some STD, viruses are curable and some aren't. Both HIV and AIDS is incurable. At the moment, it is a slow version of the death penalty.

It is very easy to get HIV/AIDS ... sexual intercourse, sharing needles, being exposed to wounds on both sides without protection ... condoms.

Ma'am ... you must be faithful to one partner.

Every time you have sex without the use of a condom. I think ... it is necessary because it is 99% safe and prevents pregnancy and HIV..

Mainly AIDS is spread through sexual intercourse.

Sometimes you can be faithful to one partner but your partner isn't faithful to you, you must use a condom or abstain from sex.

By having sex without the use of condoms, mother to child transmission, blood, mixing of cuts, drugs, sharing of needles.

HIV ... Human Immune Virus is a disease that is transmitted in our blood, the disease is caused by different ways. Having unprotected sex, using a needle, an HIV person has used on their body.

Ma'am you can get condoms from a chemist or disco.

If two people want to have sex they both should go for an HIV test first to find out whether they have AIDS.

Ma'am I will wait to have sex after marriage ... if I enter a relationship it will only go as far as kissing.

You also need to be responsible and you know that your partner is also responsible and in that ... eh. The proper age where you can be involved in sex with each other.

The best time to use condoms obviously is just before sexual intercourse, it is very important to use it from the start and not halfway through the excitement otherwise its too late and best after marriage. Have children after marriage.

You should use a condom during intercourse. I think it is necessary because it prevents you from falling pregnant and also prevents you from getting the disease but it is not 100% sure.

Ma'am my religion is very strict. If you join a church then they don't allow you to have sex before marriage.

Religion plays a big role because I am Muslim and in my culture they say that you are not allowed to go and have sex with anyone so this saves you a lot of sexually transmitted diseases.

If someone has AIDS, I will still be the same, I won't change I will talk to them more about the condition and try and support that person.

Ma'am I would be careful .. But I won't change ... just careful.

I will give her advise ... and ask her how I can support her if she has AIDS.

It shouldn't eh ... it doesn't mean she got AIDS it shouldn't mean we can't have a relationship.
I think... if a person has AIDS it should be confidential because no one will want to be their friends and they won't want everybody to know what they are going through ... they just want to be treated the same.

People don't want to communicate with you ma'am ... if you have AIDS, they have a right to keep it confidential.

I must say people are very critical. It should not be left to us to make their decision. If they want to keep it confidential they have a right to do so because if they love you enough or care about you enough they will tell you they have AIDS. I will ask my boyfriend ... if in a relationship to always use condoms ... but Ma'am only if I am in a committed relationship.

Sex should be after marriage and .. Eh .. Now there are teenagers they want to be more experienced eh but condoms are not 100% and eh they should be more careful about it.

If my boyfriend had to ask me to have sex I will tell him to use a condom and wait for it after marriage.

At this stage we shouldn't be thinking about that at this moment we should worry about our career and goals in life and what we are going to become.

Ma'am I will wait for sex after marriage, eh ... I don't want to have children now, there'll be no one to care for them.

If a girl sleeps with a boy, the boys would think he did a great thing and the boys would think maybe she is a slut or cheap.

If you sleep with many boys, boys call you names and say that I know you sleep with everyone ...

Ma'am ... the boys think you are cheap and easy if you have sex with them.

EMERGING THEMES OF FEMALE PARTICIPANTS

Knowledge, attitudes and beliefs

Both HIV and AIDS are very alike and along with STD's they are transmitted from one body to another by sex. Some STD viruses are curable and some aren't. Both HIV and AIDS is incurable..... at this moment, it is a very slow version of the death penalty. It is very easy to get HIV/AIDS.... sexual intercourse, sharing needles, being exposed to wounds on both sides, without protection ... condoms.

Every time you have sex use a condom. I think it is necessary because it is 99% safe and prevents pregnancy and HIV.

By having sex without the use of condoms mother to child transmission, blood mixing of cuts, drugs, sharing of needles.

HIV ... Human Immune Virus is a disease that is transmitted in our blood, the disease is caused by different ways . Having unprotected sex, using a needle a HIV person has used on their body.

Mainly AIDS is spread through sexual intercourse.

Sometimes you can be faithful to one partner but your partner isn't faithful to you, you must use a condom or abstain from sex.

If two people want to have sex they both should go for an HIV test first to find out whether they have AIDS.

The best time to use condoms obviously is just before sexual intercourse, it is very important to use if from the start and not halfway through the excitement. Otherwise its too late and best after marriage. Have children after marriage.

You should use a condom during intercourse. I think it is necessary because it prevents you from falling pregnant and also prevents you from getting the disease but it is not 100% sure.

You need to be responsible and you know that your partner is also responsible and in that ... eh.. The proper age where you can be involved in sex with each other.

Religion plays a big role because I am Muslim and in my culture they say that you are not allowed to go and have sex with anyone so this saves you a lot of sexually transmitted diseases.

If you join a church then they do not allow you to have sex before marriage.

If someone has AIDS, I will still be the same, I won't change. I will talk to them more about their condition and try and support that person.

It shouldn't eh ... it doesn't mean she got AIDS, it shouldn't mean we can't have a relationship.

I think if a person has AIDS it should be confidential because no one will want to be their friends and they won't want everybody to know what they are going through .... they just want to be treated the same.

I must say people are very critical. It should not be left to us to make their decision. If they want to keep it confidential they have a right to do so because if they love you enough or care about you enough they will tell you if they have AIDS.

Sex should be after marriage and .. Eh.... now there are teenagers they want to be more experienced eh ... but condoms are not 100% and eh they should be more careful about it.

At this stage we shouldn't be thinking about that at this moment. We should worry about our career and our goals in life and what we are going to become.

If my boyfriend had to ask me to have sex I will tell him to use a condom and wait for it after marriage.

If a girl sleeps with a boy, the boys would think he did a great thing and the boys would think that maybe she is a slut or cheap.

If you sleep with many boys, boys call you names and say that I know you sleep with everyone ....

Vignettes of male participants

These are bad diseases that affects your immune system and these diseases will turn into AIDS and kill you. AIDS is caused by unprotected sex, drug users sharing of needles, mother to baby transmission, when an AIDS victims blood is mixed into a person without AIDS.

Ma'am AIDS is spread through mother to baby but mainly through sexual intercourse.

Ma'am, it can be spread if a person has a cut in their mouth and he kisses someone else.

These diseases are mainly transmitted by sexual intercourse but they can be passed on by mother to their unborn children when she is breast feeding her infant. HIV can also be passed on you by blood transfusion, sharing blades and needles. It cannot be transmitted by kissing unless the person has an open wound in their mouth.
Ma'am we are informed about HIV and all those things but we don't really believe the STD's people. They haven't told us what it is.

Ma'am HIV/AIDS can be fatal ... I am afraid to die early.

The disease can be passed from one person to another by blood to blood, mother to baby transmission, needles, unprotected sex and sometimes can be caused by kissing a person who has an open cut on the mouth.

People don't want to join you, there is a stigma if you tell people you have AIDS.

Ma'am I will have sex with a person depending on her attitude .. If she wants it too.

When you have sex you should use a condom. I think it is absolutely necessary to use a condom when having sex, it can prevent pregnancy or from getting AIDS.

Condoms are safe but only to a certain extent because people have fallen pregnant using condoms and the AIDS virus is even smaller than sperm cells so no one is completely safe.

Ma'am most of the boys will talk about it and most of them are cowards. They don't need any sexual activities themselves but they ... ask other people to do it just for fun.

Ma'am they expect you to take a risk but they won't ...

Sometimes, I'm, we take it to another level we kiss ma'am but we don't go to sexual intercourse. But Ma'am there are peer pressures ma'am where people, ma'am are pressurizing us into having sex and if maybe we get a girlfriend, ma'am we don't have sex ma'am they think you are stupid.

Religion is not important to me when it comes to sex. If you love someone it doesn't matter what religion they are.

Religion is not an important part of my sex life ... I go clubbing regularly, I drink and I have experimented with drugs so... how can it prevent me from having sex.

But ma'am sometimes in the family when you want to be in love with someone who is a Muslim but your family wants you to be in love with a person of the same religion.

Ma'am you tell people that you have AIDS, ma'am there are people who would not employ you because you have AIDS.

I think people have the right to privacy.

Ma'am people who have AIDS should have rights they are just like you and me ...

I think if my best friend told me that he got AIDS, I wouldn't change my attitude to him but I would change my attitude to life. So if he had AIDS ... I would much rather stay without sex.

Ma'am I won't change my attitude towards that person, you know, say we boys like to play rough games that's why I will be careful in the way when I play with that person because if he gets hurt and bleeds I need to be careful.

Ma'am if you tell people you have AIDS eh there is a stigma attached to you people won't employ you and you cant go to school they won't treat you the same ... with respect.

If you want to register in school and then they find you are HIV positive they will not allow you to come to school in case HIV spreads in the school.

My friends and I joke about sex but we rarely talk about using condoms.

Yes Ma'am sometimes we may get to the clubs and we didn't take any condoms and the girl wants to make out and at the same time you don't want to lose the opportunity of having sex.

No ma'am I won't always use a condom unless I go for a blood test....

Ma'am, I'll use a condom, I don't want to get AIDS ... from anybody, say what happens if the girl falls pregnant at a young age.

Sometimes ma'am when you use a condom that person will think in the circumstances that you don't trust her or maybe she thinks you've got AIDS.

Ma'am sometimes ... when you use a condom she will think that eh maybe you have AIDS and that's why you want protection.

Say if a girl sleeps with a boy we will think you are cheap yet if a boy sleeps with a girl his friends or other boys will think more high of him.

Ma'am if you can go around the world it is the same thing, if a girl sleeps with a boy she is cheap if a boy sleeps with a girl he is seen as someone great.

EMERGING THEMES OF MALE PARTICIPANTS

Knowledge, attitudes and beliefs

These diseases are mainly transmitted by sexual intercourse but they can be passed on by mother to her unborn children when she is breast-feeding her infant. HIV can also be passed on by blood transfusion, sharing blades and needles. It cannot be transmitted by kissing unless the person has an open wound in their mouth.

These are bad diseases that affect your immune system and these diseases will turn into aids and kill you. AIDS is caused by unprotected sex, drug users sharing of needles, mother to baby transmission, when an AIDS victim blood is mixed into a person without AIDS.

The disease can be passed from one person to another by blood to blood, mother to baby transmission, needles, unprotected sex and sometimes can be caused by kissing a person who has an open cut on the mouth.

Ma'am we are informed about HIV and all those things but we don't really believe the STDS people. They haven't told us what it is.

People don't want to join you, there is a stigma if you tell people you have AIDS.

When you have sex you should use a condom. I think it is absolutely necessary to use a condom when having sex, it can prevent pregnancy or from getting AIDS.

Condoms are safe but only to a certain extent because people have fallen pregnant using condoms and the AIDS virus is even smaller than sperm cells so no one is completely safe.

Sometimes, I'm... we take it to another level, we kiss Ma'am but we don't go to sexual intercourse. But ma'am there are peer pressures ma'am where people ma'am are pressurizing us into having sex, and if maybe we get a girlfriend, ma'am we don't have sex ma'am then they think you are stupid.

Ma'am most of the boys will talk about it and most of them are cowards. They don't need any sexual activities themselves but they ... ask other people to do it just for fun.

Another significant aspect that provides interesting information is the impact of religion on sexual behaviour.

Religion is not important to me when it comes to sex. If you love someone it doesn't matter what religion they are.

But ma'am sometimes in the family you want to be in love with someone who is a Muslim but your family wants you to be in love with a person of the same religion.

I think if my best friend told me that he got AIDS, I wouldn't change my attitude to him but I would change my attitude to life. So if he had AIDS... I would much rather stay without sex.

Ma'am I won't change my attitude towards that person, you know, say we boys like to play rough games that's why I will be careful in the way when I play with that person because if he gets hurt and bleeds I need to be careful.

I think people have the right to privacy.

Ma'am you tell people that you have AIDS, Ma'am there are people who would not employ you because you have AIDS.

If you want to register in school and then they find you are HIV positive they will not allow you to come to school in case HIV spreads in the school.

Yes, Ma'am sometimes we may get to the club and we didn't take any condoms and the girl wants to make out and at the same time you don't want to lose the opportunity of having sex.

No ma'am I won't always use a condom unless I go for a blood test ...

Sometimes Ma'am when you use a condom that person will think in the circumstances that you don't trust her or maybe she thinks you've got AIDS.

Say if a girl sleeps with a boy we will think you are cheap yet if a boy sleeps with a girl, his friends or other boys will think more high of him...

Ma'am if you can go around the world it is the same thing, if a girl sleeps with a boy she is cheap if a boy sleeps with a girl he is seen as someone great.

OVERALL VIEWS OF BOTH MALE AND FEMALE PARTICIPANTS IN RESPECT OF PREDISPOSING FACTORS - KNOWLEDGE, ATTITUDE AND BELIEFS TOWARDS HIV/AIDS, STDS AND CONDOM USE

- Adolescents displayed good knowledge on how HIV/AIDS is transmitted and on how to prevent HIV and other STDS. However, this information was presented in a biological manner and rather remote from their own sexual experiences.

- Young people's beliefs and perceptions towards using condoms, consistently were negatively related to their experience with sexual intercourse. Male participants especially emphasized that if a sexual opportunity arose they would indulge in unsafe sex practices or nonuse of condoms. Female participants emphasized the need to engage in safe sex behavior or carry condoms more for moral reasons and to prevent unwanted pregnancies rather than to prevent

HIV/AIDS and STDs.

- Both male and female participants agreed that HIV is stigmatized by the general community, the education system and the workplace. They would not display a discriminatory attitude towards a person with HIV/AIDS and that every individual who has contracted the virus has a right to confidentiality.

- Religion; female participants emphasized the importance of religious values and beliefs and its impact on their sexuality. Sex was viewed as taboo prior to marriage. Male participants showed little evidence that religious values and beliefs influence abstinence.

- Social expectations and gender norms influenced adolescent sexual behavior. Female participants agreed that women are expected to behave in socially acceptable ways. They are unable to speak freely about sex and if they are involved in several relationships with the opposite sex, they are seen as sluts, cheap and easy targets to obtain sexual favours. Male participants agreed that men are allowed to have more than one partner and are expected to have sex. They feel that they have undisputed power over girls and sexual interactions and are highly regarded by peers, if they sleep with a girl. Another important aspect was that of fidelity which was emphasized by black male participants. They believed that if a girl asked a boy to use a condom, it meant that she did not trust him or that she has been unfaithful and promiscuous. Male participants also viewed it as a universal belief that if a man sleeps with a woman prior to marriage his status is elevated in society. However if a woman indulges in a similar sexual behavior she is seen as "cheap".

ENABLING FACTORS. IT FOCUSES ON SKILLS, POLICY AND HEALTH RESOURCES

Vignettes of Female Participants

Ma'am posters are uninteresting and dull and they don't appeal to us.

I don't think the government is doing enough .. Not really. I know that they are trying hard but what about the people in rural areas, they don't have newspaper access everyday and don't have television sets and sure they warn us a lot on TV but I know that not many people are taking it seriously. They should show us shots of one minute of a break during adverts about HIV/AIDS/STD's. Good looking people are telling us to be careful of these viruses and we must use condoms. But in real life people that have the AIDS virus and are about to die are very unhealthy looking, they already look half dead and that will scare people and make them aware if an actual AIDS/HIV victim speaks to them and how much he has to go through and warn them not to follow his mistakes. Its reality that's more effective.

The media effectiveness in educating, practicing safe sex behaviour, I believe is not what I would do cos, telling them to use condoms is more like encouraging them to have sexual intercourse, meanwhile they are forgetting that its not 100% safe, its better to abstain, what happens if it breaks. He is going to regret it and wish he saved himself till marriage.

There is no community resource that I know of. A family doctor is not someone I would talk to about sex.

The media is teaching young children how to have sex because there are movies doing the same things and that's how they are getting HIV/AIDS.

Yes, nurses, teachers and my parents talk about it but most of the youth ignore facts about AIDS.

The government should organise more drama on AIDS and the government should ... talk to teachers to talk to us more about sex.

The nurses at the clinic chase you they say you are too small and you must go away from there, especially if you are wearing a school uniform.

At the clinic there should be more doctors and nurses who are keen to talk to teenagers about safe sex.

An ad. that interests me .... ma'am is girl and boy in classroom ... passes a letter to meet her in the toilet but she refuses.

Ma'am film stars from Hollywood... Bollywood should be used to promote safe sex .. It will be effective people will follow them.

Ma'am at the clinic... I can't demand to speak to someone about something confidential.

I don't know... anyone or anywhere I could get information about sex. But I would like to know someone who will help me.

EMERGING THEMES OF FEMALE PARTICIPANTS

Enabling factors

I don't think the government is doing enough .... not really. I know that they are trying hard but what about the people in rural areas, they don't have newspaper access everyday and don't have television

sets and sure they warn us a lot on TV but I know that not many people are taking it seriously. They should show us shots of one minute of a break during adverts about HIV/AIDS/STD's. Good looking people are telling us to be careful of these viruses and we must use condoms. But in real life people that have the AIDS virus and are about to die are very unhealthy looking, they already look half dead and that will scare people and make them aware if an actual AIDS/HIV victim speaks to them and how much he has to go through and warn them not to follow his mistakes. Its reality that's more effective.

The media's effectiveness in educating, practising safe sex behaviour, I believe is not what I would do cos, telling them to use condoms is more like encouraging them to have sexual intercourse, meanwhile they are forgetting that its not 100% safe, its better to abstain what happens if it breaks. He is going to regret it and wish he saved himself till marriage.

The media is teaching young children how to have sex because there are movies doing the same things and that's how they are getting HIV/AIDS.

Yes nurses, teachers and my parents talk about it but most of the youth ignore facts about AIDS.

The nurses at the clinic chase you they say you are too small and you must go away from there, especially if you are wearing a school uniform.

At the clinic there should be more doctors and nurses who are keen to talk to teenagers about safe sex.

An ad that interests me ... Ma'am is girl and boy in classroom ..passes a letter to meet her in the toilet but he refuses.

Ma'am film stars from Hollywood ... Bollywood should be used to promote safe sex ... it will be effective people will follow them.

VIGNETTES OF MALE PARTICIPANTS

Ma'am I heard that we must use condoms to protect ourselves from AIDS on the radio. The posters ... are no good

The media is not good... they are not stating their point. I think if a young person had to meet a person with HIV/AIDS, they would change their ways.

The government is not doing enough there should be more days set out to teach the youth and other people about AIDS/STDs ... There should be more adverts, programmes on radio and TV to teach people about AIDS.

The hospital and clinics ... don't make teenager's sexuality a priority.

At the Clinic ma'am you never feel comfortable if you have a problem with STD you won't feel comfortable in this clinic. I have never seen a male doctor, I will be uncomfortable when a girl has to check me.

It is better to go to a private doctor because sometimes at the clinic they even shout at you in front of people, the nurses talk about you openly.

Ma'am I feel awkward getting condoms from a condom vending machine and the line at the clinic is too long.

Ma'am also the clinic should not only open during the day because people don't only need help during the day but it should be open during the night as well.

There are no centres for teenagers to talk to someone ... about sex.
Ma'am at the clinic we should have a private place for teenagers where you don't see your aunties or neighbours.

Ma'am the message of safe sex should be conveyed through music. Because as teenagers we like music so I feel creating a song to educate people about HIV is a brilliant idea.

We should use rap artists like Zigi Zigi..... not Mandoza he is too old. I do look up to him for his music but not to promote safe sex.

Ma'am we should also use sports stars from South Africa ... like stars from Kaizer Chiefs ...Bafana Bafana and some cricket stars.

We should use local celebrities and not stars from oversees because ma'am we can't use celebrities from oversees and make them solve problems in South Africa. We can also use the President himself.

Ma'am an advert that interest me is one where this guy buys this girl ma'am eh... a ring... earrings and this girl refuses and he says ma'am maybe there's more where that came from ma'am he is doing that to all the girls ma'am. This does send a message ma'am to abstain ... you must practice safe sex.

EMERGING THEMES OF MALE PARTICIPANTS

Enabling Factors

Although there are signs everywhere, people take it as a joke and the fact that they say don't have sex or use a condom just encourages people to do the opposite because it is in human nature to rebel. Although the signs are creating an awareness, it is not effective as people think this will never happen to me.

The media is not good ..., they are not stating their point. I think if a young person had to meet a person with HIV/AIDS, they would change their ways.

The government is not doing enough there should be more days set out to teach the youth and other people about AIDS/STDs... There must be more adverts, programmes on radio, TV to teach people about AIDS.

At the Clinic ma'am you never feel comfortable if you have a problem with STD you won't feel comfortable in this clinic. I have never seen a male doctor, I will be uncomfortable when a girl has to check me.

It is better to go to a private doctor because sometimes at the clinic they even shout at you in front of people, the nurses talk about you openly.

Ma'am also at the clinic they give out condoms but... I don't see any teaching going on or what to do with it.

Ma'am also the clinic should not only be open during the day because people don't only need help during the day but it should be open during the night as well.

Ma'am at the clinic we should have a private place for teenagers where you don't see your aunties or neighbours.

Ma'am the message of safe sex should be conveyed through music. Because as teenagers we like music so I feel creating a song to educate people about HIV is a brilliant idea.

We should use local celebrities and not stars from overseas because Ma'am we can't use celebrities from overseas and make them solve problems in South Africa. We can also use the president himself.

OVERALL VIEWS OF BOTH MALE AND FEMALE PARTICIPANTS IN RESPECT OF ENABLING FACTORS WHICH FOCUS ON SKILLS, POLICY AND HEALTH RESOURCES

- Media; both male and female participants emphasized that posters containing information of HIV were dull and "boring" did not relate to their own sexual experiences and were largely ignored by them. Adverts on television that promoted safe sex were too biological and included healthy and attractive individuals sending messages about HIV prevention which was confusing to young people, not taken seriously by them and not reality based. However, adverts that promoted safe sex with romantic and sexual overtones related to their sexual experiences and sparked their interest.

- Government; both male and female participants agreed that the government was not doing enough to prevent HIV and other STD's however suggestions were made that the government should initiate drama groups about promoting and educating safe sex behavior in schools and motivating teachers to do the same.

- Community resources: both male and female participants emphasized that they were not assured of confidentiality at their local clinics, nurses shouted out their problems in front of other patients and very often members of their own and extended family were present at these clinics. Young people were concerned that if they presented with a sexual health problem, professionals need to spell out that such information will not be "leaked" back to their families, friends and others who are linked to the young person. The nurses treated them with disdain and "chased" them away indicating that they are too young to obtain assistance with sexual problems and thus they had difficulty in obtaining contraceptives and condoms. Male participants emphasized that they would be more comfortable discussing their sexual problems with a health professional of the same gender. It was generally agreed that these clinics were not accessible to the youth, health professionals were unhelpful and a centre addressing problems relate to adolescent sexuality and assuring confidentiality should be made available so as to create an enabling environment.
- Ambassadors to promote safe sex messages; Most male and female participants agreed that stars, song artists and film stars from hollywood and bollywood should be used to promote safe sex messages. There was a general consensus that local South African celebrities as well as the President himself should be used rather than celebrities from overseas, as sexual health matters need to be placed in the context of other issues facing South Africa today.

REINFORCING FACTORS: IT FOCUSES ON PEER GROUP, SUPPORT, PARENTS, TEACHERS, EMPLOYEES, DECISION MAKERS AND COMMUNITY.

Vignettes of female participants

Ma'am I was taught by my teachers that it is best not to indulge in sex because of the risk of HIV and for moral reasons.

My teachers are like my second parents they tell me all the things I need to know and never sugar coat any of the harsh realities.

Ma'am I can talk to my teachers about sex and I don't feel awkward.

I can tell my teachers anything because they listen and they understand.

Ma'am, I can talk to my parents about most things but not sex.

I can't talk to my parents about sex they will get angry and tell me I'm too young.

My parents and I don't talk much about sex ... there is no real communication about sex ... it doesn't exist.

It can be easy to talk to my parents only if they ask you first, ma'am if they approach you and talk about sex, you can't talk about this problem about sex unless they ask you.

My friends influence me about sex, they say that you cannot trust condoms because they say it always gets in the way and they can't feel the person when they are in each other and they like to have sex without it.

My friends tell me you cannot eat a sweet in the paper so why use condoms.

My friends influence me most about sex they say that you need to be careful because of the diseases out there. You have to be cautious and do it after marriage.

Sex is something... I talk to my friends about.

EMERGING THEMES OF FEMALE PARTICIPANTS

Reinforcing factors

My teachers are like my second parents they tell me all the things I need to know and never sugar coat any of the harsh realities.

I have a good relationship with my teachers they educate us about how important it is to save ourselves from diseases. I feel comfortable talking to my female teachers about sex.

I can tell my teachers anything because they listen and they understand.

I can't talk to my parents about sex they will get angry and tell me I'm too young.

It can be easy to talk to parents only if they ask you first, ma'am if they approach you and talk about sex you can't talk about this problem about sex unless they ask you.

My friends influence me about sex, they say that you cannot trust condoms because they say it always gets in the way and they can't feel the person when they are in each other and they like to have sex without it.

My friend tells me you cannot eat a sweet in the paper so why use condoms.

My friends influence me most about sex they say that you need to be careful because of the diseases out there. You have to be cautious and do it after marriage.

Vignettes of male participants

Ma'am my parents and I do not share a very good relationship... I talk to them only in relation to my schoolwork.

If I try to talk to my parents about sex they will either ignore me or change the topic.

My relationship with my parents is good but I cannot talk to them about sex because as black people it is not good as we must respect our parents.

Ma'am I rather go to my friends ... If I need to talk about sex... my parents won't understand my needs.

My parents ... I'm afraid even to ask for money. How can I go and ask them if it is okay. There's this girl I love and I want to take her home... its not right for men, in, our African community, ma'am they still have this respect for their parents, they can't talk to them about sex.

Ma'am my teachers are cool, especially my English teacher... I can speak to him about anything.
I have got a close friendship with most of my teachers and I could talk to them about sex if I needed to.

Our teachers do talk to us about HIV/AIDS and the importance of using .. Condoms.

Teachers tell us not to have sex unless we're ready for it.

My friends and I joke about sex, condoms rarely comes up in the conversation.

My friends tell me to have sex protected or unprotected is my choice. I hope to have it with a pretty girl, preferably a virgin.

My friends influence me because they are always forcing me to kiss girls and do other things. I try not to give in but peer pressure is something that is very hard to say no.

Yeah ma'am, my friends and I do anything together, we drink, go to clubs... I trust them.

My friends treat condoms as a joke, they use them to make balloons and then to play with them.

Most of my friends believe that you must only love a girl for sexual intercourse and if you do they say that you are a player.

EMERGING THEMES OF MALE PARTICIPANTS

Reinforcing Factors

If I try to talk to my parents about sex they will either ignore me or change the topic.

My relationship with my parents is good but I cannot talk to them about sex because as black people it is not good as we must respect our parents.

My parents.... I'm afraid even to ask for money. How can I go and ask them if its okay. There's this girl I love and I want to take her home ... its not right for men, in our African community ma'am they still have this respect for their parents, they can't talk to them about sex.

I have got a close friendship with most of my teachers and I could talk to them about sex if I needed to.

Teachers tell us not to have sex unless we're ready for it.

My friends influence me because they are always forcing me to kiss girls and do other things. I try not to give in but peer pressure is something that is very hard to say no.

My friends treat condoms as a joke, they use them to make balloons and then to play with it.

Most of my friends believe that you must only love a girl for sexual intercourse and if you do they say that you are a player.

My friends and I joke about sex.... condoms doesn't come up in the conversation.

OVERALL VIEWS OF MALE AND FEMALE PARTICIPANTS IN RESPECT OF REINFORCING FACTORS THAT FOCUS ON PEER GROUP SUPPORT, PARENTS, TEACHERS, EMPLOYERS, DECISION MAKERS AND COMMUNITY LEADERS.

- Parents; both male and female participants agreed that sex and sexual health matters are taboo subjects within their immediate family. Parents ignore the fact that adolescents have sexual needs, become angry and refuse to offer sex education to young people. It was emphasized that in the African community it was not culturally appropriate to discuss sexual health with parents as it was a sign of disrespect.

- Teachers; both male and female participants demonstrated that teachers played an effective role in influencing young people's beliefs, expectations and behaviour with regards to their sexuality and AIDS/STD risk reducing behaviour. They did not see adolescent sexuality as taboo and could be easily engaged in discussing sexuality issues.

- Peers; both male and female participants emphasized that their peers played a major role in influencing their beliefs and behaviour in respect of their sexuality. They turned to their peers for guidance and approval regarding their sexuality rather than parents. All participants particularly emphasized that peer pressure influenced them to engage in high risk behaviour so as to gain recognition amongst their peers.

4.2 Discussion

The precede - proceed model as originally outlined by (Green and Kreuter, 1991) focuses on the importance of planning any intervention that aims to short circuit illness or promote health by changing health related behaviour and/or living conditions. This model was developed in response to the observation that in many instances people responsible for health education had determined in advance which intervention strategy they were going to employ. There was often no apparent reason for selecting the health problem or the target population. Other practitioners selected techniques that

they were comfortable with rather than the one that was most strategic or tactical. Thus, this model will be used as a theoretical guide to analyze and interpret the sexual practices of adolescents in relation to HIV/AIDS and STDs.

The model explains the sequence as follows. A person has an initial reason, impulse, or motivation **(predisposing factor)** to pursue a given course of action, (eg a previous STD and the knowledge that this infection is transmitted sexually). This factor may be sufficient in the casual chain to start the behaviour, but will not be enough to complete it unless the person has resources (eg condoms) or skills (eg the ability to procure condoms) needed to carry out the behaviour. The motivation is followed by the use of resources to enable action **(enabling factor),** accessibility of condoms and ability to use a condom). This usually results in a behaviour, (eg using a condom with a casual partner) followed by a reaction to the behaviour, which is emotional, physical or social, **(reinforcing factor),** (eg positive sexual experience and support from the partner). Reinforcement strengthens behaviour, future resources and motivation, (eg a community norm that caring couples have protected sex). The ready availability of enabling factors provide cues for further action and heightens other factors predisposing the behaviour. From the environmental perspective of health promotion the building of social reinforcement for a behaviour can lead to the enabling of the behaviour in the form of social support and assistance. (Green and Kreuter, 1991).

In respect of motivation i.e. **(Predisposing factor)** to pursue a given course of action, Schaalma (1995) indicates that until 1990 theoretically based research on the psychological determinants of sexual risk taking and sexual risk reducing behaviour with regard to AIDS was very scarce. Besides, a lot of studies addressed condom use in general and as such failed to provide insight into the factors related to the use of condom use to prevent HIV transmission. He further argues that a review of studies on young people and their sexual practices to prevent HIV transmission showed that most of these studies primarily focused on knowledge and perceived susceptibility in relation to sexual aids risk reduction and only few addressed attitudes, social influences and self efficacy expectations with regard to condom use and related behaviour.

Macphail (1998) agrees with the argument indicating that most studies addressing AIDS knowledge and perceived susceptibility showed that misconceptions about the transmission and prevention of HIV still exist among young people and that a large majority of young people did not consider themselves to be at risk for HIV infection. On the other hand, these studies suggest that neither high levels of knowledge, nor high levels of perceived susceptibility lead to behaviourial risk reduction regarding HIV infection. Furthermore the surveys among Dutch young people suggest that they think of condoms primarily as a remedy for unwanted pregnancy and secondly as a remedy for STDs.

The views of the above authors are consistent with findings in this study that attitudes, social influences and self efficacy expectations may be important determinants in safe sex practices and

condom use to prevent HIV transmission. The female participants demonstrated good knowledge and strong awareness of AIDS/STD's in their lives, however most of them are encouraged not to engage in sex or carry condoms more for moral reasons i.e there are religious taboos to have sex prior to marriage and to protect their social reputations so that they are not viewed as cheap or easy and to avoid unwanted pregnancies rather than to prevent STD/AIDS.

Hamilton (2001), argues that girls have difficulty seeking information about sex and sexual health. They fear rejection by the community if they ask for help after experiencing sexual abuse. They have little power to negotiate sexual practices with boys. "Good" girls would not be involved in such things. Girls fear being labeled as cheap or loose. Boys have great freedom or movement and are expected to have sex. They feel they have undisputed power over girls and sexual interactions. If a girl agrees to a boys proposals, she is seen as cheap, unclean and diseased and he will use a condom, if the girl delays she is "genuine" and he need not wear a condom. The notion that only certain girls are "unclean" means that boys use of condoms is inconsistent.

Oostergaard (1997), further argues that carrying a condom implies a degree of sexual freedom and a need for sex which directly contradicts society's norms of the pursued female and can lead to labels such as slut and slag. Mudari (1998) agrees that girls are taught to leave the initiative and decision making about sex to males whose needs and demands are expected to dominate. Male predominance often comes with a tolerance for predatory, violent sexuality. It also carries a double standard whereby women are blamed or thrown out for infidelity, real or suspected, while men are tacitly expected or allowed to have multiple sex partners.

Most male participants demonstrated that they had knowledge of what was required for safe sex, broadly endorsing notions of responsibility to avoid infection, however this did not always fit their experiences of relationships i.e. if a sexual opportunity arose, they would indulge in unsafe sex practices or non use of condoms, religious values and beliefs did not impact on their sexuality, having multiple partners elevated their status in society and females who engaged in sexual intercourse were cheap and easy targets to obtain sexual favours. Thus, it was evident from their discussions that practicing safe sex and condom use remained disappointingly low. In addition there has been realization that much of the risk behaviour associated with adolescence has its roots in the way that adolescent's construct their identities within the context of a heterosexual society. (Buysse and Van Oost, 1997).

Oostergaard (1997) agrees that male adolescents negatively impact on their health behaviour by utilizing inappropriate safe sex messages in a way which enables continued male pursuit of sex as a social norm. Additionally, men place themselves at increased health risk due to their engagement in casual sex to prove their masculinity whilst disapproving of female sex as non feminist.

In addition Mudari (1998) argues that religion is serious issue and does have an impact on sexuality. Some Christian denominations forbid the use of condoms by their members. She indicates that religious communities should adopt holistic aids prevention strategies if they are really committed to AIDS prevention. She further argues that promiscuity and sex before marriage, even within the religious community are happening anyway. Church leaders are not therefore advocating such behaviour by sanctioning the use of condoms. If we are to grade sins, having sex, with a condom is a far lesser evil than risk killing someone by having unprotected sex.

Thus Schaalma (1995), states that interventions solely aimed at the increase of knowledge may have an impact on the attitudes of young people, but changes in perceived social norms, efficacy of own skills and behaviour are not very likely. In addition to a transfer of knowledge, health education should provide people with opportunities to involve their social environment and with opportunities to develop skills that are necessary for an adequate performance of the desired behaviour.

The motivation **(predisposing factor)** is followed by the use of skills, policy and health resources to enable the action, **(enabling factors)** (eg accessibility of condoms and ability to use a condom).

The overall views of both male and female participants suggests that there is an urgent need for more attention to be paid to societal perspectives and health promotion and education to promote safer sexual behaviour. Data collected from the participants indicated that in respect of community resources, primary health care clinics are not accessible to obtain information with regards to their sexuality and access condoms. There is a dire need for accessible youth based centres that assure confidentiality. School based programmes by the state to reduce transmission of HIV and increase positive behaviour is needed and the media should advertise more youth friendly posters and television adverts on safe sex practices that are congruent with adolescent sexual experiences. Furthermore, ambassadors such as sport stars, song artists and even the president himself should be used to promote safe sex messages.

Macphail (1998) argues that exploration of sexuality cannot be divorced from the social context which informs behaviour and in which behaviour takes place. Research and possible health promotion solutions stemming from research has to embrace more than just the individual. For adolescents to effectively access safe sex behaviour, research questions need to be directed towards the creation of enabling environments.

Mudari (1998), argues that young people are seen as being irresponsible citizens. She believes that given the information and skills young people can be responsible. AIDS education should focus on skills building as opposed to awareness creation as experience has shown does not help young people to change their behaviour. They should be given the skills to negotiate abstinence or safe sex. She further states that an environment should be created which encourages and enables young

people to change their behaviour. This includes advocating the abolition of policies and activities that hinder the process of behaviour change. The biggest obstacle is the discrimination against young people infected with HIV. You cannot encourage these young people to live openly and positively with HIV if they are going to be discriminated against, isolated and denied education and health services. We need to create a culture of human rights that enables the youth to live positively.

Schaalma (1995) argues that on a national level we have little knowledge of the impact of mass media activities on sex and AIDS as most of these campaigns are not systematically evaluated. In an attempt to trace the impact of the various safe sex and condom campaigns on knowledge, attitude and behaviour several telephone surveys were conducted by him between 1987 and 1989. It was concluded that knowledge regarding the use of condoms had increased to a high level and that there was a significant increase in self reported condom use of subjects with casual partners and young people. However, these developments could not be attributed solely to the mass media campaigns on AIDS.

He suggested that these campaigns could have had an indirect effect such as making people more aware of AIDS information in general. As a result mass media campaigns could have been a help to get going interpersonal conversations on AIDS and AIDS prevention and they could have paved the way for other educational activities such as education at schools. In most cases the objective of the mass media campaigns on AIDS was the promotion of condom use, a behaviourial change. However such a goal is very ambitious of not impossible. Generally, the impact of mass media campaigns will be limited to "agenda setting" and at best to a consolidation of behavioural changes. In order to produce behavioural changes a more interpersonal education such as behavioural skills training in classrooms seems to be unavoidable.

Thus health promotion should be undertaken by building healthy public policy creating supportive environments, developing personal skills and ensuring that individuals, community groups, health professionals, health service institutions and governments work towards a health care system that supports the needs of individuals and communities for a healthier life and open channels between the health sector and broader social, political, economic and physical environment components. (Ottawa Charter for health promotion, 1986).

The motivation **(predisposing factor)** is followed by the use of resources to enable the action **(enabling factor).** This usually results in a behaviour eg using a condom with a casual partner) followed by a reaction to the behaviour which is emotional, physical or social **(reinforcing factor)** eg (positive sexual experience and support from the partner. **Reinforcement** strengthens behaviour, future resources and motivation.

The overall views of both male and female participants indicates that much of what young men and women do is influenced and entrenched by what others like themselves are doing. Peer influence is the key component in shaping adolescents behaviour and research has shown that this influence has resulted in reducing the positive effects of intervention. Most of the adolescents in this study indicated that they would rather talk to their teachers about sexuality issues than their parents. They viewed teachers as friends and confidants and felt encouraged and supported by them. Parents were seen as disciplinarians and unapproachable in discussing issues related to sexuality. This was especially emphasised in the African community where it was culturally inappropriate to discuss sexual health with parents as it was a sign of disrespect.

Adolescence is a period characterized by the development and formation of sexuality, a process which frequently involves a high turnover of sexual partners. In addition adolescents are vulnerable to the normative social influences of their peers. These influences among adolescents tend to discourage the adoption of safe sex method by encouraging negative associations to be attached to condoms and their use. (Di Clemente, 1992)

While adolescents have knowledge about HIV, most have not personalized the threat of AIDS. While adolescent females are encouraged by parents and teachers not to engage in sex, those who do are under great pressure to identify relationships as serious or committed, as justification for their sexual behaviour, whilst the views held by young men are that condoms are incompatible with male notions of masculinity and pleasure (Holland et al, 1990; Preston-Whyte and Zondi, 1991), as cited in (Oostergaard, 1997).

Serovich and Green (1997), as cited in (Reddy, Meyer-Weitz 1999) also make a comment on the influence of educators in promoting safe sex behaviour, who should seek to reduce the transmission of HIV to develop programmes at schools, to reduce overall positive attitudes towards risky behaviour. This indicates that well liked peers and influential others are needed to promote HIV prevention as the fashion or norm.

This is further supported by (Kelly, Sikkema and Kalichman, 1993) that perception of social or peer norms concerning the acceptability of safer sex practices is an important determinant of HIV risk taking behaviour. To the extent that individuals believe that condom use or other safer sex changes supported and are expected likely to be reinforced within their peer network, they are more likely to conform to these perceived norms.

Mudari (1998), states that the provision of sexual health education by parents to African youth is a challenge. Sexual matters are predominantly "taboo subjects" and so is talking about sex within the family setting. HIV is itself highly stigmatized, so many young people and children are unaware of HIV in their households. There are different types of sex education, informal and formal. Informal sex

education is learning by observation and also through the socialization process. Many a times girls are told to "sit properly", "hide your tampax or pads", "don't play with boys". Often reasons for giving such instructions are not specified to young people. Formal sex education is found within the school setting. Young people found that this was too biological and rather remote from their own experiences.

She further states that even if parents are not talking to their children about sex young people observe interactions within their own social worlds, some of these observations could have sexual overtones. The ways in which young people interpret their observations is varied and may give rise to questions and curiosity. She recommends that parents listened, talked to and answered their children's questions as honestly as they possibly could. Age specific education was advocated with each child's needs and circumstances being taken into account.

Thus she concludes that presently sex education either formal or informal fails to meet young peoples sexual needs and encourage safe sex practices as it is usually too late, too minimal and too biological.

CHAPTER 5 - CONCLUSION AND RECOMMENDATIONS

Much of the research results have shown that adolescents have high levels of knowledge about the transmission of HIV virus and are fully cognizant of the value of barrier contraception such as condoms in preventing HIV transmission, however, most of them do not personalize the threat of AIDS.

Despite the high profile given to HIV, few adolescents are able to transfer their knowledge in adopting safe sex behaviour. More attention needs to be paid to the way in which adolescent sexuality is a complex process embedded with norms and values rather than the result of informed decision making. In addition teenager's lives are dominated by feelings of invulnerability which allow them to take chances they see as developmentally important. (Macphail, 1998)

The impression is that normative peer influences encourage sexual behaviour in the direction of safety, however, Fischer, Misovich and Fischer (1992) as cited in (Reddy and Meyer-Weitz, 1999), point to the failure of many HIV interventions as being the result of peer norms which encourage risk. They indicate that both behaviour specific and general norms function to promote unsafe sexual behaviour which encourage concern for sexual health to be seen in a negative light which is evident in this research findings.

Within South Africa a number of meaningful issues surrounding adolescent sexuality have been identified, although their full investigation is limited. The South African situation has been described

as one with a particularly negative view towards condoms. Condoms are seen to be directly incompatible with social notions of masculinity and their use limited to persons already infected with either HIV or an STD.

It has been suggested that the South African Government is wary of offending a powerful constituency by openly declaring that the spread of HIV/AIDS has a great deal to do with sexual behaviour of men. Politicians, it is assumed, tread carefully around the intricate web of sensitivities, signifiers, self-descriptions and understandings that inform the psychic structure and behaviour of South African men. Rather let HIV/AIDS be construed as a colonial plot, or a wasting disease brought on by poverty, than a virus spread primarily through sexual intercourse that too frequently includes violence and rape.

This is a tricky subject. Even to mention it, is to stereotype half the population and to be accused of demonizing the African male. Yet to fail to mention patriarchal attitudes and sexual behaviour as major contributors to the spread of HIV/AIDS is to sustain silences and taboos that nurture the insidious and deathly intruder. While silence prevails, the possibilities of containment are limited. Above all the HIV virus seems to thrive on silence and secrecy.

This is evident in the research findings as gender expectations of girls and boys are translated into adulthood. There was a universal belief amongst adolescent males in this study that in order to be "real men" they are expected to have multiple sexual partners. This does not only elevate their status in society but gives them power and control, which is in line with age old patriarchical attitudes and beliefs. The females in the study found it difficult to negotiate sexual practices with their partners. They were under pressure to bear children, and to have sexual relationships within the confines of marriage. They were also expected not to talk about sex and to behave in socially acceptable ways. Moreover, carrying condoms and getting involved in sexual relationships with males, outside marriage meant that they were viewed as cheap and easy targets to obtain sexual favours. Furthermore, it was evident that inaccessible health facilities, poor communication with parents and discrimination by society of young people who have tested positive causes young people to shy away from getting more information about HIV/AIDS, disclosing their status and practicing safe sex.

It is therefore with good reason that campaigns worldwide have emphasised disclosure as a major step towards treating HIV as a manageable if demanding house-guest, rather than a dangerous murderer. As Judith Soal (1997) as cited in (Hamilton, 2001) argues in her article "Treatment is prevention", disclosure remains unlikely without the inducement of treatment. As long as HIV/AIDS carries a death sentence, it is shrouded by the two great taboos of sex and death. Treatment can pull back the shroud of death. Creative behaviourial interventions responsive to local contexts and sensitivities may be the way to get the subject of sex out into the open.

In "steps to sexual equity", Mzikazi and Jama, (2000) as cited in (Hamilton, 2001), describe their structured attempts to enable boys and girls to understand how their social and sexual assumptions and behaviour make them vulnerable to HIV/AIDS. In "Once there were heroes", the formidable Gethwana Makhaye explains why she wooed the south African Football Association, a bastion of conservative, strutting maleness, in order to help women.

The unfortunate perception that HIV/AIDS is a disease of poverty leads many to think that its economic consequences will be less profound. In fact HIV does not discriminate. Certainly it attacks people weakened by poverty more frequently and more virulently. But in many cases it attacks the very young people who are the most likely beneficiaries of an African renaissance, leaving their families bereft and without wage earners. This reality is drawn in poignant articles by Deborah Ewing and Elinor Sisulu.

A further problem with depicting HIV/AIDS as primarily a disease of poverty is that it is met with a kind of hopelessness. The refrain runs thus: we cannot yet deliver food, fresh water and shelter to all the poor in this country. How on earth will be able to afford drug treatment for everyone with HIV/AIDS?

This is also the logic of many HIV/AIDS activists and it is compelling. It is extraordinary that it has not taken root in national policy. It is astounding that there is still quibbling about saving babies with nevirapine, when we could also be saving mothers to look after these babies instead of designing systems to care for orphans. Treatment activists are not such dreamers that they expect treatment to reach everyone at once. What they ask for is clear policy establishing the intention to treat HIV/AIDS as a chronic but manageable condition rather than a death sentence. (Hamilton, 2001).
The South African government and non-governmental sector's prevention efforts include the promotion of condom use through mass media campaigns, the free distribution of condoms as well as the promotion of condom use by the health service delivery system. However condoms are not readily available to the South African population at large and distribution mechanisms are inadequate. Colvin (1997) notes that although free condoms are being distributed, only an annual average of 7,7% of these condoms per year are distributed to those who are sexually active. This is a matter of grave concern as it has been suggested that easy access to condoms is an important way of preventing the spread of HIV. With regard to the use of condoms with the health care delivery system, (Reddy, Meyer-Weitz, Van den Borne, Kok, 1998) have shown that a reluctance to promote the use of condoms by some health workers has stemmed from their own negative attitudes towards condom use. Furthermore, the negative attitudes towards STD patients, it is argued, reflects the existing negative social and cultural norms by associating condom use with death, promiscuity, STDs and AIDS, as well as a lack of trust and love. These findings have been widely reported in other South African studies (Abdool Karim, Nkomokazi, 1991: Abdool Karim, Soldan & Zondi, 1995: Bletcher, Steinberg, Pick, Hennink & Durcan, 1995: brooks, 1996; Colvin, 1997: Govender, Bhana, Pillay, Pancia, Padayachee & De Beer, 1991; Whiteside & Barnett, 1996). It is however, important to note

that most of the above mentioned studies were conducted in narrow geographical areas and with relatively small sample sizes thus making it difficult to extrapolate the rate of condom use nationally. In a national study conducted among the general population a condom-use prevalence rate of 22% was reported (Du Plessis, Meyer-Weitz & Steyn, 1993).

While various South African and international studies have tried to demonstrate the effect of demographic variables on sexual behaviour and condom use, little attention has been paid to the determinants of condom use within the context of different relationships. One of the explanations for the ineffectiveness of existing health education programs is that these programs lack a theoretical base and have not been adequately pretested and/or evaluated. Further, there is a lack of theoretically based investigations into the determinants of, for example, condom use by young people to prevent HIV infection. Many of the studies on AIDS and young people have primarily focused on knowledge and perceived susceptibility in relation to behaviourial risk reduction. Most of these studies indicate that misconceptions about the transmission and the prevention of HIV still exist in the teenage population, and that a large majority of young people do not consider themselves to be at risk for HIV. Schaalma (1995) argues that although these studies undoubtedly provide information that is valuable for health educators, they fail to identify the determinants of safer sexual behaviour. After all, neither knowledge nor perceived susceptibility seems to be related to behaviourial risk reduction regarding HIV infection.

Thus, this study has uncovered the possible reasons for the continued failure of HIV prevention efforts directed at adolescents. It is imperative from the research findings that investigation into the knowledge, attitudes and beliefs of adolescents in respect of their sexuality is not sufficient for HIV prevention, without investigation of the social construction of sexuality, i.e. the social dimensions of adolescents sexuality and societal perspectives and the implications for health behaviour. The unique social norms and values affecting adolescents in South Africa require localized research to meaningfully understand issues surrounding adolescents sexuality. (Macphail, 1988). **Intervention strategies** require multi sectoral effort, involving medical, public, health, social services, education and social community service in preventing high risk behaviour and condom use, appropriate sexuality education at school based programmes, health promotions and education in the community at all levels and the implementation of accessible community based clinics and counselling centres that address the needs of the youth, that are user friendly and ensure confidentiality.

Future intervention strategies should focus on the following issues.

- In order to induce behaviourial changes, prevention and education programmes should include cognitive and behaviourial skills training addressed to interpersonal problem solving, planning and assertive communication. To strengthen young peoples ability to deal with contraception and AIDS they should at least be taught how to start a conversation on condom

use with a sex partner, how to discuss condom use and how to cope with unacceptable requests. Teaching methods could include dramatic techniques, role playing, homework assignments and rehearsal of communicative techniques. It is frequently suggested that self confidence, the ability to buy condoms, to take them along (eg. When having a date and to discuss the use of condoms with a sex partner are major preconditions for adequate use of condoms. Therefore apart from attitudes, social influences and self efficacy expectations, attention should be paid to perceived personal vulnerability regarding HIV infection when having unprotected intercourse. (Schaalma, 1995).

- Young people want to talk to parents about HIV and sexual health matters so that teachers and other professionals then "add on" to what parents have already said. Parents need to be equally educated and empowered to discuss sexual health with young people so that sex and sexual health matters are not taboo. Cultures are dynamic, communication within families on sexual health should be seen as part of cultural change (Mudari, 1998).

- There is a need to acknowledge the economic and social difficulties that young people and their families are facing as parents are at times too engrossed with economic problems to focus on young people's sexual health education.

- Strengthen the emerging structures found among some communities, eg the "community auntie" notion. Some communities (eg the Ugandans have community aunties who provide traditional sex education to young people. (Hamilton, 2001).

- Peer education approaches with volunteers serving as risk reduction educators, encouraging groups of friends and acquaintances who meet in one another's homes should be implemented. This networking approach combines risk education and skills training. It also creates expectations that safer sex practices are socially valued and accepted by members of one's peer network. To the extent that individuals believe that condom use or other safer sex changes are expected, supported and likely to be reinforced within their peer network, they are more likely to conform to these perceived norms. (Kelly, Murphy, Sikkema and Kalichman, 1993).

- Mass media activities addressing sex and AIDS should be youth friendly. Besides factual information on contraception and condom use, posters, adverts and campaigns should concentrate on communication aspects of intimate matters, and sexual behaviour , it should reach young people at events such as discos, schools, cinemas, colleges, youth clubs and drug stores. The campaigns should also affect social norms regarding condom use by suggesting that popular men and women such as film stars and popstars use condom themselves. The main goal of the campaign should be to integrate safe sex into common

dating practices.

- A structured AIDS curriculum should be introduced at schools. Topics should include, puberty, contraception, masturbation, prevention of STDS/AIDS and unwanted pregnancies. Methods that could be used involve group discussions, role plays, interviews, questionnaires, supporting maternal such as books, videos, slides and films. Counsellors need to teach students how to talk about sex and to reflect on their own values and opinions and on those of others. Major goals should be the improvement of knowledge about AIDS and AIDS prevention, the promotion of a positive attitude towards the use of condoms, safe sex and a related behavioural change. (Schaalma, 1995).

- Improve utilization of family planning and health clinic services to meet adolescent needs.

- To undertake literacy programmes and skills training to empower women to become economically independent and thus make safe choices about their sexuality. Support women's groups and community organizations in questioning behavioural traditions which have become deadly with the advent of AIDS, including tolerance of rape and sexual coercion. Educate boys and men to respect girls and women, engage in responsible sexual behaviour and to share responsibility for protecting themselves, their partners and their children. (Perkel and Strebel, 1991).

- According to Kelly, Murphy, Sikemma and Kalichman, (1993) behaviour change remains the only means for primary prevention of HIV disease. Psychology should take a leading role in efforts to curtail the epidemic, but so far has not contributed to HIV prevention at a level proportionate to the urgency of the crisis. The authors propose an updated agenda for behavioural research on AIDS/HIV prevention, implementing accelerated community trials of promising behaviour change models, conducting trials of community level interventions on a large scale and focused on populations most vulnerable to HIV infection. They further propose establishing partnerships between HIV research and community service organizations, integrating efforts from across psychology discipline to advance and refine HIV prevention. Furthermore, by mobilizing interdisciplinary HIV prevention resources and communication mechanisms to rapidly translate research findings to community and public policy arenas.

- Finally it is envisaged that the results and recommendations arising from this research could be utilized by Departments of Health, Welfare and education, as well as community based and/or non governmental organisations, collaboratively as part of their business plan to undertake AIDS education and prevention programme with the youth in schools and in rural areas. These programmes should emphasise behavioural and cognitive skills training and

ensure that health facilities are accessible, so as to empower the youth in South Africa to make health choices responsibly.

Limitations of the study and direction for future research

With regard to the methodology of the present study it can be argued that quantitative questionnaire based research imposes constraints upon respondents and that qualitative methods of data collection are more useful when studying condom use and AIDS prevention. However, further qualitative data gathering may be needed to facilitate the development of a programme on AIDS prevention to test the internal validity of a longitudinal effect-evaluation and to improve the process of implementation and adoption of the programme.

The model (precede-proceed) as originally outlined by Green and Kreuter (1991), used in the present study also deserves some critical remarks. The model emphasizes predisposing factors, antecedents that provide individual motivation for the behaviour, enabling factors, antecedents to individual behaviour that enables a motivation to be realized and reinforcing factors subsequent to individual behaviour that provides continued reward, as incentive for the behaviour to be maintained. Although the model focuses on the individuals interaction to perform a given behaviour one can never be certain to which degree behaviourial determinants and intentions will influence the sexual behaviour.

According to (Macphail, 1988) intentions are good predictors in general of behaviour, if the behaviour in question is under volitional control. Although the model pays attention to the degree of volitional control by means of the concept of self efficacy, one can never tell regarding sex. For example, heterosexual interactions often are not under volitional control, especially not for younger women, as already outlined in this study regarding gender expectations of society regarding female sexuality. This, however seems to support the conclusion that education on sex and AIDS should incorporate an interchange of values, acknowledge cultural diversities and differences and offer a training of refuse skills and assertiveness so that young people can learn to cope with situational pressures.

The development of AIDS education and prevention programmes and campaigns can be enhanced if it is carefully planned and if it addresses a variety of variables that are important in the process of behavioural change and maintenance. Presently, there is little research in the South African context that addresses these needs, which presented the researcher with difficulties in presenting a strong theoretical framework for this study. Thus, future research that is theory based and focuses on behavioural determinants should offer suggestions on how to tackle the ineffective use of condoms and promote safe sex amongst adolescents. Besides future education should be pretested and evaluated thoroughly. Only then, is some guarantee for the education to be or become effective.

Finally, to address some comments and suggestions to the issue of cooperation between researchers and practitioners as well as to the issue of implementation and the feasability of health education interventions in respect of condom use and AIDS prevention. Various local and national organisations as well as health, education and welfare are developing programmes to meet these needs, independently of each other. This inefficient use of people, time and money should be avoided. To be most effective and efficient small scale projects should be coordinated intersectorally both on a regional and national level with the participation of local groups so that small scale versions of big projects can be tested and researched to avoid expensive failures.

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