TITLE: RISKY SEXUAL BEHAVIOUR AMONGST SOUTH AFRICAN TEENAGERS AND THE ROLE OF HIV/AIDS EDUCATIONAL PROGRAMS: A CRITICAL LITERATURE SURVEY

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MINI-DISSERTATION

Submitted in partial fulfilment
of the requirements for the degree

M. A. PSYCHOLOGY

In the
FACULTY OF ARTS

At the

RAND AFRIKAANS UNIVERSITY

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OCTOBER 2003

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1. INTRODUCTION

Adolescence is a crucial developmental period with profound physical and psychological changes. During this time, youth need to take control of their lives and make mature decisions, which have long-term implications for their health and the overall well-being of society as a whole (WHO, in Call, 2002). Sub-Saharan Africa is the poorest, most underdeveloped region in the world, which accounts for 10% of the world's population. However, 85% of AIDS –related deaths have occurred in this region. (World Bank, in HIV InSite, 2000). This region has also accounted for more than 90% of AIDS orphans and children affected with HIV (UNAIDS, 2001).

With one in nine of South Africa's 43 million people infected, we have the highest incidence of HIV/AIDS in the world (Phatlane, 2003). Fewer than 50 percent of South Africans currently alive will reach the age of 60, compared to an average of 70 percent for all developing countries and 90 percent for industrialized countries (UNAIDS, 1999). Due to AIDS, the life expectancy in 2010 will be 48, whereas it would have been 68 in the absence of AIDS (U.S. Bureau of the Census, in HIV InSite, 2000). Youth (between the ages of 15 and 20 years), have the fastest growing infection rates. In 1998, the HIV infection rates among South African youth aged 14-19 years and 20-24 years were 21% and 26% (Adler, in Stadler & Hlongwa, 2002). Since approximately 45% of South Africa's population is under the age of 20, reductions in the rate of HIV infection among youth, would lead to a substantial reduction in the spread of the epidemic over the next 5-10 years (Stadler & Hlongwa, 2002).

1.1 Aims and Rationale for this study

South African teenagers name HIV/AIDS as the top concern facing them. Despite this, a large majority of them believe that they personally are at very low, or no risk for infection (loveLife, 2001). Furthermore, the onset of sexual activity has become progressively earlier, with many teenagers becoming sexually active at around 13-14 years old (Stadler & Hlongwa, 2002). 50% of young people are sexually active by the age of 16 (Eaton, Flisher, & Aaro, 2002). However, only 30% of sexually experienced youth report using a condom every time they have sexual intercourse. Sexually experienced teenagers report that they are most likely to get condoms from clinics, but only 32% have been to a clinic in the past year for sexual health advice or care (loveLife, 2001).

In the light of the alarming statistics mentioned above, youth represent an important target group for interventions, particularly those which address and effect changes in attitudes and behavior relating to sexuality. As a large number of children and teenagers attend school, information, skills, as well as values relayed in schools, can therefore have a considerable impact on their lives. Education systems should thoroughly educate children about HIV/AIDS infection, transmission and means of prevention, whilst assisting them to develop the life skills to apply their knowledge and communicate it to others. Programmes should assist in teaching children how to maintain health-enhancing behaviour and change, or avoid health-reducing behaviour (WHO, 1992).

2. BARRIERS IN CHANGING ATTITUDES AMONGST TEENAGERS

2.1 THE IMPACT OF POVERTY

In 1996, it was estimated that 52 percent of the 11 million South Africans aged 16 to 30 are unemployed. One-half of those unemployed are classified as marginalized, with few prospects of formal sector employment. Given this scenario, young people put short-term survival over long-term well-being. Short-term survival strategies often include exchanging sex for schooling, employment, money, or shelter (UNAIDS, 1999). According to the Development Bank of South Africa, in 1991, 56.4 percent of women aged 15 and older were without income of any sort, constituting the most deprived sector of the population. The country's GDP per capita of 3210 USD (1997) masks the disparities that exist within it. About 13 percent of the population (about 5.4 million people), live in "First World" conditions, whereas 53 percent (about 22 million people) live in "Third World" conditions. Among this 53 percent, only 25 percent of households have access to electricity and running water, only half have primary school education, and over one-third of children suffer from chronic malnutrition (World Bank, in HIV InSite, 2000). The impact of the apartheid era is closely entwined with poverty and thus HIV.

Poverty is recognized internationally as a major cause of ill health. Therefore, Africa, which accounts for 34 of the world's 49 poorest nations, has been identified as the epicenter of the AIDS epidemic (Pretoria News, in Phatlane, 2003). Ironically, however, even though South Africa is one of the richest countries in Africa, the highest per capita HIV prevalence and infection rates in the world occur here (Van Aardt, in Phatlane, 2003). It seems likely that the reason why the infection rate is so

high among the poor is that besides the vulnerability to ill health, poor people are undereducated on health topics in general, and those infected with HIV, are more likely to seek assistance from inappropriate sources and are less likely to participate in preventive programmes. The legacy of apartheid, resulting in poverty in certain sections of the population, made South Africa much more vulnerable to mass infection and hindered the implementation of preventive efforts (Phatlane, 2003).

2.2 The link between Apartheid and Disease

Apartheid divided the South African population on racial lines and this division extended in terms of health care. When the relative discrepancy between rich and poor is considered, the racial distinction is clear. The mere occurrence of certain kinds of diseases (malaria, tuberculosis and HIV) in one socio-economic group and not another, indicates social inequality, which is the product of apartheid. This explains why many AIDS fatalities in South Africa are not a result of new or rare infections, rather, a by-product of old, reactivated infections, such as malaria and tuberculosis (Clumeck N., H. Sonnet, H. Taelman, and F. Mascart-Lemone (1984). Additionally, apartheid has, through the creation of impoverished Bantustans and other instruments of social control, provided the basis for the high prevalence of the HIV epidemic. The creation of "Bantustans" (specific rural "homelands" where Blacks were confined to, because they were not allowed to live in "White" cities) resulted in large numbers of unemployed, aged and sick Africans (Phatlane, 2003). The cost of supporting all these "economically surplus" people, led to them being exported to such impoverished areas (Price, 1986). Overcrowded conditions in these Bantustans, led to high incidences of diseases such as tuberculosis. Research has shown that tuberculosis is a disease of poverty, and that the prevalence of tuberculosis accelerates the course of

HIV infection (Maartens, 1999). In 1981, when AIDS was first recognized, an average of about ten people died of tuberculosis daily, and at least 45 000 new cases were reported annually. The disease accounted for 83 percent of all noted infectious diseases in South Africa (Natal Mercury, in Phatlane, 2003).

Changes have been slow with the birth of democracy. The legacy of a segregated society is still reflected in the levels of tuberculosis infection by provinces, which can be attributed to poverty (Floyd et al, in Phatlane, 2003). In the early 1990's, when the country had a unique opportunity to contain the epidemic, it was occupied with negotiating a peaceful transition from White rule and thus did not allocate sufficient resources to addressing an impending epidemic and its associated sexual issues (New York Times, in HIV InSite, 2000).

According to the Medical Research Council, in 1999, it was estimated that between 40 and 50 percent of people with tuberculosis in South Africa, were also co-infected with HIV, with the result that one-third of all HIV-positive people would die of tuberculosis (SAIRR, in Phatlane, 2003). This indicates that tuberculosis is a significant opportunistic disease, whose prevention and control would greatly be influenced by control of HIV transmission (Phatlane, 2003).

2.3 Unemployment and Malnutrition

Unemployment was a phenomenon prevalent in most Bantustans. One of the most visible effects of unemployment is malnutrition, which contributes significantly to the lowering of the body's immune system (SAIRR, 1981). In the 1980's, a survey conducted in the Ciskei homeland, revealed that 64 percent of schoolchildren, ate only

once a day (SAIRR, 1981). Body cells require protein and calories to grow and without them essential tissues cannot develop properly. Also, malnutrition may lead to slower production of antibodies and white blood corpuscles, resulting in lowered resistance to infection. The victims of forced removals, who were relegated to the Bantustans, were exposed to inadequate health care, endemic infections and unsanitary water supplies (Phatlane, 2003). Thus, we can see how poverty provides the conducive breeding ground for disease in a recurrent cycle of re-infection.

2.4 The impact of the Migrant Labour System on Family breakdown and HIV incidence

Whilst the aim of the Bantustans was to relegate Blacks to the homelands, males of these families relied on work in the "White" cities to support their families in the homelands. Beginning in the 19th century, South African mining industries had a legally enforced migratory black labour system. African men were denied the right to settle in cities with their families. This resulted in a large gender imbalance, with an excess of males in urban areas and of females in rural areas. Most men in their reproductive years were separated from their homes and from the sexual norms of settled rural societies. Confined in squalid conditions rural- or urban-men and their female partners were rendered particularly vulnerable to the HIV epidemic (Washington Post, in HIV InSite, 2000). Migrant labour practices led to the breakdown of the male-headed households and the concept of the family unit (Phatlane, 2003). Research (Murray, 1980) has shown that in every human society, the family serves as an important social-support system and the primary socializing agent. Adult males in the Bantustans were faced with the double-bind of leaving for the cities to provide economic security for their families, whilst their absence led to

the breakdown of the conjugal stability from which the family derives identity. This led to the destruction of long-term monogamous relationships between spouses.

Black male migrants, who worked in the cities' mines, were housed in single-sex compounds, where they turned to one another for friendship and possible sexual intimacy and used the services of prostitutes. These conditions were conducive to the spread of sexually transmitted diseases not only amongst places of work, but also in the rural areas, where the men periodically returned (Phatlane, 2003). Migrant labour is also associated with hazardous physical work, relieved primarily by alcohol and sex, contributing to HIV transmission. The National Union of Mineworkers in South Africa introduced an education campaign on HIV/AIDS in the late 1980's and has fought for the provision of family accommodation, yet the union estimates that there could be between 12 000 and 14 000 AIDS-related deaths among miners each year by 2010 (STD AIDS, in HIV InSite, 2000).

The mining town of Carltonville in the Gauteng province epitomizes how HIV is spread via population mobility. This region is home to approximately 100 000 miners (whose families live in the rural areas), and is the centre of the sex and recreational drug trafficking. Approximately 22 percent of adults in Carltonville are infected with HIV. Through periodical visits to their families, their wives are also infected. Preventive education efforts are hampered by the fatalistic approach of facing greater risk of injury or death through their work, than through an invisible, slow death related to HIV infection (HIV InSite, 2000). Studies conducted by South Africa's Council for Scientific and Industrial Research indicate that many miners of this

region, do not practice safe sex, or even perceive of themselves to be at risk of contracting HIV (Village Voice, in HIV In Site, 2000).

In another mining town called Welkom, a recent study has shown that significant behaviour change has occurred between miners, during 1995 and 1997. This change is attributed to the mining industry's AIDS awareness programmes, as well as the efforts of a condom social marketing campaign, targeted at miners and sex workers in the mining community (STD AIDS, in HIV In Site, 2000).

The Medical Research Council reports that in the late 1990's, one in three girls were pregnant before the age of twenty. A survey conducted by the South African Demographic and Health survey found that less than 30 percent of respondents between the ages of 15 and 49 had ever used condoms (WHO, 1983)

2.5 Unemployment and Prostitution

In a country where there are still huge income disparities between Blacks and Whites, unemployment contributes to feelings of helplessness and despair. This contributes to young people engaging in prostitution, as a means of income. While some may insist on condom use with their clients, poverty plays a crucial role in that it limits their bargaining power, putting them at risk for HIV through unprotected sex (Phatlane, 2003). The services offered by prostitutes are also a product of unequal male and female power relations.

3. GENDER AND VULNERABILITY

Men have more control over the labour market, while women possess limited opportunities to achieve economic independence through the formal labour market. While women work longer hours than men (UNDP, 1995), they have less access to income and possess much less wealth. This inequality is related to the fact that women's labour is confined mainly to the domestic spheres, which do not have fiscal value. This results in economic dependence on men. Such dependency is also reflected through sexual relations, whereby females are "expected to pay for life's opportunities, from passing grades in school, to a trading license, or permission to cross a border". (UNAIDS, 1997: 4).

This dependency is a contributing factor to women's vulnerability for HIV infection. This vulnerability has a societal, patriarchal basis, in that women tend to occupy a subordinate position to men in their sexual relationships, which contributes to their general inability to refuse unprotected sex, or to negotiate the use of condoms with their partners. Heise and Elias (1995:931) states that "in large measure, women's vulnerability to HIV infection derives from their low status in society". Similarly, Hamlin et al, argues that it is the link between powerlessness and risk of HIV, which is "the key to understanding the sources of women's vulnerability" (in Heise & Elias, 1995). Heise and Elias, state that "women often have too little power within their relationships to insist on condom use, and they have too little power outside of these relationships to abandon partnerships that put them at risk" (1995, p.939).

Although women live longer than men, their quality of life is poorer than that of men. Elson (1995) has argued that there is a systematic disadvantage to women in terms of

access to food, healthcare and education. This is a product of male bias and privilege. Such bias, entrenched in the "deep structures" of society and reflected in daily behaviour, is derived from legislation, official policy and practice, political and religious ideologies and cultural conventions (Baylies & Bujra, 2000).

In African countries, women's limited access to education and lower levels of literacy, contribute to their more limited access to information about STDs and HIV. Their limited access to adequate healthcare, results in their illnesses not being treated efficiently (de Bruyn, in Baylies & Bujra, 2000). They may be subject to legal restraints, which impede their access to, or their continuity of economic resources and place them in positions of dependence on men, as fathers, brothers and husbands (WHO, in Baylies & Bujra, 2000).

In many Third World countries, women are still legal minors, or have only recently succeeded in achieving legal "equality", as adults (Akeroyd, in Baylies & Bujra, 2000). Cultural status quos (sometimes reinforced by religious ideologies) prevent women from lobbying for their needs in public spheres, which, in turn, limit their decision-making power in policy formation and change. Of course, the above constraints vary from country to country, but overall, they are a reflection of gender relations (Baylies & Bujra, 2000).

Women are also more vulnerable to male violence and coercive sex. This is also an effect of cultural factors and African patriarchal practices and beliefs (Phatlane, 2003). The HIV epidemic in young South African women begins and peaks about five years earlier than that in young men. Older men, particularly schoolteachers, can

attribute this vulnerability to sexual harassment and exploitation of schoolgirls. Almost one third of South African teenage girls report forced sexual initiation (Buga, in HIV In Site, 2000). In South Africa, a woman is raped every 26 seconds. Gang rape is also common. Annually, 52 000 women report a rape, however, police officials estimate that only 1 in every 36 victims actually report the crime, suggesting that the real figures could be in excess of one million. Urban, white, educated women, who are raped by strangers, are likely to report their cases to the police. The more common scenario, however, is that of poor, Black township women, who are raped by men they know and who do not report the case to the authorities. Of reported cases, only 7 percent are ever taken to trial (Christian Science Monitor, in HIV In Site, 2000). Violence, or the fear of violence, has been shown to reduce women's ability to negotiate condom use (Heise, 1993).

One study found that 57 percent of women living in the Eastern Cape believed that they could not refuse sex with their partner (Jewkes, 1999). The same study noted a common form of spousal emotional abuse that involves a husband boasting about his other sex partners and/or bringing them home for sex in the marital bed. Unsurprisingly, HIV prevention was discussed significantly less often in relationships with physical violence (Jewkes, 1999). Boyfriends, who claim that a romantic relationship must involve full penetrative sex, (when and how they want it), feel justified in using physical assault or threats of violence to coerce their girlfriends into having sex (Varga & Makubalo, 1996). The threat of violence or rejection prevents girls and women from insisting on condom use (Meyer-Weitz, 1998). While young women in such relationships may be violently punished for perceived unfaithfulness, their boyfriends claim the right to have multiple sexual partners (Meyer-Weitz, 1998).

It is not therefore surprising that in South Africa, more than 60 % of new HIV infections occur among 15 to 25 year olds, with adolescent girls being among the most frequently diagnosed (UNAIDS/WHO, 1998). By December 1998, women accounted for 43 percent of all people over 15 years of age living with AIDS in sub – Saharan Africa (UNAIDS/WHO, 1998).

According to a report by UNESCO/UNICEF (1993), 26 million girls do not attend school in sub-Saharan Africa, especially secondary schools. Only 14 percent of the 63 percent of school-aged females, who enroll for primary school, attend secondary school. Due to declining household incomes and the increasing costs of education, fewer girls attend schools in an already gender-biased education system (Baylies & Bujra, 2000)

This lack of education, results in these girls failing to develop marketable and professional skills that can enable them to compete equally with men in the open labour market. This results in young women resorting to either early marriage, or forming relationships with older men ("sugar daddies"), mainly for economic reasons, and therefore become more vulnerable to HIV infection. (Baylies & Bujra, 2000) When resources are scarce, the preference for sending boys to schools is exacerbated by the need to utilize girls' labour in large households, to care for the family. There is also societal pressure on girls to marry early, and to replace the older generations of women who fall ill and die, as men seek younger, uninfected spouses (Baylies & Bujra, 2000). Traditional norms and values are also challenged through economic needs. A young girl with access to wealthy men can bring home more in one evening than the official monthly minimum wage a normal worker gets. If a family is

experiencing economic hardship, some parents are tempted to turn a blind eye when their daughters help support the family by selling sex (Baylies & Bujra, 2000)

Taffa (2002) states that in Addis Ababa, Ethiopia, it was reported that gender socialization norms, peer pressure, electronic media influence and economic gains had significant contributions in shaping young people's sexual behaviour. Young girls are expected to abstain from sex, be faithful sex partners, and take prime responsibility for personal precautions against pregnancy and sexually transmitted diseases, including HIV/AIDS. By contrast, young men could be sexually active and face no sanctions, need not be faithful and could choose to say no to condom use during sex. Above all, to be a female and out-of-school youth was a serious source of vulnerability. This example of gender discrimination, which begins early in life, characterizes womanhood. It also forms part of the structural factors driving the HIV/AIDS scourge, namely poverty and inequality (Taffa, 2002).

According to Matthews (in Taffa, 2002: 7), the gendered/sexual social positioning of young women in relation to their boyfriends, obliges them not to be assertive, not to initiate, not to say no. The problem lies not in a lack of self-confidence, but "in the obligations of institutional, hierarchal sexuality, which presents itself as the truth of femininity as well as the truth of sex". Therefore, there is a tension between young women's gendered sexual/social positioning and "safe sex" discourses. However, despite the gender inequality and differences in power and privilege that accompany heterosexual relationships, the pay-off for young women who conform to norms of femininity in terms of attention and acceptance from men and their female peers, teachers and society at large cannot be underestimated (Holland et al, in Taffa, 2002).

The meaning of gender is originated from patriarchy and by institutionalized heterosexuality. Gender identity development is a process that begins in early childhood and heightens during early adolescence (Galambos, Almeida & Petersen, 1990). As the body matures, new questions of identity and new types of relationships enter the lives of adolescents in compelling ways. For instance, norms of femininity push girls to avoid conflict and attend to others' needs more than their own (Brown, 1999).

The Women, Risk and AIDS Project (WRAP), a collective of feminist sociologists conducted discourse analysis of young women's narratives about their sexual relationships. The analyses assess "the power relations within which sexual identities, beliefs and practices are embedded". The findings reveal dominant cultural perceptions of female sexuality as "passive, devoid of desire and subordinate to male needs and desires make it difficult for women to negotiate safer sex" (Holland et al, in Tolman, Striepe & Harmon, 2003, p. 6).

Therefore, failing to address the realities of gender discrimination, impede preventive efforts to prevent unwanted pregnancies, HIV/AIDS and other STD's. Fine (in Tolman, D.L., Striepe, M.I. & Harmon, T. 2003) argues that sex education in schools only focuses on victimization, morality, and disease. She reported that this silence about girls' sexual feelings (sexual pleasure and the joy of sexual relationships), were challenged by girls themselves, who did discuss sexual desire. On the other hand, Kitzinger (in Tolman et al, 2003) reports how alternative discourses of girls' sexuality

(e.g. I'm sexually attractive, but I'm powerful); require overt and ongoing resistance to negative constructions.

According to Baylies and Bujra (2000), "relations of intimacy are informed by the same cultural prescriptions and notions of personhood that operate within the larger society to influence the gender division of labour, educational opportunities, the legal system and the gendered structure of employment". Therefore, "manifestations of gender ideologies can be seen in wider society and in intimate social systems and mutually reinforce one another" (p.7). They reflect in sexual practices and sexual understandings within the sphere of private relations. This often involves general passivity for females and the prescription of sexual decision-making and initiative for men, along with the sanction of men's promiscuity both prior to and after marriage. Women are often expected to give, rather than receive sexual pleasure (Rivers et al, in Baylies & Bujra, 2000).

Pleck et al report that heterosexual boys' ideology predicts their use of condoms and other aspects of their sexual decision-making. This suggests that the more boys accept conventional masculinity (i.e. "machismo"), the more likely they are to take sexual risks (in Tolman et al, 2003). Boys' behaviour in sexual relationships, reflecting the "menacing, predatory, possessive and possibly punitive" sexuality that proves one's manhood, especially to male peers. (Kimmel, 1996:121).

This behaviour is underpinned by the social imperative not only to demonstrate successful heterosexuality, but also to deny any possibility of homosexuality and to

reject thoughts, feelings or behaviours that hint at femininity. (Tolman, D.L., Striepe, M.I. & Harmon, T. (2003)

Research on adolescent sexuality also tends to focus on either girls or boys exclusively. This reinforces the assumption of gender dichotomies and denies the correlation between girls' and boys' perceptions and expectations about femininity, masculinity and male and female sexuality (Martin, 1996).

4. CULTURAL INFLUENCES

If education and prevention programmes are to be successful in Africa, it is imperative that we understand and appreciate the traditional African worldview. Definitions of health, sickness and sexuality have different meanings in the traditional African context, than in the Western world. HIV/AIDS education and prevention programmes have mostly been based on Western principles, without incorporating or understanding the diverse cultural and belief systems of Africa into such programmes (Van Dyk, 2000).

4.1 Perception of Illness in Traditional Africa

Illness is not a random event according to tradition in Africa. Rather, every illness is a product of destiny and has a specific cause. In order to eliminate the illness, "it is necessary to identify, uproot, punish, eliminate and neutralize the cause, the intention behind the cause and the agent of the cause and intention" (Van Dyk, 2000:112). Illness, according to cultural beliefs, can be a result of "disharmony" between a person and the ancestors, by a god, spirits, witches and sorcerers, by natural causes, or by a breakdown in relationships between people (Van Dyk, 2000)

4.2 The ancestors and God as causal agents of illness

Ancestors are seen as having an integral influence in the lives of Africans. They are believed to protect against evil. H owever, ancestors could purportedly punish their people through sending illness and "bad luck", if people are ignorant of observing traditions that keep the ancestors happy. People can also cause disharmony between themselves and the ancestors if certain s ocial norms and taboos are violated (Van Dyk, 2000)

It is also believed that ancestors do not always "send" illness, but, through the withdrawal of their "protection", people become susceptible to illness, tragedy and spells cast by witches and sorcerers. The illnesses "caused" by ancestors are seldom serious or fatal and through offerings and sacrifices, a positive relationship is restored between traditional Africans and the ancestors. (Beuster, 1997)

Van Dyk (1991) states that there is no available evidence that traditional Africans link AIDS to the anger of ancestors or punishment from God. Some Christian sects do, however, believe that AIDS is God's punishment for immorality and sin.

4.3 Witches and sorcerers as causal agents of illness

Witches and sorcerers are frequently blamed for illness and misfortune in traditional African societies. (Felhaber, 1997) Because traditional Africans often use the services of witches and sorcerers to send illness and misfortune to their enemies, they, in turn, believe that whatever bad luck or illness is incurred on them, is a product of witches or sorcerers (Van Dyk, 2000).

4.4 Witchcraft and HIV/AIDS

Amongst many rural, poor and uneducated Africans, HIV/AIDS is seen as caused by witchcraft. (Boahene, 1996) In a study conducted in Zambia by Yamba (1997), more than 25% of respondents ascribed STD's to witchcraft. "Why else, they argued, "will one man become infected and the other remain uninfected when both men have had sexual contact with the same woman?" (in Van Dyk, 2000, 114).

4.5 The psychological function of witchcraft beliefs

When relationships are in conflict, or threatened, accusations of witchcraft are raised against members of a group or community. (Beuster, 1997; Hammond-Tooke, 1989) In African societies, death is only accepted as natural when the elderly die. When younger people die, it is viewed as untimely and attributed to punishment, or as the work of evil spirits and witches. (Okwu, 1978) This psychological rationale of blaming witchcraft implies Africans are not taking responsibility for their actions and are displaying an external locus of control. This viewpoint prevents people from exercising their personal initiative in preventing fatal illnesses such as HIV/AIDS (Viljoen, 1997; in Van Dyk, 2000).

Due to this misconception, many Africans cannot fully appreciate the need for engaging in HIV-preventative methods (Van Dyk, 2000). Through blaming "witches" as the cause of illness, the "victim" status suits those infected. However, this faulty belief has resulted in many witch-hunts and deaths (Seeley et al, in Van Dyk, 2000).

4.6 Implications of the belief in witches for HIV/AIDS education in Africa

By ignoring, or undermining traditional witchcraft beliefs, prevention efforts are hindered. Van Dyk (2000) believes that these beliefs should be incorporated into HIV/AIDS prevention programmes. Interventions should recognize the belief that the *personal*, or *ultimate* cause of an illness may be witchcraft, but the fact should be emphasized that the *immediate* cause is a "germ" which is sexually transmitted (Van Dyk, 2000.)

In her counseling of traditional Africans in South Africa, Zazayokwe (1989) tackled the problem of causality by saying to people that "*they* may know where the HIV infection originated, but that *she* knows what the disease does inside the body and how they can prevent contracting it" (Van Dyk, 2000:124).

Many traditional Africans believe that witches or sorcerers use sexual intercourse as the entry point for their medicines or spells to infect people with STDs and HIV (Green et al, in Van Dyk, 2000). For many years, traditional Africans have worn charms which they believe have preventative and proactive powers. (Hammond-Tooke, 1989) If the uses of these "protective" charms prevent misfortune and illness, then Van Dyk (2000) argues why the introduction of condoms "blessed" by traditional healers, cannot be used to increase their use amongst traditional people.

4.7 "Pollution" as cause of illness

Traditional Africans believe that some causes of illness can be ascribed to a failure to adequately "purify" themselves through rituals. The difference between this viewpoint ("pollution") and ancestors and witchcraft, "is that illness caused by neglect to

perform routine rituals is not actually *sent* by a person or spirit, but that they are the consequence of neglecting the proper prescribed traditional routines of everyday life" (Hammond-Tooke, 1997 in Van Dyk, 2000:117).

Ritual impurities are usually associated with sexual intercourse (especially sex with a taboo person), with the activities of the reproductive system, or after coming into contact with corpses and death. In order to cleanse oneself from "impurity", a person has to perform extensive cleansing rituals that involve washing, vomiting and purging. (Beuster, 1997; Felhaber, 1997; Hammond-Tooke, 1989)

4.8 Pollution and AIDS

Van Dyk (2000) states that although AIDS is not commonly thought to be a consequence of "pollution" or "ritual impurity", some of the sexual prohibitions may be useful in HIV-prevention programmes. For example, the prohibition against sexual intercourse with a woman during menstruation; with a widow before she is cleansed (her husband might have died of AIDS), or with women who have had an abortion or miscarriage, should be encouraged, because they can prevent HIV infection (Van Dyk, 2000).

4.9 Germs and viruses as a cause of illness: The STD-AIDS connection

Traditional Africans believe that some diseases (such as colds, influenza, diarrhoea in children, STD's and malaria) are caused by natural causes, i.e. germs and viruses (Felhaber, in Van Dyk, 2000). Although it is believed that witches may sometimes *use* germs and sexual intercourse to cause illness, traditional Africans acknowledge that the *immediate* cause of STDs is virus-related, that it is transmitted through sexual

intercourse and that it can be prevented by behaviour change (Green, in Van Dyk, 2000).

However, the link between STDs, AIDS and sexual behaviour change is often not made in traditional Africa. Many Africans do not understand that they have to alter their sexual behaviour to prevent HIV infection, since the disease affects all organs in the body besides the sexual organs (Van Dyk, 2000). The AIDS message should therefore be strongly linked to STD prevention in Africa. The knowledge and assistance of traditional healers should be actively employed in the control and prevention of HIV (Green, in Van Dyk, 2000).

Most African patients consult traditional healers for STD treatment, and they are believed to be competent in preventing the spread of STD's. Traditional healers advise their patients to: abstain from sex while undergoing STD treatment; to choose healthy sex partners who are unlikely to have STD's; not to have sex with prostitutes; and to locate and advise all recent sex partners to be treated (Green, in Van Dyk, 2000).

4.10 Traditional African Perceptions of Sexuality

Many Africans believe that children are important legacies, through whom one is remembered and through which personal immortality can be achieved. Therefore, it is an obligation for everyone to get married and if a man has no children or only daughters, he needs to find another wife so that sons may be born who would survive him and keep him (with the other living-dead of the family), in personal immortality. (Mbiti, 1969) Therefore, the failure to bear children is for African women worse than committing genocide.

4.11 Polygamy in Africa

The Western world disagrees with polygamy, yet it can assist in preventing prostitution, STDs and HIV (Van Dyk, 2000). Polygamy is valuable with migrant labour, where men leave their wives in the rural areas to seek work in the cities. If a man has several wives, he could take one at a time to live with him in the city, while the other wife/wives remain behind to take care of the household. (Mbiti, 1969)

In some societies, sexual intercourse between husband and wife is banned while she is pregnant and this abstinence is practiced until after childbirth, or even until the child is weaned. In such situations, polygamy prevents husbands from turning to casual sex (Van Dyk, 2000). Therefore, in areas where polygamy is practiced, AIDS educators cannot effectively preach monogamy. They need to emphasise loyalty and fidelity between a husband and all his wives and by discouraging sex outside that group (Van Dyk, 2000).

4.12 Traditional African perception of condoms

Taylor (1990), found that the resistance to condom use in Rwanda had nothing to do with ignorance, but related to social and cultural dimensions of Rwandan sexuality. They believe that the flow of fluids involved in sexual intercourse and reproduction is indicative of the exchange of “gifts of self “, which Rwandans regard as vital in a relationship. The use of condoms will block this vital flow between partners, and cause infertility and other illnesses. There is also fear that the condom may stay blocked in the vagina, which causes “blocked beings”.

In many parts of Africa, there is a widespread belief that repeated inseminations of semen are needed to form or "ripen" the growing foetus in the womb. It is also believed that semen contains important vitamins that are necessary for the continued physical and mental health, beauty and future fertility of women (Van Dyk, 2000).

HIV prevention programmes have largely relied on campaigns to raise public knowledge and awareness about HIV risks and modes of prevention. These preventative strategies presuppose that the informed person will take appropriate steps to change risky behaviour, to reduce exposure and possible infection. (Stadler & Hlongwa, 2002). In South Africa, there are a wide range of prevention programmes currently being implemented including: distribution of condoms and other protection measures, voluntary counseling and testing, as well as mass media campaigns. Two such media campaigns will be evaluated, namely, loveLife and Soul City.

5. EXISTING HIV/AIDS PROGRAMMES IN SOUTH AFRICA

5.1 LOVELIFE

5.1.2 Background and Aims of loveLife

LoveLife is a programme that is based on the premise that the prevention of AIDS is dependent on changes in sexual behaviour. They state that the key to success is open communication about sex and early sexual education (Stadler & Hlongwa, 2002). Backed by the Melinda and Bill Gates foundation, Bill Clinton and the Kaiser Foundation, it is financially able, through high-powered media awareness and education, to provide adolescent-friendly reproductive health services, as well as outreach and support programmes (loveLife, 2001).

LoveLife is a national programme that aims at positively influencing adolescent sexual behaviour by advocating a new lifestyle for young people based on informed choice, shared responsibility and positive sexuality. This campaign advocates that the best opportunity to positively impact on adolescent behaviour is prior to the onset of sexual activity (Stadler & Hlongwa, 2002).

LoveLife aims at achieving a 50% reduction in the rate of new HIV infection among 15-20 year olds by the end of 2005. It combines media with nation-wide adolescent sexual health services and outreach programmes. Lovelife specifically targets youth between the ages of 12-17 years (Stadler & Hlongwa, 2002). According to loveLife (2001), sixty percent of South Africans nationally recognize their brand, with 90% of these correctly identifying the brand with "healthy living and positive lifestyle". (Stadler & Hlongwa, 2002). Introduced in 1999, loveLife "reached" more than four million youngsters in the first year (loveLife, 2001).

5.1.3 LoveLife's strategies

Creating Awareness through the media

According to Stadler and Hlongwa (2002), during the first year of lovelife's inception, they focused on creating awareness of the loveLife brand and messaging. This was done through a national, multimedia awareness campaign, implemented in four phases.

Phase I: This was initiated by a "teaser" called "Foreplay", designed to create anticipation and curiosity. This was followed a month later with a "reveal" campaign,

consisting of the loveLife brand prominently displayed across the "Foreplay" billboards.

Phase II: consisted of expanding the number of billboards, as well as advertising on mini-bus taxis and printing brochures and leaflets about loveLife. This phase was also reiterated by the launch of the first loveLife television series, "Jika Jika", and the toll free telephone help-line. The print media campaign sought to test the waters regarding popular opinion concerning loveLife, especially that of conservative sectors of the population.

Phase III: included the launch of loveLife's second television series called "Scam'to" and publication of "The Impending Catastrophe", a comprehensive analysis of data on the AIDS epidemic and statistical predictions to anticipate the epidemic's impact on a range of sectors. 1.5 million copies of the publication was printed and distributed free of charge to the public. (Stadler & Hlongwa, 2002)

Print Publications

LoveLife produces two weekly teenage print publications – "thethaNathi, distributed in newspapers such as: "The Star", "Pretoria News", "Cape Argus", and in "Daily News". "S'camto PRINT, is distributed by "Sunday Times". These publications have been criticized for containing sexually explicit material. Commenting on these images, Warren Parker (a public health communications expert and Director of the Centre for AIDS development), asks: "What is the point and what is really being achieved?" He furthermore doubts that this can contribute to HIV prevention. Harrison (CEO of loveLife) argues that the pictures are intended to attract youths'

attention, so that they will read the contents. However, many young people interviewed state that many images may even reinforce the very behaviour loveLife seeks to discourage (Delate, 2003: 35).

Television Programmes

There are two loveLife television series a year. "S'camto Groundbreakers", is a weekly television series that features youngsters discussing issues such as HIV/AIDS, sexual health, relationships and peer pressure. "loveLife Games", on the other hand, is a series that shows scenes from the lovelife Games, where teenagers from all over the country participate in an Olympic-style sporting event (Delate, 2003).

Groundbreakers and peer educators

Central to loveLife's outreach programmes, are the "groundbreakers"- a volunteer corps of approximately 600 youth between the ages of 18 and 25. The Department of Social Development and the Nelson Mandela Children's Fund support this initiative. The participants are selected from formal applications submitted to loveLife. Trained by the Planned Parenthood Association of South Africa (PPASA), in sexual health counseling, motivational and leadership skills, groundbreakers receive an allowance of R800 a month to educate their peers about HIV and other sexual-health related issues in schools and other social areas. They also lead life-skills, sport and other recreational activities (Delate, 2003).

Y-Centers

There are currently sixteen centers in impoverished areas across South Africa. Each one costs approximately R1.25 million to establish, and costs a further R1 million a

year to maintain. They consist of a 'vitality centre', which is overseen by a nurse who provides counseling, advice, pregnancy testing and treatment for sexually transmitted diseases. They also offer motivational and self-development training programmes, recreational facilities, basketball courts, computer training and a radio studio (from where music and talk shows are broadcast). LoveLife publications claim that over 3000 youngsters visit each of its Y-centres every week. (Delate, 2003). It has been reported, however, that many youth only visit these centers because of the recreational facilities and not for educational purposes. (loveLife, 2001).

Adolescent-friendly clinics (NAFCI)

There are sixty government-sponsored clinics, each consisting of brightly coloured youth sections that include a "chill" room, a counseling room, a recreational shed and basketball courts. In addition to personnel who are trained by government and loveLife to provide adolescent-friendly services, a "groundbreaker" has a dedicated corner in the adult section of the clinic, where parents are provided with information on how to talk about sex with their children (Delate, 2003).

5.1.4 Limitations of loveLife

The first limitation is that intervention programmes, such as loveLife, rely heavily on the media to relay their messages. People living in poor areas do not always have access to television, radio or the Internet, as forms of communication.

Secondly, teenagers mostly access their youth centres for recreational purposes (basketball courts and games rooms), and not for the use of clinical and advice services, i.e. AIDS help lines and health clinics (loveLife, 2001).

Love Life's messaging and programmes are unfortunately only in English. This certainly has an impact on the large majority of Black teenagers, as they may not fully understand the positive life messaging. Organisations, such as National People Living with AIDS (NAPWA), furthermore question loveLife's cultural relevance and appeal. LoveLife's messaging brands seem far too American, disregarding cultural barriers to sexuality (Delate, 2003).

Most of their billboards adopt an overly explicit sexual approach. In many traditional and conservative sectors of African, Muslim and Christian society, it is offensive for women to be photographed in a scantily dressed manner. Such an example is found in a picture on the front cover of a "thethaNathi", which was intended to promote abstinence, and is entitled, "Like a Virgin" (taken from a song by the pop singer Madonna). This picture portrays a young girl only wearing a chastity belt and tight brassiere-like top. A young woman that was interviewed regarding her opinion about the advertisement remarked that this picture was "kinky" (a provocative, sexual superlative). Another interviewee stated: "the average young person doesn't understand what this thing with chains is. They think it's just a kinky belt because it's leather, it's black, and she's wearing a kinky top. They think this is just a "sex-game type of thing" (Delate, 2003: 35). Also, the use of Madonna's song ("Like a Virgin") reinforces the double-message, as she is the opposite of a chaste, moral virgin. In fact, one could definitely question the aim of this ironic and tasteless image of virginity, as Madonna (her name itself a mockery of the archetypal Virgin Mary), dresses in this explicit manner to defy society's traditional perception of women as chaste beings. Furthermore, this reinforces the gender stereotype of women as sexual objects.

Another loveLife billboard depicts a Black man holding a White woman's bare breasts. In the picture, she is gesticulating a "peace" sign and the caption reads, "The future's so bright. Uncovering 2002" (Delate, 2003:35). The aim of this message is vague. It is not certain whether this advertisement is aimed at improving race relations with regard to interracial relationships, or freedom in sexual expression (the depiction of a half-naked woman). Whether this promotes safe sexual behaviour, or the awareness of sexually transmitted diseases, is unclear, or even non-existent. Once again, this billboard (as with the "Like a Virgin") billboard seems to reinforce a gender stereotype, depicting women as sex objects.

Even Tim Modise (a member of loveLife's advisory board), describes the general feeling towards loveLife as "mixed". He says that although the campaign has made AIDS an "everyday, in-your-face issue", he admits that some messages are "abstract, with the emphasis more on sex itself, than on relationships". He also argues "maybe the messages are not culturally and religiously sensitive" (Delate, 2003:34)

Additionally, while loveLife may create awareness, it is just a first step in a long-term process of impacting on actual attitudes and behaviour. Public health communications experts also accuse loveLife's messaging as being too vague and often contradictory, which undermines the aims of the campaign by positioning sex as being "hip" and "cool", with less emphasis on safer sex (Delate, 2003).

With a R200 million annual budget, loveLife is possibly the best-funded campaign n the country. A similar AIDS awareness campaign "Soul City", has a total annual

budget of R35 million. Of loveLife's R200 million budget, R37 million is allocated for television, radio and print advertising. Its total media budget each year is R78 million, and according to the organization, the majority of funding can be used for sexual and reproductive health services (Delate, 2003).

However, according to John Farquhar, editor of 'Advantage" magazine (a trade magazine for the advertising and media industries), loveLife has more buying power in terms of advertising, than most brands in South Africa, including private corporations. This means that loveLife has the capacity to effectively address HIV/AIDS within its target market. The question Farquhar raises is whether the R200 million budget is being used effectively. He also says that it's very difficult to measure social programmes, as advertising cannot solve social issues (Delate, 2003).

The commercial contracts loveLife has with many of the country's major media houses are causing some concern among non-governmental organizations (NGO's), working with HIV/AIDS and targeting the same youth market as loveLife. Many of these organizations report that it is difficult for them to distribute their material through the media, which they often used to do free of charge. They claim that multimillion rand commercial deals between lovelife and media groups are making the approach to HIV/AIDS more about money, than about the media's responsibility to a social pandemic (Delate, 2003).

According to Mark Heywood of the Treatment Action Campaign, a proper assessment of all AIDS prevention programmes needs to be implemented. He argues, "loveLife is not the first organsiation that is spending large amounts with little effect". However,

loveLife's CEO David Harrison, states, "although there is no definite proof of success, loveLife appears to be on the right track". On the other hand, David Patient (an AIDS activist), argues that loveLife's 1600 multi-coloured billboards are "ambiguous, obscure and abstract" (Delate, 2003:34)

An advisory board of international public health experts covened by loveLife has also criticized the vagueness of the messages and called for the billboards to make the link with the services that the campaign is providing (Delate, 2003).

5.2 SOUL CITY: IHDC

5.2.1 Background:

Soul City: Institute for Health and Development Communication (Soul City: IHDC), is a South African Non-Governmental Organization. It was established in 1992 to harness the power of the mass media and to promote health and development in South Africa and other African countries (Soul City, 2002a).

Through drama and entertainment, Soul City reaches about 20 million South Africans and many others in the Southern African region. Soul City makes information popular and accessible. It examines many different health issues and empowers learners to make healthy choices, both as individuals and in communities (Soul City, 2002a).

5.2.2 The Soul City project consists of:

- A prime time television series
- A daily radio drama

- Three booklets on health topics covered in the broadcast media
- A publicity campaign which keeps people talking and thinking about Soul City
- Adult education and youth life skills materials
- A children's edutainment vehicle called "Soul Buddyz"

Television

This consists of six series of thirteen episodes each. Each series boasts a greater audience than the preceding one. Over the last three series, Soul City TV has been one of the most watched programmes in the country. Soul City TV has won multiple awards for drama, as well as education.

Radio

Six series of Soul City radio programmes are broadcast.

Print media

Fifteen information booklets with a combined distribution of over 17 million copies are utilized. The topics of these booklets range from: entrepreneurial skills, violence against women, and HIV/AIDS. Approximately 60 % of the content has dealt with various aspects of the HIV/AIDS epidemic (Soul City, 2002a).

Life skills

The popularity of Soul City has allowed them to undertake a number of other interventions. These have included:

- A grade 8 life skills pack, based on the TV drama. This was distributed to all grade 8 learners in schools across South Africa (900 000 learners in total).
- A grade 9 life skills pack, based on the TV drama, distributed to all grade 9 learners in the country.

  Life skills dealt with included the following topics: 1) Getting to know one's body; 2) Identity: "Who am I"; 3) Building relationships; 4) Talking about sex; 5) Love and sex; 6) Staying safe; 7) Understanding HIV and AIDS; and 8) Living with HIV and AIDS in our world. (Soul City, 2002b)

- Interactive learning materials on HIV and AIDS, mother and child health, water and sanitation, and violence against women have also been produced. According to Soul City, at least a million people have accessed these materials.
- An annual "Soul City Search for the Star Competition" which recruits novice actors to the television industry.
- An annual "Soul City Health Worker of the Year Competition" which honours and publicises community-based health workers doing outstanding work.
- Large scale advocacy campaigns that have successfully impacted on health policy. These include efforts to implement the Domestic Violence Act and work to ensure that needy children have access to social security (Soul City, 2002a).

5.2.2 Soul Buddyz

Soul Buddyz is a co-production between Soul City (IHDC) and SABC Education. This is an effective partnership, as it brings together two sets of expertise and commitment to excellence in education, children's television and health communication. Key topics in the Soul Buddyz intervention are: AIDS and Sexuality,

trauma (which includes bullying, abuse, road safety and accidents), and disability (especially the rights of children with disabilities). It is a multimedia intervention aimed at 8-12 year old children and their parents. The first series was instituted between the years 1999 and 2000. Soul Buddyz consists of:

- Two series of Soul Buddyz TV, consisting of 26-part half-hour dramas. The first series was the most popular children's show in South African television history.
- Two series of a 26-part radio magazine show in nine languages.
- Two million copies of two parenting booklets: 560 000 of which were distributed through the Sunday Times and through non-governmental organizations.
- Two grade seven life skills books that are based on the television component and distributed to all grade seven learners countrywide. The book is designed in compliance with Outcomes Based Education (the National Educational Curriculum) (Soul City, 2002b).

5.3 Evaluation of the efficacy of Soul Buddyz

- The first series was independently researched. Results show that it was thought to be the most successful family television show ever produced in South Africa. It has been re-broadcast four times.
- After only one season of broadcasting, 74% of respondents aged between 8 to 13 years, recognized Soul Buddyz, with 67% reporting that they have watched, listened to, or used the primary Soul Buddyz material (television, radio, or the grade 7 booklets).

- 92.9% of caregivers, who have been exposed to Soul Buddyz television and radio media, reported that this intervention had given them a new understanding of challenges children face.
- Both quantitative and qualitative analysis indicates that Soul Buddyz is relevant to its primary target audience. Messages were reported to be transmitted accurately, explicitly and that message retention was high.
- Factors such as the extent to which life skills are taught in schools, interpersonal discussion of topics, parental values, as well as demographic factors, such as race, sex, urban or rural residency, are often better predictors of desired responses, than direct exposure to Soul Buddyz media. However, Soul Buddyz material has been reported to impact directly on these interpersonal and environmental factors.
- 36% of teachers utilized the Soul Buddyz Life Skills booklet for grade seven learners and 32% made use of other Soul City materials in preparing their life skills lessons.
- 81.2% of children, who had watched all or some Soul Buddyz television episodes, reported that these programmes had assisted them in dealing with daily events in their lives.
- Soul Buddyz plays a dual role in interpersonal and environmentally supportive factors (particularly with reference to discussion of topics with parents, peers or teachers). It seems to play a positive, facilitating role and "fills the gap" where either above-mentioned parties are absent or ineptly equipped to deal with pertinent issues. Where open rapport does exist, Soul Buddyz serves to reinforce the positive impact of these discussions. Therefore, Soul Buddyz seems to serve

both a facilitating and supplementary role in terms of interpersonal communication.

- The areas, in which Soul Buddyz seems to have had the least consistent impact, was knowledge of what to do in the case of accidents and trauma.
- The areas in which Soul Buddyz seem to have had the most consistent impact are:
    - The quality and frequency of interpersonal communication or discussion of issues.
    - Destigmatization and tolerance for diversity.
    - Youth sexuality.
    - Peer Support (Soul City, 2002b).

5.4 Evaluation of the efficacy of Soul City

- 47% of members of the South African public spontaneously quoted Soul City as their leading source of information on HIV and AIDS on television. An evaluation of the Radio show showed similar results.
- Soul City's multimedia intervention reaches 79% of South Africans. This includes 65% of rural people and 50% of people without any formal education. According to Soul City, this is more than any other social change intervention. .
- In terms of impact, the evaluations of the Soul City series show that there is a strong statistical association between positive change and Soul City exposure. Both qualitative and quantitative evidence show that Soul City has played a major role in increasing accurate knowledge about HIV and AIDS. This evidence also indicates a shift in people's attitudes, subjective social norms, as

well as direct practice towards sustaining increased safer sexual behaviours and a number of other health behaviours.

- A brand analysis conducted with Black South Africans, has indicated that Soul City is as well known as Coca Cola. Soul City is also perceived as a trusted source of help and information.
- Cost analysis has indicated that the cost per person reached by television is R0.44, by radio is R0.05, and via print is R0.05. The cost of mobilizing people regarding HIV/AIDS has been R2.70 per action measured (Soul City, 2002a)

Having discussed the HIV/AIDS programmes in this country, it has now become necessary to turn the discourse to more general aspects concerning attitude changes relating to safe sex practices.

6. CHANGING ATTITUDES AND BEHAVIOUR AMONGST YOUTH

Much of the research related to risk-reduction behaviour, focuses on attitudes, susceptibility, beliefs and efficacy. Catania, Kegeles & Coates (1989), studied the motivational components of sexual involvement among American, adolescent girls and their use of condoms. The authors assessed several beliefs and attitude variables in relation to frequency of condom use. The only significant factor was perceived lack of sexual enjoyment with condom use. In addition, self-perceived ability to communicate about condom use was also significantly related to frequency of use. The total number of sexual partners over the past year was significantly related to predictor variables, including: self-perception toward vulnerability in contracting sexually transmitted diseases, poorer sexual communication with primary partners and greater peer acceptance of being sexually active.

Catania et al (1989) further reported that youth are at a relatively high risk for STDs and AIDS, with self-reported early initiation of sexual activity, relatively high levels of vaginal intercourse and low rate of condom use. The researchers also concluded that a low level of the ability to communicate with primary partners about sex, might indeed lead to engagement with multiple partners, further increasing the risk level. Also, if one were part of a peer group that endorsed sexual activity, then the likelihood of non-engagement would be low. It was reported that if an individual perceived to be invulnerable to sexually transmitted diseases, then greater sexual involvement and a low frequency of condom use would be evident.

The study by Catania et al (1989) does not allocate adequate sexual responsibility for the male partners of these teenage girls. It seems as if the researcher has taken a judgmental stance in terms of "weak" females, who are not assertive in sexual activity. Gender inequality and patriarchal influences are not addressed. Even in First World Countries, such as the U.S.A, women are socialized to be passive in communicating their needs. If researchers and health care professionals are to be effective in changing popular opinions, then we need to aggressively challenge double standards in our societies.

For instance, teenagers are bombarded by media images of the "coolness" of engaging in sexual activity. Films and magazines almost always emphasize the social acceptability of being sexual active, without adequately depicting the dangers of risky sexual behaviour. Additionally, the beauty industry generates huge amounts of wealth through the sale of diet and beauty products. This encourages youngsters to focus on

their outward appearance in order to be socially acceptable, without emphasizing positive self-esteem and values.

In a similar study, Rickman et al (1994), investigated condom use and communication of sexual history. With over 2000 participants, they found that although two-thirds of the youth surveyed did not use condoms regularly, those who did were those who communicated with their partners about sexual history. They strongly suggested that any intervention programme include components targeted at communication practices. They also noted that, simply "knowing" that communication and lack of condom use are correlated, is insufficient for targeted interventions.

The researchers in this study argue that, it is essential to further explore the content and scope of communication, i.e. number of partners, feelings about condom use, and frequency or ratio of such conversations, to ascertain which aspects of communication are most predictive of risk-reduction behaviours. They state that researchers should also investigate how adolescents learn the negotiation and communication skills they use.

Peer influence is also vital when engaging with teenagers. DiClemente (1991:389), noted that, "if adolescents, even high-risk adolescents, can be convinced that their use of condoms is consistent with referent-group norms, they may be more likely to practice low-risk behaviour". Furthermore, if a teenager were, for example, part of a Christian youth group that advocated abstinence, and pre-marital sex were considered deviant, then he/she, would be less likely to engage in sexual activity.

However, as discussed previously, even institutions such as the Church, are part of a more media-bombarded, secular society. Even if celibate teenagers were celebrated by a significant peer group, individual perception of the advantages and disadvantages of pre-marital sex, need to be taken into account. Instead of teaching the catchphrase of saying "no" to sex, churches, schools and parents, need to educate youth about the beauty of sex. In addition, youth need to be educated about the dangers of the abuse of sexual activity for instant gratification without pre-considering the emotional and physical dangers associated with this.

Making sex and sexual discussion taboo, only reinforces the subliminal message of endorsing sexual practices, as youth tend to be more attracted to that which is risky and exciting. Positive behaviour can only be sustained if it forms part of a personal value system and not an external restriction placed on youth.

6.1 The effectiveness of using Psycho social theories to explain and prevent risky behaviour

The initial reaction of public health authorities in many countries, as they tried to cope with the AIDS epidemic, was to try to persuade individual and targeted groups to change their behaviour by providing them with relevant information about HIV/AIDS. However, research has shown that if behaviour is to be modified, we need to do more than supply correct information to vulnerable groups (Van Dyk, 2000).

According to Fishbein, "the AIDS epidemic is much too serious to allow interventions to be based upon some educator's untested and all too often incorrect intuitions, about

the factors that will influence the performance or nonperformance of a given behaviour in a given population." (In Melkote, Muppidi & Goswami, 2000:18)

According to the Theories of "Reasoned Action" and "Planned Behaviour", people are seen as "reasonable" beings that systematically process and use all information available to them, when they plan their behaviour (Ajzen, 1991; Fishbein, 1975). To change other's behaviour, it is therefore necessary to understand and change the cognitive structures that govern specific behaviour. Health care professionals cannot understand and help change a person's behaviour if they do not have an appreciation, or understanding, of that individual's intentions, beliefs, attitudes, subjective norms and his/her self efficacy (Van Dyk, 2000).

The Health Belief Model and Theory of Reasoned Action, base themselves on cognitive determinants to bring about behaviour change. In other words, these theories advocate that a change in one's thoughts concerning life events and personal choices, determine a change in behaviour (Melkote et al, 2000). However, Bandura (1994), states that "to achieve self-directed change, people need to be given not only reasons to alter risky habits, but also the behavioural means, resources and social support to do so. It will require certain skills, self-motivation and self-guidance" (p. 25). This argument is particularly pertinent in the context of AIDS awareness and prevention.

Self-efficacy and social modeling are two elements of Bandura's theory that have been used widely in AIDS prevention campaigns (Freimuth, in Melkote et al, 2000). Self-efficacy refers to a person's belief in his/her personal ability, which determines

what course of action that person will choose, how long it would be sustained in the face of resistance, and his/her resiliency to persevere after crises (Melkote et al, 2000).

Social modeling is based on the principle that people subconsciously do what is "normal" through observing the actions of others. Furthermore, an individual is more likely to assess his/her capabilities, through observing the coping mechanisms of his/her significant peers. In other words, if one observes significant others as being capable of overcoming obstacles, then he/she would not doubt his/her own ability in similar situations (Melkote et al, 2000).

Both the "Theory of Reasoned Action" and the "Social Cognitive Theory", fail in their assumption that individuals have unprecedented control over their behaviour. These theories do not give account for the influence of socio-demographic variables over behavioural choices. For example, "low socioeconomic background; low parental education; residing in a female-headed household; and residing in households with a large number of children are not in the theory, but have been linked to heightened sexual activity." (Jemmot & Jemmott,1994:149).

Although psychosocial theories have provided conceptual frameworks that have contributed to the creation of AIDS prevention campaigns, they have not been reliable predictors of behavioural change. They have preconceived perceptions regarding an individual's behaviour. There is no evidence to predict that good intentions to behave in a certain way, and self-efficacy beliefs to do so, automatically lead to the execution of the positive behaviour (Auerbach et al, in Melkote et al, 2000).

In fact, it has been proven that the contrary is usually the norm. These models assume that individuals make calculated, informed decisions before engaging in sexual activity. Sexual behaviour, however, is not only impulsive, but also driven by physiological needs (Melkote et al, 2000).

Furthermore, according to Auerbach et al (in Melkote et al, 2000:19), the theoretical models do not account for socio-cultural variables which impact on behaviour, such as gender and racial/ethnic culture: " gender roles and cultural values and norms influence the behaviour of women and men and the nature of the relationships in which sexual activity occurs".

Unsafe sexual practices often are not the result of a deficit of knowledge, motivation or skill, but instead have meaning within a given personal and socio-cultural context. For example, an educated Black woman in South Africa, who sanctions her husband in engaging in extra-marital affairs, may fully comprehend the risk of contracting HIV/AIDS. However, she may feel obliged to comply with socio-cultural norms regarding the elevated status of men and their "rights" in having multiple partners.

Also, people who are poor are not only economically deprived, but also find themselves with severely restricted access to information. This has led to an unequal distribution of knowledge in the population resulting in "knowledge gaps", between people of low and high socioeconomic status (SES).

However, people will only change their behaviour if they perceive the new behaviour as potentially effective, beneficial and practically feasible (Rosenstock, in Van Dyk, 2000). The probability of a person changing his/her behaviour therefore depends on that person's perception of the benefits or rewards that will be gained from the new behaviour, as well as that person's perceptions of the disadvantages, or barriers that will result from changed behaviour. Researchers have discovered that people are prepared to change their sexual behaviour in different ways, if they perceive that this behavior is beneficial (in the sense of decreasing their risk of infection), and if they know that they have social support (from significant others and the wider community) (Montgomery et al, in Van Dyk, 2000)

One of the primary reasons why people do not alter negative behaviour, is because they perceive the existence of obstacles that (in their perception) hinder the possibility of behaviour change (Janz et al, in Van Dyk, 2000). Research (Van Dyk, 2000, p.88-89) regarding the prevention of HIV infection, identified the following factors as hindrances to sexual behaviour change:

6.2 Factors that hinder sexual behaviour change:

i) "People will abandon all attempts to use condoms if they find it stressful to initiate or to maintain the behaviour. For example, condoms are generally not available and easily accessible. Youngsters will generally not make an effort to obtain condoms, if they are not readily available. They are either too ashamed to ask for them at clinics, or in pharmacies. Also, they might not be able to afford them, especially since they do not make use of the clinic's supply of free stock. In a Zimbabwean study, students stated that

inaccessibility, lack of privacy (problems about storing condoms for future use, in the fear that parents might find them), and an inability to effectively communicate to their partners about the importance of using them, impeded the frequency of their use."

ii) "Society's intolerance towards certain sex practices and safer sex makes it more difficult for people to change their behaviour". For instance, cultural norms and values favouring patriarchal practices such as fertility testing and early sexual initiation for males, or conversely, the Catholic Church views the use of birth control and condoms as sacrilegious.

iii) "Unsupportive sex partners and peers lead to abandonment of all attempts at safer sex. Research found that people often do not use condoms, as they do not want to offend their sex partners, or because they are afraid that their partners might leave them. Partners often refuse to use condoms because it "feels different" and because of the stigma attached to the use of condoms. Condoms are of ten associated with syphilis and uncleanliness".

iv) "The lack of communication skills is one of the greatest obstacles that stand in the way of behaviour change. People find it difficult to ask partners to use condoms-especially if they don't know their partner well. They are also afraid their partner might think they have AIDS. Women, in many cases, do not have the power to negotiate condom use with their partners or husbands".

v) "A fatalistic attitude to life hinders sexual behaviour change. Many young South Africans, for example, currently believe that they are at much greater risk from the possibility of violence than from the possibility of infection by HIV".

vi) "The use of alcohol and recreational drugs limits the power of individuals to make informed choices. These substances tend to inhibit their "responsibility threshold".

Van Dyk (2000) argues that it is up to health care professionals to identify the barriers that stand in the way of safer sex practices, and to help people overcome these obstacles. She states that people are more likely to change their behaviour if the rewards inherent in changed behavior are made obvious. For example, if youth are exposed to people who are already inflicted with the HIV virus, and are made aware that they need to make decisions early for longevity and a brighter future, then they would be more readily able to make connections between risky behaviour and impending illness and death. They also need to be motivated in achieving educational goals as incentives for prosperous futures.

According to the "health locus of control theory", people who believe that they have no control over their own health (external locus of control), will be less inclined to get involved in preventative behaviour, than people who believe that they are able to influence and control their health (internal locus of control). Those who have an external locus of control believe that they don't have much control over their own health, because their health depends on external factors such as luck, cha nce, fate or

other people. The assumption is therefore that people with an external locus of control, will often not do much to prevent illness or to improve their health (Van Dyk, 2000).

According to Van Dyk (2000), research on locus of control and sexual behaviour, have generally found that people with an internal locus of control, will be more inclined to change high-risk sexual behaviour, than people with an external locus of control. Locus of control is also a cultural issue. Many African cultures believe that disease is something beyond their control and attributed to the ancestors, and spiritual sources (as discussed before). Van Dyk (2000) states that health care professionals who work in Africa should accept the fact that many Africans ascribe to an external locus of control, and that we need to work within this framework, instead of trying to nullify it. The family, community and peer counselors should be involved in prevention projects, as they have the authority and status to dictate sexual norms and customs (Van Dyk, 2000).

7. THE IMPORTANCE OF LIFE SKILLS IN PROMOTING POSITIVE BEHAVIOUR

A study conducted by the World Health Organization confirms that school health education programmes that focus only on knowledge may fail to foster the skills, attitudes and support that can assist in reducing the prevalence of sexually transmitted diseases. The development of appropriate knowledge, skills and attitudes must therefore be considered as core objectives of any such programme (WHO, 1992).

Educational authorities must join forces with community leaders, health authorities, teachers, parents and youth in devising objectives, which are in accordance with the programmes objectives. Life skills that are imperative in any AIDS prevention programme include: Communication (including listening skills), self-awareness, information gathering (resources), creative thinking, a sense of responsibility, conflict resolution, refusal skills, positive self-esteem, goal setting, critical thinking, decision-making, handling emotions, self-discipline, assertiveness, negotiation, and delaying gratification (in order to meet long-term objectives) (Schonfeld, 1996).

Therefore, the goal of any life skills programme is to empower youth with skills to assist them in making informed decisions regarding their sexuality, as a first and critical step toward curbing HIV/STD infection. Similarly, researchers of a study concerning the implementation of Sex education in South African schools, state that although the crux of any Sex Education programme is to reduce the incidence of sexually transmitted diseases, it is believed that HIV infection should not be viewed in isolation. A holistic approach focusing on developing decision-making skills and increasing self-efficacy and self-confidence among teenagers would enable them to behave in a mature and responsible manner (C.A.S.E., 1998).

Verbal communication skills, negotiation skills and problem-solving skills are all necessary, before one can get one's partner successfully to commit to safer sex behaviour. Health care professionals should assist people to practice their communication and negotiation skills through experiential activities, such as modeling and role-play (Van Dyk, 2000).

According to Van Dyk (2000, p.154-156), HIV/AIDS education should comply with the following requirements if it is to be successful in schools:

i) "HIV/AIDS education should never be presented in isolation. Children may acquire an irrational fear of the disease. Such a distorted emphasis may interfere with the child's healthy sexual development because the child may become accustomed to equating sex with disease and death.

ii) HIV/AIDS education should preferably form part of a life skills education programme, which includes sexuality education, as well as information on HIV and AIDS.

iii) HIV/AIDS information can also be integrated into the existing school curriculum, either as part of other health-related subjects, or with one or more subject areas such as biology, science, social science and religious studies.

iv) HIV/AIDS education should begin as early as the junior primary school phase. At this early age, the child's behaviour patterns have not yet been formed and they are very receptive to the principles that govern healthy behaviour.

v) HIV/AIDS education should be an ongoing process. A single lesson or video is insufficient, because it is necessary to begin instilling the life-skills one needs to prevent HIV infection at a young age.

vi) It is important to include parents, community leaders and spiritual leaders so they make an active contribution to all stages of programme development. The full support of all community stakeholders needs to be sought, to reflect the whole spectrum of religious, cultural and moral values found in any particular community.

vii) The CDC (1988) recommends that the **class-teacher** should teach HIV/AIDS education, especially in the lower grades, because of the familiarity they share with children. Teachers are also best equipped to use teaching strategies that are appropriate to the children's age group. It is preferable for specially trained guidance or life skills teachers, to present HIV/AIDS education and life skills training in the more senior or secondary grades.

viii) The teacher should feel comfortable with the content of the HIV/AIDS curriculum and should be a role model with whom learners can easily identify.

ix) HIV/AIDS education that focuses on problems, while ignoring sexuality as a normal aspect of all human life, may well impede the normal sexual development of the child. Children must be made aware that sexual feelings and impulses-which are presented from birth-are both pleasant and normal. However, they must be informed that, although sexual feelings are normal, the active expression of sexuality is not appropriate behaviour for young children (Quackenbush et al, 1988).

x) Sexuality and HIV/AIDS education should always be tailored so that it is appropriate to a child or teenager's particular developmental stage. It is therefore important to have a clear understanding of the degree of cognitive, emotional, social, moral and sexual development in children in specific age groups so that the sexual education will be appropriate and suited to the developmental stage of the child. Teachers should always remain sensitive to individual and cultural development needs and differences and adjust their education programmes accordingly."

8. CONCLUSION

As evidenced above, the HIV/AIDS infection is the leading cause of mortality amongst sub-Saharan people. Despite increased media awareness surrounding the epidemic, many people (especially youth), still engage in unsafe sexual practices. Youth account for the highest age group affected by the disease. As most children and teenagers attend school, the educational system is an excellent avenue through which sex education, and the necessary life skills to apply knowledge, could be taught. However, as previously noted, sex education and life skills should be done in cognizance with cultural and religious practices. Media programmes such as "Soul City" which work collaboratively with schools should continue to optimize their efficacy. The content, efficacy and implementation of the existing Life Skills and Sex Education programmes in South African schools, will be investigated in future research.

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