

**ADOLESCENTS' PERCEPTION OF RISK OF AIDS AND CONDOM
USE**

Mbongeleni Thembalihle Mgwaba

Submitted in partial fulfilment of the requirement for the degree of Master of Science in
Urban and Regional Planning (Development Studies),
University of Natal, Durban (2002)

Declaration

This dissertation represents my original work and has not been submitted in any other form to any University. Where use has been made of the work of others it has been acknowledged and referenced in the text. The views expressed in this paper are that of the author and do not represent that of the organisations or people involved in the “Transitions to Adulthood in the context of HIV/AIDS” study.

06/12/2002

Acknowledgement

My special gratitude goes to my supervisor, Ms Pranitha Maharaj, without whose guidance, assistance, and professional advise this dissertation would not been a success.

I would like to thank my family, my friends and colleagues who have motivated, helped and supported me whilst writing this dissertation. In particular I would like to thank my mother, Mrs. Busisiwe Mgwaba, for being so strong always. I would also like to thank all the members of staff at the School of Development Studies who have directly and indirectly helped. I would like thank Ntsiki Manzini for always helping where she can, Lesley Anderson and Kanagie Naidoo for the excellent administrative service they rendered during all the time I have spent in the School of Development Studies. I would also like to thank God for all the strength He has given in completing this dissertation. In this instance

I like to thank the brethrens, from Eshowe in particular, for their love, emotional and spiritual support. Financial assistance from the following donors is hereby acknowledged:

- ❑ Mellon Foundation
- ❑ National Research Foundation
- ❑ Graduate Assistant Scholarship

Abstract

A significant proportion of people living with HIV/AIDS are aged 15-24. The aim of this study is to investigate adolescent's perception of risk of AIDS and their use of condoms. The study draws on focus group discussions with adolescents in two districts in KwaZulu-Natal. The study found that awareness of AIDS is high. Most adolescents had heard of AIDS. However, there were some common misconceptions about AIDS. African adolescents are more likely to perceive themselves at risk than other race groups. Perception of risk is important to promote protective behaviour. There are however many barriers to condom use. One of the major barriers to condom use is the association of condoms with lack of trust.

[Handwritten signature]

Contents

1.	Introduction	
1.1.	Background	1
1.2.	Purpose of Research	2
1.3.	Conceptual Framework	3
1.3.1.	Health Belief Model	3
1.3.2.	Theory of Reasoned Action	4
1.3.3.	Social Cognitive Theory	5
2.	Global Overview of the HIV/AIDS Epidemic	
2.1.	Global view of the epidemic	7
2.2.	African countries	8
2.3.	South Africa	9
2.3.1.	Progression of HIV/AIDS epidemic	9
2.3.2.	Age Specificity	11
2.3.3.	Demographic Implications	12
2.3.4.	The socio-economic effects of HIV/AIDS Epidemic	13
2.3.5.	HIV/AIDS and gender	15
3.	Literature Review	
3.1.	Introduction	16
3.2.	Perception of Risk	17
3.3.	Early Sexual Initiation	19
3.4.	Condom Use	22
3.5.	Condom Negotiation	24
3.6.	Violence against women	26
3.7.	Parent-Child Communication	28
4.	Research Techniques	
4.1.	Description of KwaZulu-Natal	30
4.2.	Research Methods	31
4.2.1.	Focus Group Methods	32
4.2.2.	Advantages of Focus Group Methods	32
4.2.3.	Disadvantages of Focus Group Methods	34
4.3.	Research Objectives	35
4.4.	Sample Size	35
4.5.	Data Analysis	36
5.	Results and Discussion	
5.1.	Background	38
5.2.	Perceived Susceptibility to AIDS	39
5.3.	Factors influencing Risk Behaviour	41

5.4.	Perceived Severity of AIDS	47
5.5.	Perceived Benefits of Condoms	47
5.6.	Perceived Barriers to Condom Use	48
	5.6.1. Trust	49
	5.6.2. Reduction in Sexual Pleasure	51
	5.6.3. Effectiveness of Condoms	52
	5.6.4. Access to Condoms	53
	5.6.5. Economic Dependence of Women	54
	5.6.6. Peer Influence	56
5.7.	Cues to Action	57
	5.7.1. Knowing someone with AIDS	57
	5.7.2. Communication about AIDS	58
5.8.	Perceived Self-Efficacy	58
6.	Conclusions	60
7.	Bibliography	66

Chapter One

Introduction

1.1. Background

Research shows that HIV/AIDS affects mostly people who are in their young productive ages (UNAIDS, 2000a). According to UNAIDS (2002), an estimated 11.8 million young people aged 15-24 are living with HIV/AIDS. Almost about half of all new infections (around 6000 daily) are occurring among young people (UNAIDS, 2002). South Africa is one of the countries in Sub-Saharan Africa that is most severely affected by the AIDS epidemic. It is estimated that 150 young people under the age of 15 are infected with HIV infection in South Africa everyday (Maart, 2000). Young people are particularly vulnerable to HIV infection for a number of various reasons. Adolescents in both developed and developing countries begin sexual activity at a relatively early age and thereby expose themselves to the risk of contracting HIV/AIDS (UNAIDS, 2002). A significant proportion of young people, in many countries, start sexual activity before the age of 15 (UNAIDS, 2002:70).

Adolescence refers to a particular development stage that spans the period from puberty into young adulthood and is characterised by transition, physical and emotional development and change (WHO, 1995). Adolescence is a phase of discovery and experimentation in which young people develop new feelings, which (coupled with physical maturing) lead to exploring new behaviours and relationships (Maart, 2000:145). Adolescents should be targeted because they are just beginning to face social situations in which their decisions and actions will determine their exposure (Venier et al, 1998). In areas of high seroprevalance, infection will most likely occur in adolescence with early sexual exposure (Venier et al,

1998). South Africa, having a high HIV prevalence rate (UNAIDS, 2000a), has a huge compelling need to focus on young people. The South African Demographic and Health Survey found that 8 percent of women in the reproductive age group, who have had sexual intercourse, did so by age of 15 whilst half of all women, who had sexual intercourse, had their first experience by the age of 18 (Department of Health, 1998). Given that approximately 50% of South Africa's population is under 15 years of age, unless rigorous and well-designed interventions are targeted at youth, it is unlikely that the level of HIV infection will be halted or reversed (Maart, 2000:147). However, the implementation of national programmes to address youth-specific health, whilst gaining momentum, is still limited and poorly co-ordinated.

Adolescent sexual behaviour remains under-researched, particularly, in developing countries. Kaufman (1997) in Rutenberg et al. (2001) points out that very little research exists on adolescent reproductive behaviour in South Africa due to academic isolation and the politicisation of population and family planning issues under the former regime. Tillotson and Maharaj (2001) concur that, considering the extent of the HIV/AIDS epidemic in South Africa, research on factors that impact risk-taking, and barriers to protective behaviour is sparse. Some of the most comprehensive research on adolescent sexual behaviour has been carried out in developed countries than in developing countries (MacPhail and Campbell, 2001).

1.2. Purpose of the research

The aim of this paper is fourfold. Firstly, it aims to gain a better understanding of adolescents' perceptions of risk of HIV/AIDS. Secondly, it investigates the factors

influencing these perceptions and the extent to which these factors are interrelated. Thirdly, the aim is to examine the link between adolescents' risk perception and condom use. Finally, the paper explores some of the barriers, if any, to condom use amongst adolescents in the era of HIV/AIDS.

1.3. Conceptual Framework

There are a number of theories to explain behavioural change. The main theories are the health belief model, the theory of reasoned action and social cognitive approach.

1.3.1 Health Belief Model

The Health Belief Model (HBM) was originally developed in the 1950s by a group of social psychologists to explain widespread failure of people to participate in public health programs to prevent or detect disease (Witte, 1999; Stroebe, 2000). The HBM suggests that preventive health behaviour is influenced by the following factors: perceived barriers to performing the recommended response; perceived benefits of performing the recommended action; perceived susceptibility to the health threat; perceived severity of the consequences; and cues to action (Witte, 1999). People weigh the benefits against the costs of engaging in certain health promoting behaviour and if the perceived benefits outweigh the perceived costs they will engage in that particular behaviour (Stroebe, 2000). Witte (1999) points out that the barriers to health behaviour could be psychological, physical, and financial costs. In the case of HIV/AIDS, for example, people (when considering using condoms) will weigh the benefits of protection from sexually transmitted infections (STIs) (including HIV) against the costs of reduced sexual pleasure.

The health belief model further assumes that the likelihood that an individual will engage in a given health behaviour will depend on the magnitude of the perceived threat posed by the disease (Stroebe, 2000). According to this approach, an individual must perceive him or herself vulnerable to HIV infection and also realise that the consequences are severe.

Rosenstock (1974) cited in Stroebe (2000) further suggested that a cue to action might be necessary to trigger appropriate health behaviour. This could be an internal cue like a bodily symptom, or an external cue such as a mass media campaign, medical advice, or death of a friend of similar age and lifestyle (Stroebe, 2000). In this way the massive HIV/AIDS awareness campaigns, death of an acquaintance, friend or family member (external cue) or contracting a sexually transmitted infection other than HIV (internal cue) can help prompt the adolescents to begin using condoms.

This approach has come under criticism for failing to include a number of important determinants of health behaviour e.g. the positive aspect of health impairing behaviour like the enjoyment of smoking, self-efficacy (i.e. belief in the ability to engage in health promoting behaviour effectively), and failure to include social influence variables that are considered in other theories (Stroebe, 2000).

1.3.2 Theory of Reasoned Action (TRA)

The theory was introduced in 1967 (Ajzen and Fishbein, 1980). The theory assumes that human beings are quite rational and make systematic use of information available to them. People consider the implications of their actions before they decide to engage in a given

behaviour (Ajzen and Fishbein, 1980). The theory also highlights the significance of social influence in deciding whether or not to engage in the behaviour. It has been proven, for example, that peers have a significant influence on whether or not adolescents practice safe sex or not (MacPhail and Campbell, 2001).

According to this theory, the major factors determining the person's intention to perform the particular behaviour are positive or negative attitude towards the action and the person's perceived social norms, especially, from significant associates e.g. friends or family members (Ajzen and Fishbein, 1980). Attitudes are influenced by the individual's belief about the likelihood and evaluation of the consequences of performing the behaviour. In addition, the decision to engage in the health promoting behaviour is dependent on the perceived beliefs that relevant specific referents hold about engaging in the behaviour (Ajzen and Fishbein, 1980).

1.3.3 Social –Cognitive Theory

The social cognitive theory, developed by Albert Bandura, assumes that perceived self-efficacy is central to peoples' decision to engage or not to engage in health promoting behaviours (Witte, 1999). Self-efficacy is the belief in the ability to implement the necessary behaviour (UNAIDS, 2000). Perceived self-efficacy is what you believe about your capability to perform a certain action (Witte, 1999). Another important construct of Bandura's theory is outcome expectations. Outcome expectations refer to individual's belief that certain behaviour will lead to certain outcome (Witte, 1999). In order for the adolescents to begin using condoms it is important that they are confident about how to use them and they must believe that using condoms will protect them from STIs (including HIV).

In tackling the topic it will be appropriate to begin by elaborating on the magnitude, nature and effects of the HIV/AIDS epidemic.

Chapter Two

Global Overview of the HIV/AIDS Epidemic

2.1. Global view of the epidemic

It is now two decades since the epidemic of HIV and AIDS emerged on the planet earth. Ever since its emergence the epidemic has been growing on daily basis and gaining momentum over time. In 1998, 30.6 million people were living with HIV/AIDS (UNAIDS, 1998) whilst 40 million people, a figure equivalent to the entire population of South Africa, were living with HIV/AIDS at the end of 2001 (UNAIDS, 2002). A large proportion of the People Living with HIV and AIDS (PLWHA) comes from the sub-Saharan Africa. It is estimated that 28.5 million of PLWHA come from sub-Saharan Africa (UNAIDS, 2002). Globally, the total number of people that have died of AIDS since the beginning of the epidemic stood at 21.8 million at the end of 2000 (UNAIDS, 2000b).

In most of the industrialised, high income countries the epidemic is largely under control (UNAIDS, 2000 & Whiteside and Sunter, 2000). In the United States of America, for example, AIDS deaths decreased by 42 percent between 1996 and 1997 (Whiteside and Sunter, 2000:39). In Western Europe, deaths fell by 20 per cent in 1999 (Ibid). Whiteside and Sunter (2000) state that UNAIDS/WHO estimated that at the end of 1999, only 1.5 million people were living with HIV in the West (defined as North America, Western Europe, Australia and New Zealand).

There is, however, some evidence suggesting that risk taking behaviour amongst vulnerable groups, especially injecting drug users, may be beginning to increase in high-income

countries. The rise in risk taking behaviour is positively correlated with the availability of life prolonging drugs and therapies (UNAIDS, 2000a). A study in San Francisco, for example, showed that in 1993-1994 just over one-third of gay men were reported to have had unprotected anal intercourse (Whiteside and Sunter, 2000). Three years later, when effective death-postponing therapy had become available, one-half of men were reported to be having anal sex without a condom (Whiteside and Sunter, 2000).

A rise in the number of the injecting drug users in the Russian Federation is reported, leading to the increasing number of infections. The estimated number of infections in the year 2000 were 50 000 which is far more than a total of 29 000 infections which were registered between 1987 and 1999 (UNAIDS, 2000b). The number of adults and children living with HIV or AIDS in Eastern Europe and countries of the former Soviet Union has increased significantly. At the end of 1999, 420 000 adults and children were living with HIV or AIDS whilst a year later this figure had increased to 700 000 (Ibid).

In addition to the increase in risk taking behaviour in high income countries prevalence rates are reported to be increasing. The increase is, mainly, attributed to the availability of anti-retroviral drugs, which are keeping HIV positive people living for longer period (UNAIDS, 2000b).

2.2. African countries

The impact of the epidemic is severe in African countries. The severity of the epidemic is however not homogeneous across African countries. The countries of West Africa are less affected by the epidemic. The prevalence rate remains below 3 per cent in some West African

countries (UNAIDS, 2000a). In Mali, for example, the HIV prevalence was 1.7% in 2001 (UNAIDS, 2002). There are however signs that the prevalence rates are beginning to increase in Cameroon and Nigeria. In Cameroon the HIV prevalence stood at 4.7% in 1996 whilst in 2000 this has increased to 11% (UNAIDS, 2002). In Nigeria the HIV prevalence rate has increased slightly from 1.9% in 1993 to 5.8% in 2001 (Ibid).

The countries that have been most severely hit in the Sub-Saharan Africa are, amongst others, Botswana, Zimbabwe, South Africa, Namibia and Swaziland. In Botswana, median HIV prevalence among pregnant women in urban areas stood at 38.5% in 1997 whilst in 2001 the figure had risen to 44.9% (UNAIDS, 2002). In Zimbabwe, HIV prevalence among pregnant women climbed from 29% in 1997 to 35% in 2000, while in Namibia it rose from 26% in 1998 to 29.6% in 2000, and in Swaziland from 30.3% to 32.3% in the same period (Ibid).

Some African countries have, however, been successful in their efforts in the fight against the AIDS epidemic. Uganda has brought its estimated prevalence rate down to around 8% from almost 14% in the early 1990s (UNAIDS, 2000). In 2001 the prevalence rate among the adult population in Uganda stood at 5% (UNAIDS, 2002). Senegal has also, through the collaboration of civil society, community organisations, and churches, brought down the rates of infection rates (UNAIDS, 2000a; UNAIDS 2002).

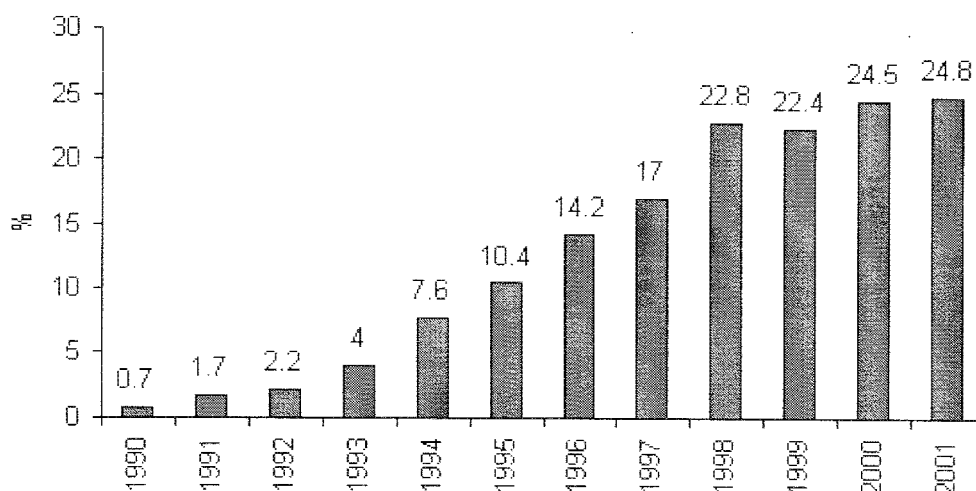
2.3. South Africa

2.3.1. Progression of HIV/AIDS epidemic

The first two AIDS cases in South Africa were diagnosed in 1982 with the first recorded death occurring in 1985 (Department of Social Development 2000). The prevalence rate has been growing annually since the beginning of the epidemic. It is important to note, as has

been pointed out earlier, that South Africa has the largest number of people infected with the virus in the world. In 1999, 3.4 million people were living with HIV and in 2001, it had increased to 4.74 million (UNAIDS, 2000a).

Figure 1: National prevalence trends among antenatal clinic attendees in South Africa: 1990-2001



Source: Dept. of Health – National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa (2001)

Figure 1 clearly shows that the HIV prevalence rate among antenatal attendees in South Africa has been continuously increasing from 1990 to 2001. Future projections indicate that it is going to continue increasing unless something drastic is done. At the end of the year 2001, 24.8% of the women attending antenatal clinic were infected compared to 24.5% in 2000 and 22.4% in 1999 (Department of Health, 2001). The prevalence rate in South Africa increased by only 0.3% between 2000 and 2001 leading the Department of Health to conclude that the prevalence rate, effectively, did not increase during this period (Department of Health, 2001). The factors that have been identified as fuelling and nurturing the epidemics are: high

geographical mobility, extensive migrant labour system, and presence of untreated sexually transmitted infections (Department of Social Development, 2000).

KwaZulu-Natal has been most affected by the HIV epidemic. HIV prevalence amongst women attending antenatal clinics in 1999 was 32.5 % in KwaZulu-Natal whilst the country's average stood at 22.4 % (UNAIDS, 2000a, & Department of Health, 2000a). In 2000 the prevalence rate among women attending antenatal clinics had increased to 36.2% (Department of Health, 2000a). The prevalence rate decreased in KwaZulu-Natal from 36.2% in 2000 to 33.5% in 2001.

2.3.2. Age specificity

It is important to point out that most of those who are infected are still in their productive and reproductive ages. Whiteside and Sunter (2000) points out that “around half of all people who acquire HIV become infected before they turn 25 and typically die before their 35th birthday”(p.37). Table 1, below, indicates that the most infected age groups, in South Africa, are between 20 – 24 and 25 - 29 years. Between 1999 and 2000 HIV prevalence increased drastically in the 25 – 29 age group and showed the highest rate of infection the year 2000. In 2000 women aged 20-24 had an infection rate, which was effectively equal to that of the most infected age group, that is, 29.1%. There has been some decline in the infection rate amongst under 20 year olds and 20-24 year olds. Amongst the under 20 year olds the level of HIV infection decreased from 16.1% in 2000 to 15.4% in 2001 whilst amongst the 20-24 year olds the infection rates decreased from 29.1% in 2000 to 28.4%. The level of HIV infection in other age groups, except 40-44, increased in 2001.

Table 1: HIV prevalence trends by province among antenatal clinic attendees in SA 1999-2001

AGE GROUP	Est HIV+ (95%CI) 1999	Est HIV+ (95%CI) 2000	Est HIV+ (95%CI) 2001
<20	16.5 (14.9-18.1)	16.1 (14.5 –17.7)	15.4 (13.8 –16.9)
20-24	25.6 (24.0-27.3)	29.1 (27.4-30.8)	28.4 (26.5 –30.2)
25-29	26.4 (24.6-28.3)	30.6 (28.8-32.4)	31.4 (29.5 –33.3)
30-34	21.7 (19.1-23.8)	23.3 (21.5-25.1)	25.6 (23.5 –27.7)
35-39	16.2 (14.1-18.3)	15.8 (13.9-17.7)	19.3 (17.0 –21.5)
40-44*	12.0 (8.5- 15.6)	10.2 (6.9- 13.3)	9.1 (6.2 –11.9)
45-49*	7.5 (-.77-15.9)	13.1 (2.1-24.0)	17.8 (4.3 –31.4)

Source: Dept. of Health- National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa (2001)

2.3.3. Demographic implications

The HIV/AIDS epidemic will have demographic implications by changing demographic trends, for example, the age structure of the population, fertility, mortality, and morbidity. Whiteside and Sunter (2000) point out that the population size is not projected to decrease since even in most severely hit countries the population has not decreased. There will, however, be an adverse effect on the population structure. The HIV/AIDS epidemic adversely affects the population structure by killing the most economically active sectors of the population. There will be a decline in the number of people in specific age groups, namely 0-4 year-olds and 25-34 year-olds. In other words, AIDS mainly increases mortality in the adult age groups that have historically enjoyed the lowest mortality rates, and their offspring (Department of Social Development, 2000). AIDS deaths increases mortality rates in South Africa. The number of burials and cremations in Durban has shown a sharp increase in the past few years, from 2 592 in 1993/94 to 8 983 in 1997/98 (Whiteside and Sunter, 2000). It is expected that by 2006 AIDS death will be equal to deaths from all other causes (Ibid.).

**Table 2: child mortality 1998 and 2010 with and without AIDS
(rate per 1000)**

Country	1998		2010	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	121	57	120	89
South Africa	96	70	100	49
Swaziland	103	64	152	70
Zimbabwe	123	60	115	32

Source: Whiteside and Sunter (2000) – AIDS – The challenge for South Africa

Table 2 shows that child mortality rates for Botswana and Zimbabwe more than doubled, the rate it would have been without AIDS, in 1998. Child mortality rates for both South Africa and Swaziland showed very significant increases in 1998 because of the epidemic. In 2010 the impact of the epidemic is projected to be very severe on child mortality.

Fertility rates are bound to decrease. The fertility rates will decrease because of the following three major reasons, as outlined by Whiteside and Sunter (2000). Firstly, women die before reaching the end of their childbearing years. Secondly, the infections physiologically reduce fertility. Thirdly, the increases in condom use to prevent infection.

2.3.4. The socio-economic effects of HIV/AIDS epidemic

The economic impact of HIV/AIDS occurs at two levels, that is, at the household (micro) level and at the national (macro) level. At the household level, the loss of income as a result of the death of the income earner and the diversion of assets to caring for those affected, impoverishes families. In Zambia it is reported that in two thirds of families where the father died the monthly income fell by more than 80 percent (Loewenson and Whiteside, 2001). Nearly half of households (41%) in Chiang Mai, Thailand disposed of land after an adult death, and in Zimbabwe households disposed of cattle, goats, furniture, clothes, televisions,

poultry and wardrobes. The costs and expenses for the health care of ill family members will reduce savings and thus investments. The HIV/AIDS will therefore have an indirect impact by reducing private investment in the economy (Whiteside and Sunter, 2000).

At the firm and macro level, the HIV/AIDS epidemic will have profound negative economic effects, both in the short and long term. The death of productive people will lower the productivity of the firms and increase costs such as employee benefits, medical expenses, and training costs for the new replacement employees. Over the next ten years the number of employees lost to AIDS is expected to be equivalent of 40-50% of the current workforce in many South African firms. By 2010 it is estimated that approximately 15% of highly skilled employees will have contracted HIV (Department of Health, 2000b). The companies will divert their investments to countries where HIV/AIDS infections are low. The potential impact of AIDS on customer purchasing power in Southern Africa led one retail firm, for example, to diversify geographically and open stores in Poland and Czech Republic (Loewenson and Whiteside, 2001:9). The epidemic is projected to reduce the South Africa's economic growth rate by 0.3-0.4% annually. This will result in a gross domestic product (GDP) that is 17% lower by the year 2010, to the value of US\$22 billion (UNAIDS, 2000b). This value (US\$22 billion) is more than twice the entire national production of any other country in the region except Nigeria (Ibid).

The HIV/AIDS epidemic stands to increase the dependency ratio. High deaths in young adults will result in a large number of children without parents. These children will have to be cared for by grandparents, relatives, or the community. It has been estimated that KwaZulu-Natal will have 65 500 AIDS orphans by 2000 and nearly 500 000 by the year 2010 (Whiteside and Sunter, 2000).

2.3.5. HIV/AIDS and gender

Women are more infected and affected because of biological, social, and economic factors, which place them in a more vulnerable position. UNAIDS (2000) points out that girl's infection rate is always higher than boy's infection rate. In the 11 population-based studies, the average rates of infection in teenage girls were over five times higher than those in teenage boys (UNAIDS 2000). In South Africa, in 1996, 73% of all reported HIV cases was female (Department of Social Development, 2000). According to UNAIDS (2000), there are an estimated 12 women living with HIV for every 10 men in Africa.

Chapter Three

Literature Review

3.1. Introduction

In the past few years, adolescents' sexual behaviour has become an area of great curiosity among researchers and policy makers. Recently, there has been a growing number of studies on adolescent sexual behaviour, however, traditionally most of the research on the sexual behaviour of adolescents was conducted in developed countries whilst there has been a tendency in developing countries to focus on fertility (Varga, 1997). In the wake of the spreading HIV/AIDS epidemic, with its devastating effects for the countries, policy makers have designed interventions and programmes geared at combating the epidemic.

Research shows that knowledge is necessary, but insufficient, for behavioural change (Rutenberg et al, 2001; Varga, 1997). A variety of factors have a role in shaping people's behaviour. MacPhail and Campbell (2001) identify these factors as including, amongst others, individual-level perceptions of health and vulnerability, community-level factors such as peer and parental pressure, wider social influences including the social construction of male and female sexuality and gendered power relations, as well as economic constraints. In order to successfully curb the further spread of AIDS, it is crucially important to examine these factors and their relationship to adolescent sexual behaviour.

3.2. Perception of Risk

Most teenagers, even in places with a high prevalence of HIV infection, do not think they are at risk of contracting the virus and as a result they have not changed their behaviour. Kalunde (1997) as cited in Dallimore (2000), who examined the sexual behaviour of youth in Zambia found that, regardless of the race, sex or educational background of the respondents, they did not believe HIV/AIDS to be a personal threat to their own lives. As a result they have not altered their sexual behaviour.

In their study of high school students in Florida, Langer et al (1994) found that female Hispanic and black respondents were the most likely to consider pregnancy and AIDS prevention to be equally important. On the other hand, males, non-Hispanics and Whites were more likely to believe that pregnancy is less important than preventing AIDS. Langer et al (1994) further found that males and females in steady relationships placed more emphasis on pregnancy prevention than preventing AIDS. However, in casual relationships, the major concern was HIV/AIDS.

In a study of adolescents in Uganda, Hulton et al (2000) found that the risk of pregnancy was high. The girls expressed a concern about the health risks to the young mother and the infant of a young mother and the risk of undergoing an abortion for a mistimed pregnancy. The girls were concerned about the economic hardships and lost education that the mother of the child confronts as a result of unplanned pregnancy. The boys, on the other hand, did not perceive pregnancy as a risk except with regard to a possible fine or imprisonment if a boy impregnated a young, unmarried woman. Having a child could, in fact, enhance a boy's status and demonstrate his manhood (Hulton et al, 2000).

In their study among young men in Nepal, Tumang et al (2001) found that the majority of young men who have had sex with non-regular partners felt they were not at risk of contracting any form of STIs (including HIV). The study showed that, generally, men who indulged in risky sexual behaviour were unconcerned about transmission. They become worried about their exposure to HIV only when they began to experience signs or symptoms of STIs (Tumang et al, 2001).

In the qualitative study investigating perceptions of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections in Kenya, Nzioka (2001) found that the boys had ambivalent feelings about making a girl pregnant. The boys felt that impregnating the girl was a sign of male prowess. In addition, having a treatable STI was seen as a sign of masculinity and a way of gaining experience (Nzioka, 2001). Boys are socialised to know that sex is necessary and an integral part of the relationship. Failure to have sex carried a risk of being looked down upon by one's peers. For the boys sex was seen as a pleasurable experience. Most boys blamed the pregnancy on the girl and her parents. Some boys adopted the view that girls who become pregnant are the "stupid ones because the clever ones know how to protect themselves." The participants further pointed out that it is the girl's parents who should provide her with "basic sex education" (Ibid:p112). However, some boys expressed concerned about the negative impact on the girl's education and economic prospects.

There is some evidence showing that not all adolescents in South Africa view pregnancy in a positive light. The first wave of the "transitions to adulthood" study conducted in KwaZulu-Natal in 1999 amongst 3 096 adolescents aged 14-22, found that the majority of respondents

felt if they or their partner fell pregnant it would be a big problem (Rutenberg et al, 2000). However, the study found that younger respondents were more likely than older respondents to regard the pregnancy as a problem.

In their study of University students, Friedland et al (1991) found that the level of knowledge and awareness of AIDS is high. However, they did not find that high knowledge is matched by a corresponding behavioural change. In their study of street children in South Africa, Swart-Kruger and Richter (1997) also found no evidence to suggest behavioural change. They found that a significant proportion of the boys engaged in risky sexual practices in exchange for money, good and clothes. The risk of HIV infection was seen a distant threat. Another study in South Africa found that the belief that AIDS is a conspiracy to reduce the African population also contributed to some of the complacency among teenagers about their vulnerability to the risk of HIV infection (Mtshali, 1994 in Gage, 1998).

3.3. Early Sexual Initiation and Childbearing

Research shows that early sexual initiation has become the practice in South Africa and other countries (Preston-Whyte and Zondi 1991, Hulton et al 2000, Manzini 2001, UNAIDS, 2002). Almost half of all women who have had sexual intercourse had their first experience by the age of 18 in South Africa (Department of Health, 2000). The findings of a study conducted by Preston-Whyte and Zondi (1991), amongst African adolescents to explore adolescent sexuality and its implications for teenage pregnancy, showed that early sexual initiation was the common practice amongst adolescent boys and girls. In their study Preston-Whyte and Zondi (1991) found that both girls and boys experimented with sex before their 12th and 13th year and that some had begun sexual activity before reaching sexual maturity.

Preston-Whyte and Zondi (1991) further point out that the girls engage in sexual activity because of fear of being branded by their peers as incapable of sex or unable to attract men. There are some benefits that are associated with pregnancy. For instance, some women felt that having a child may persuade their partners to marry them.

In some African societies, there is a strong emphasis placed on childbearing. Preston-Whyte and Zondi (1991) found that many African teenagers grow up in households in which there are already one or more children that have been born out of wedlock. The girls see households that headed by females, which are relatively successful, and this sends a message to them that having a child is not a complete disaster.

Manzini (2001) in her paper on sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa, found that age at first intercourse ranged from 10-21 years old, with the mean at age 16. Of the 796 girls who were sexually active, about half had ever been pregnant and a large percentage of those who had ever been pregnant said their pregnancies were unplanned.

The research conducted by Kaufman et al (2001) among African adolescents shows that early childbearing is dependent on changing socio-economic and cultural factors. Kaufman et al (2001), for example, found that the presence of lobola (bride wealth) makes it difficult for the youth to get married and as a result they have children out of wedlock. In an environment where marriage is unaffordable, many boys and girls consider childbearing as a means to cement a relationship. The study revealed that the adolescents usually choose to have fewer children after their first birth. This is because they place more emphasis on completing their studies, obtaining financial security, and maintaining stable relationship.

A broad array of factors surrounds the early initiation of sex among the adolescents. In their study investigating violence in sexual relationships amongst Xhosa-speaking adolescent women in South Africa, Wood et al (1998) found the social constructions of love may influence early sexual intercourse. The social constructions of love are derived mostly from the men. As a result, girls are not able to refuse to have sex with their partners. As one adolescent reported: "he told me if you agree to having a relationship with a boy, you are committing yourself to having sex with him" (p.236).

In her study of sexual decision-making and negotiation in the midst of AIDS amongst boys and girls in Durban, South Africa, Varga (1997) found that boys believed sex must take place within the first few weeks of a relationship in order for it to be viewed as serious and legitimate. According to one man, "if someone is in love with a woman and breaks up with her before they have sex, that affair is as if it never existed" (p.55). Other studies have documented the importance of penetrative sexual intercourse (Preston-Whyte and Zondi, 1991; McPhail and Campbell, 2001). In their study of adolescent sexuality in KwaZulu-Natal, South Africa, Harrison et al (2001) found that boys and girls gave a number for early sexual initiation. They found that the girls often engage in sexual intercourse in order to please their boyfriends and demonstrate their love.

Peer pressure is one of the reasons for early sexual initiation. Adolescents may be under enormous pressure from their friends to engage in sexual activities. Girls who do not engage in sexual activity may sometimes become the object of ridicule. Woods et al (1998) in their study of adolescent Xhosa speaking adolescents in South Africa found that the sexually

inexperienced girls are expelled from the group conversations because they cannot contribute and might reveal the secrets being discussed.

3.4. Condom use

Condom use among adolescents is substantially low. In the most recent study, conducted by Macphail and Campbell (2001) in the township of Khutsong near Carletonville, South Africa, on factors hindering condom use a wide range of important factors were uncovered. Both boys and girls felt that condoms are not necessary in steady relationships because it reduces sexual pleasure. Sexual pleasure is seen as an integral of sexual relationships. The use of a condom with a regular partner may also be a sign of infidelity and untrustworthiness. Adolescents in regular relationship felt that condoms are not necessary if you trust your partner. In a regular relationship, the use of condom was seen as indicating a lack of trust.

In their study of Zulu-speaking boys in Durban, Tillotson and Maharaj (2001) found that trust was also seen as important part of the relationship. According to Tillotson and Maharaj (2001) the statement “I used a condom because I didn’t trust her” was a common response among the boys that were interviewed (p.17). The girls that were more likely to be trusted were those residing within close vicinity of the respondents whilst girls that were not were considered unsafe.

Some studies have shown that concerns about reliability of condoms may also affect use. One of the barriers to condom use that has been recorded elsewhere in the literature (Hulton et al, 2000) is the concern that condoms may have holes and this was mentioned as one of the reasons for not using condoms in the study by Tillotson and Maharaj (2001). Tillotson and

Maharaj (2001) also point out that the some boys thought that condoms might be carrying HIV themselves.

Peer pressure is reported as discouraging the adolescents from using condoms. Those who use condoms are said to be 'stupid' by some members of the community (Macphail and Campbell, 2001). Social norms make it difficult for women to carry condoms with them. Young women who carry condoms risked being labelled as 'bitch' or 'promiscuous'. The male participants were also of the view that it was not acceptable for the girls to carry condoms and they do not trust girls who carried condoms. Girls who carry condoms are seen as sexually available. Many of the participants felt that this indicated that the girl had other lovers (Macphail and Campbell, 2001).

The attitude of nursing staff may also act as a barrier to condom use. Teenagers from the Khutsong community reported that the attitudes of health care providers in clinics hinder condom use. Many of the young women mentioned that they no longer went to local clinics after experiencing unpleasant encounters with the providers (Macphail and Campbell, 2001). In their study assessing staff attitudes towards teenagers seeking condoms, Abdool Karim et al (1992b) found that condoms were perceived as a poor choice of contraception and their use was discouraged. Staff members perceived condoms as a secondary and as an unreliable method of contraception, and their use was discouraged. The staff members did not disseminate information on how to use a condom and regarded the pamphlets distributed with condom packets as providing adequate instruction on condom use.

Abdool Karim et al (1992a) also found that adolescents are often subject to unpleasant treatment by the nursing staff at clinics. The findings suggest that providers do not want to

provide condoms to adolescents. Other important findings were that at times the clinic ran out of stock and that condoms were distributed in a setting that lacked privacy.

Other noted factors, inhibiting condom use, were the powerlessness of women to negotiate sex on their terms due to their poor socio-economic conditions. Sometimes girls may engage in sexual relationships in exchange for lifts home from school, gifts and subsistence cash. In the study in Khutsong, one participant stated: “There is this school called X, it is a bit far. Sometimes the students ask for lifts and struggle to get them. Others will sleep with the guys who give them lifts (Macphail and Campbell, 2001: 1623).

3.5. Condom negotiation

Worth (1989) examined the reasons for resistance to condom use among high-risk women who are primarily intravenous drug users and the sexual partners of intravenous drug users in two New York City AIDS prevention programs. Worth (1989) points out that the primary relationships of the inner city minority women, who are at most risk of contracting HIV infection, in New York are often embedded in the context of poverty and increasingly in drug use. Given the fact that these women lack economic opportunities, sex becomes an economic commodity for them and because of their dissatisfaction with their primary relationships these women sought relationships from other partners and thus increased their risk of contracting the HIV infection. These women lacked control over their sexual lives.

In discussing HIV infection and condom use, women often express their anger about being made to feel responsible for men’s sexual behaviour. The IV-drug using women participating in The Women’s Centre said they do not perceive themselves as having the power to make

men wear condoms, and that in their world “men decide what is going to happen sexually” (Ibid: p303). These women are not able to negotiate condom use with their partners. Furthermore, Worth (1989) found that ignorance of AIDS and the means of its transmission are not the primary reason that minority women fail to protect themselves when they engage in sexual activities. These women engage in sexual risky behaviour because of the perceived threat to their social and economic survival and their lack of power in sexual decision-making.

In their study of commercial sex workers in a mining community in Carletonville, Campbell et al (1998) found that sex workers engage in risky sexual practices because they are very poor and as a result they “live a hand to mouth life” (p.53). Moreover, they find it difficult to insist on condom use with their clients. Poverty prevented the sex workers from turning away clients who refused to use condoms. Furthermore, many women did not insist on condom use because they hoped that their clients will fall in love with them and provide them with some economic support. Some women secretly cherished the hope that a client might fall in love with them and agree to support them so that they can give up their work in favour of a more dignified lifestyle. As a result women were vulnerable to false promises and often agreed to sex without condoms. The vulnerability of the sex workers was exacerbated by their beliefs and cultural values, which tend to favour males in the relationships. For instance, firstly, the sex workers viewed regular flesh-to-flesh sex as necessary for a man’s good health in order to maintain balanced levels of blood/sperm within the body. Secondly, women are vulnerable because are socialised to over-respect men. On the other hand, men claimed that using a condom constituted wasting one’s sperm while fathering many children was regarded as a sign of their masculinity.

Varga (1997) found that women often fail to refuse sexual advances from their partners who are usually older than them. Over half of girls reported having refused sexual advances from their most recent boyfriend. However, of these women the majority admitted that their attempts to avoid sex had not been successful. Refusal nearly always resulted in physical coercion, abuse or the threats of rejection (Varga, 1997). As a result many women chose to remain silent in order to maintain the stability of their relationships.

Varga (1997) found that communication between partners is limited. The women lacked close intimacy with their partners and as such were not in a position to discuss sexual matters with their partner. Other factors that contributed to a lack of communication were the threat of rejection, abandonment and physical violence. It was also thought that if one partner initiated the discussion it might suggest they suspected their partner of being infected or even worse that they are hiding their own infected status.

3.6. Violence against women

Usually men have more power in sexual relationships than women. Women are, generally, in a subordinate position to men. Heise et al (1994) reports on the scale of violence against women in countries around the world. The consequences of abuse by the intimate partner are severe. Health consequences are most severe for women who are abused. A study in Alexandria, Egypt, revealed that domestic violence was the single greatest cause of injury to women, accounting for 28% of visits to trauma units (Heise, 1994). Women who were abused were also more prone to suicide and alcoholism.

The General Social Survey (GSS) on Spousal Violence that was carried out in Canada where 26000 respondents (14 269 women and 11 607 men) aged 15 years or over were interviewed, revealed that the severity of woman abuse outweighs the kinds of violence experienced by male spouses (Jiwani, 2000). Of the women that were included in the survey, 20% reported having suffered sexual assault and 25% reported having been beaten by their male partners (Jiwani, 2000). Violence against women and the imbalance of power within sexual relationships serves as a major barrier to safe sexual behaviour.

Violence is very high against women in South Africa with 13% of women reporting being beaten by their partner (Department of Health, 2000). A study conducted among Xhosa-speaking adolescent women, aged 14-18, in South Africa by Woods et al (1998) documented high levels of male violence. They found that men often used violence and coercive practices to dominate sexual relationships. Sexual initiation of the teenagers was characterised by violence on the part of the male partner. The women reported that even though they were aware that sex was part of the relationship, most reported that they had been deceived or coerced into sex in most cases. The women reported that once their partners have taken them home it was common for the man to demand sex. Almost 22 of the 24 informants reported having been beaten by their partners on multiple occasions whilst the remaining two had been threatened with assault.

The young women continue to have sex because they are afraid of being assaulted if they refuse. The refusal to submit to sexual demands was said to signify in the man's eyes that the women had other sexual partners, which is likely to induce more violent reactions from the male partner. "I continue because he beats me up so badly I regret I said no in the first place" (p.238). The women also cherished the perception that their boyfriends loved them. This

perception was derived partly from the male actions, which were seen to be symbolic of love, in particular men's demonstrations of material generosity in the form of presents of clothes, food and money, and the fact that the boyfriend came to visit frequently or prioritised her over other girlfriends.

3.7. Parent-Child Communication

In the traditional African culture it is not acceptable to discuss sex, especially, in the home environment. In the era of HIV/AIDS, parents have an important role to play in informing and educating their teenagers. According to Blake et al (2001) there are numerous studies that show that children whose parents talk with them about sexual matters or provide them with sexuality education at home are more likely to postpone sexual activity and that when these adolescents become sexually active, they have fewer sexual partners and are more likely to use contraceptives and condoms than young people who do not discuss sexual matters with their parents. Blake et al (2001) further point out that these children are therefore at reduced risk of pregnancy, HIV and STIs.

In their analysis of students in the United States of America, Blake et al (2001) found that children were less likely to engage in risky sexual behaviour if their parents played an important role in their education. Oliver et al (1998), in their study of students in public schools found that parental involvement in school-based sex education enabled the parents to discuss topics that they would not otherwise discussed with children and that it promoted a parent-child communication which impacted positively on adolescent's sexual behaviour.

Mayekiso and Twaise (1993) examined the extent of parental involvement in imparting sexual knowledge to adolescents in Umtata. The results indicated that the girl's sexual knowledge was inadequate. The main source of sexual knowledge was the peer group. Parental involvement in imparting sexual knowledge to the adolescents after the first menstruation was very limited. None of the girls reported communication with parents about sexual matters prior to menarche. The majority of girls attributed the high rate of teenage pregnancy to lack of communication between parents and their children about sexual matters. Parent-child communication is important to promote health seeking behaviour among adolescents.

Chapter Four

Research Techniques

4.1. Description of KwaZulu-Natal

KwaZulu-Natal is the coastal province situated on the eastern seaboard and is the most densely populated province in South Africa. The province has an estimated population of 8.4 million (Statistics South Africa, 1999). The population is about 45% urban including Durban the largest port in the continent and third largest city in the country. The majority of the population are Zulu speaking. Africans constitute 76% of the population, Indians 14%, Whites 7% and Coloureds 3% (Statistics South Africa, 1999; Rutenberg et al 2001).

The provincial economy is highly dependent on the manufacturing sector with community and social services occupying second place (Whiteside et al, 1995; Statistics South Africa, 1999). Moreover, the economic base is well diversified but undersized, producing only 14.5 percent of the country's total GDP (Whiteside et al, 1995). There is substantial inequality in the distribution of the economy in favour of non-homeland areas particularly the Greater Durban Metropolitan Area (Ibid).

The level of HIV infection in KwaZulu-Natal is the highest in the country (Department of Health, 2001). The prevalence rate was 33.5 percent in 2001, a figure well above the national average of 24.5 percent (Ibid). The factors that have been noted as fuelling the epidemic in the province include: high levels of poverty, multiple partners by men and improved roads and transport system (Whiteside, 1999). The level of contraceptive prevalence in KwaZulu-

Natal is less than 60 percent (Department of Health, 1998). The most widely used contraceptive methods are injections followed by the pill (Ibid).

4.2. Research methods

Research methods are broadly split between quantitative and qualitative approaches. Quantitative research methods are usually characterized by pre-coded responses in numeric form whilst qualitative research includes such methods as ethnography, case studies, in-depth interviews and participant observation (Cook and Reichardt, 1979). Academic research has traditionally relied on quantitative research as tool for academic enquiry.

Qualitative methods have a number of strengths when used help the researchers to obtain information that cannot be collected using quantitative research techniques. Qualitative research methods are particularly useful if the purpose of the study is to understand the perceptions and beliefs of a population. As Kitzinger (1995) stipulates: “ the method is particularly useful for exploring people’s knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way” (p.299). Based on the understanding that individuals are active agents in constructing and making sense of the realities they encounter, qualitative methods explain, and seek to understand situations from the perspective of participants (Filstead, 1979). Qualitative methods acknowledge that the world is dynamic, complex, and has multiple realities. In conformity with such understanding this approach uses open-ended questions and the process oriented approach to collect information as opposed to pre-coded questions with numeric responses that used in quantitative methods (Cook and Reichardt, 1979; Filstead, 1979). A qualitative researcher, while being aware of existing theoretical frameworks or explanatory schemes for

the phenomenon under study, prefers the 'theory' to emerge from the data itself and by so doing enhances his/her ability to understand, and ultimately devise an explanation of the phenomenon that is consistent with its occurrence in the social world (Filstead, 1979). These explanations do in fact explain or make sense because of the very fact that they were generated through a process which tapped the participants' perspectives (Ibid:38).

4.2.1. Focus group method

A focus group is a discussion among a small group of six to ten members of the community of interest with the conversation being guided by the interviewer (Nichols, 1991). Focus groups are usually semi-structured since the interviewer's skills are used to introduce a list of topics, to encourage wide discussion and learn about the concerns and opinions of community members (Ibid). Goldman (1962) in Stewart and Shamdasani (1990) defines a focus group interview by examining the meaning of the three words in the name 'focus group depth-interview' as follows: A 'group' is a number of interacting individuals having a community of interest. 'Depth' involves seeking information that is more profound than is usually accessible at the level of inter-personal relationships. 'Interview' implies the presence of a moderator who uses the group as a device for eliciting information. The term 'focus' in the full title implies that the interview is limited to a small number of issues (p.10).

4.2.2. Advantages of focus group method

In focus group discussions participants can also provide mutual support in expressing feelings that are common to their group but which they consider to deviate from mainstream culture.

This is of particular importance, especially, if researching stigmatised or taboo experiences, such as HIV/AIDS and sexual matters (Kitzinger, 1995).

The focus group method enables discussion of taboo topics such as sex because the less inhibited members of the group break the ice for the shyer participants (Kitzinger, 1995). Shedlin and Schreiber (1995) state: “ focus group sessions tend to empower individuals to express their ideas by providing peer group support and reassurance”(p.139). Focus groups facilitate openness and produce detailed information about specific groups or issues. Unlike quantitative research, which only provides the researcher with numeric data, with focus groups and other qualitative research methods the researcher is made aware of the language, behaviours, and vocabularies of his/her research population (Shedlin and Schreiber, 1995). One of the great advantages of the focus group method is that the participants become actively involved in something that they feel will make a difference and are somehow in the reciprocal relationship with the researchers or policy makers (Gibbs, 1997).

Stewart and Shamdasani (1990) have made reference of two types of data, as distinguished by Krippendorf (1980), that is, emic data and etic data. Emic data are data that arise in a natural or indigenous form, they are minimally imposed by the researcher or the research settings. Etic data, on the other hand, represent the researcher’s imposed view of the situation. The strength of the focus groups in this regard is that they provide data that are closer to the emic side of the continuum because they allow individuals to respond in their own word, using their own categorizations and perceived associations.

4.2.3. Disadvantages of focus group method

Like all other research methods focus groups do have their limitations. It has been noted, for example, that in a group certain participants may influence the other participant's opinions and that the participant's ideas shift as the group discussion progresses. In this way the results that are obtained through focus groups are shaped by a group dynamic influence (Krueger, 1994). Stewart (1990) argues that when the participants change their opinions in focus groups this should not be perceived negatively as this is a depiction of peoples natural behaviours in real life. The confidentiality of information obtained through any research method must always be assured. The focus group method compromises the confidentiality of information in that the participants are aware of the information disclosed by other participants. However, if necessary measures have been put in place during the planning (e.g. inviting people not known to each other) of the focus groups and if a relaxed atmosphere is ensured, the negative impact on the quality of information arising from the concerns of the confidentiality can be eliminated (Krueger, 1994; Shedlin & Schreiber, 1995).

One of the major limitations concerning focus groups is rooted in the fact that the results cannot always be used to generalize to the entire population. The two main reasons, to the inability to generalize, are that, firstly, the size of the sample studied is usually very small and, secondly, that the qualitative nature of data makes it impossible to make statistical aggregation. As Shedlin and Schreiber (1995) notes "statistical aggregation of data and generalisability are usually neither appropriate nor possible" (p.136). Conclusions, about the entire population, should therefore be pronounced with great care when using focus groups results.

4.3. Research objectives

Focus group discussions were used as one of the methods employed in the study, '*Transitions to Adulthood in the Context of HIV/AIDS in South Africa*', that was carried out in 1999 in Durban and Mtunzini magisterial district in KwaZulu-Natal, South Africa. The objectives of the study were to develop a better understanding of the norms among adolescents related to: adolescents' sense of connectedness to their family and community, sense of risk of HIV/AIDS and other STDs, experience of sexually transmitted diseases; risk taking behaviours including unprotected sex (condom use); pregnancy; and school leaving (Rutenberg et al, 2001). The study had a number of phases: 1) a panel study of two rounds of data collection from adolescents aged (in the first round) 14-22 years. 2) Household information was collected to provide family contextual data on the immediate backgrounds of these young people. 3) Community data was collected using two instruments – a community observation module and a street intercept (or multiple key informant) instrument. 4) Additional data on the context of schools in the study area were also collected at the baseline and follow up. 5) Focus groups were held mid way between the two rounds of individual data collection (Robinson et al, 2001).

4.4. Sample Size

In the period from September 2000 to January 2001 seven focus groups were conducted in Durban and the Mtunzini magisterial district. Three racial groups were covered, namely, Africans, Asian, and White. The focus groups were broken down as follows: 1 Asian-Urban (Phoenix), 1 White- Urban (Morningside), 1 African Rural (Mthunzini), 2 African-Urban Informal (Umlazi), 2 African-Urban Formal (Umlazi). Professionally trained moderators

carried out the focus groups and a free and relaxed atmosphere was always ensured. Table 3 below indicates how the focus group discussions were broken down in terms of race, age, urban/rural and formal/informal area.

TABLE 3: Sample in terms of race, age, urban/rural and formal/informal area

Group	Race	Age	Urban/Rural	Informal/formal
1	African	13-27	Urban	Formal
2	African	16-21	Urban	Formal
3	African	16-22	Urban	Informal
4	African	16-20	Urban	Informal
5	African	15-21	Rural	N/A
6	Asian	16-22	Urban	
7	White	19-21	Urban	

Source: Robinson et al (2001) Draft report: *Focus Group Discussions among adolescents in KwaZulu Natal Province, S.A*

The focus groups were conducted in Zulu for the African groups and then translated into English, whereas Asian and White focus groups were conducted in English. The focus group sessions were all tape recorded and then transcribed together with information from field notes. To ensure confidentiality and a relaxed atmosphere, the participants first discussed less sensitive issues in one big group. The group was then divided into two smaller groups according to gender where more sensitive and serious issues (including condom use and pregnancy) were discussed. In addition, warm up questions were used in order to make everyone comfortable with voluntary participation in the discussion.

4.5. Data analysis

Usually, although not always, focus groups are tape-recorded, transcribed and then analysed. The common method of data analysis is the cut and paste technique or thematic analysis method. In this way common themes are identified and then discussed by the researcher. The

direct quotes from the transcribed focus group discussions are occasionally referred during the discussion of the results. The danger with this method is that the researchers tend to believe that inclusion of large amount of direct words will improve the quality (Stewart and Shamdasani, 1990).

In analysing the data, a thematic analysis method is used. Broad themes are identified and discussed accordingly. Discussions are analysed by means of a one-stage interpretative thematic analysis, involving the detailed reading and re-reading of the discussions. In analysing the results, as has been stated in the previous sections, the Health Belief Model (HBM) is applied. Direct quotes from transcribed focus group discussions are included in the analysis.

Chapter Five

Results and Discussions

5.1. Background

Prevention programmes have been relatively successful in creating awareness of AIDS. Knowledge of AIDS is virtually universal, with the majority reporting that they had heard of AIDS.

Yes. There is a great understanding of AIDS. Most of the people are starting to believe that there is AIDS now. They are seeing the way things are going on. Most of the people are contributing towards getting solutions to AIDS. (African Male)

Most of the participants were aware of the main modes of transmission. They identified sexual intercourse as the main mode of transmission. Others reported that it is possible to become infected by using a contaminated injection. Some also suggested that it is possible to become infected during a blood transfusion.

I would like to differ with person 2 because you can get AIDS in various ways for instance. You can get it by using an infected injection. (African Male)

Sometimes you can be involved in the car accident and there are many people also involved and you can get AIDS through blood transfusion. (African Female)

Knowledge of the means of protecting against HIV infection is also good. Most of the participants knew that using condoms can protect them from AIDS, as is illustrated in the following comments:

I do not think we need to worry that much because it is now known how this thing can be protected. (African Female)

I do not think I will get AIDS myself because there are condoms now, and I use them. (African Male)

5.2. Perceived susceptibility to AIDS

Some of the respondents felt that they were not at risk of HIV infection. Most White participants felt that they were not at risk of HIV infection. They were more likely to report that the risk of HIV infection is higher among Africans. They were more concerned about preventing pregnancy than preventing disease.

It is more common among Africans. We need to worry about pregnancy and stuff like that. (White Male)

The only person I think died of Aids is our maid. That is the only time I had exposure to it. (White Female)

The Indian participants were rather uncertain as to whether they were at risk of HIV infection. Some of the Indian participants felt that they were not at risk because they did not engage in risky sexual practices.

Most of the friends probably won't get it as their behaviour is OK. (Indian Male)

A few Indian participants felt that they were definitely at risk of contracting HIV/AIDS. They knew that it is possible to contract the virus from unfaithful sexual partners.

It is definitely possible for them to get Aids. (Indian Female)

Most of the Indian participants felt that it was difficult to comment on whether people are at risk of contracting HIV/AIDS because there is a fear of disclosing one's status in their communities. There is widespread stigma attached to HIV/AIDS.

But people don't talk about it so you don't know. They fear rejection. (Indian Female)

Most of the African participants also reported a high prevalence of stigma in their communities. They pointed out that people who revealed that they were HIV positive often faced negative consequences, as illustrated in the following statements:

In other communities what I know is that if a person has declared himself, to be suffering from AIDS, he will get killed. (African Female)

However, there is also a great deal of denial in the community. Some boys and girls reported that the level of HIV infection in the community is very low. This is likely to impact on the use of condoms.

*It is in KwaMashu where this is happening it does not happen here at Umlazi.
(African Female)*

5.3. Factors influencing risk behaviour

Many of the African participants felt they were at risk of contracting the HIV infection. They gave a number of reasons to explain why they felt that they were at risk. Most of the participants were aware of AIDS. However, they felt that their peers did not perceive the severity of HIV infection because they were ignorant.

There wouldn't be this high rate of Aids if they were using precautions. It's just that they are too stubborn to think. They just do not want to be taught. Like if you do that you will get that. Its like, No I want to experience it myself. (African Female)

Some believe that they want to see it happening to them. As long as it does not happen to some other people I won't believe it. (African Male)

Most of the adolescents have multiple sexual relationships and they often change partners regularly. It is not uncommon to find that some boys have more than one girlfriend at the same time. This increases their risk of contracting HIV/AIDS:

Some of them have got a lot of boyfriends. Some girls have as many as four boyfriends.

(African Female)

Yes because they fall in love with all taxi drivers around here. You meet a girl on the street, you tell her that you love her and then she says yes. At the next corner she meets another boy and then she says yes, and then they all want to sleep with her.

The other one say I want to sleep with you and then she says yes. They don't know how to say 'no'. (African Male)

Communication between parents and children are not frequent. Usually communication is unidirectional- from parent to child. Communication takes the form of short instructions by parents without detailed explanations. This was mostly illustrated in the following comments:

She won't tell you even if you start your periods because if you start your periods she must tell you the truth. But all she will say is that, hey, do not stay with boys because you will get pregnant. As to how, you do not even know. She just tells you, you will get pregnant. (African Female)

The parents do not tell the truth. The way they advise you is that when you see a boy do not talk to him run away. (African Female)

Our parents teach us that if you are a girl you do not hang around with boys because something bad will happen. They just put that difference and you will start asking yourself why are they saying this? And then you just get anxious and just follow the wrong track (African Female)

Peers are an important source of information for adolescents. Most teenagers turn to their friends for sexual advice. Sometimes this advice may be ill informed and increase the adolescent's risk of HIV infection. Some friends may encourage them to engage in unprotected sexual activities. The following comments illustrate how advices received from friends put young people at risk:

Sometimes when you turn to friends, your friends do lead you into bush. When for instance you happen to have a woman dream your friends will tell you "you are going to be insane you must sleep with the girl". And you end up sleeping with the girl, maybe by mistake that girl is HIV positive and then what? You are HIV positive too.
(African Male)

Parents often exert strict control over their children and are often unwilling to listen to their children. It is very common for Indian participants to report that they faced resistance from their parents. As a result, sometimes girls fall pregnant in order to get their parents to accept their relationship with their male partners. Impregnating the girl is the way of obviating the objection to the relationship by the girl's parents. The Indian male participants explained that once the girl is pregnant there is no way the parents can object to the relationship. Some girls may commit suicide because of their parent's refusal to accept their male partners.

In order for parents to accept the guy. It's the only way if they get involved. (Indian Male)

Another thing is that girls also commit suicide because they cannot be with the one that they want to be with. (Indian Male)

Boys and girls are more likely to engage in risky sexual practices under the influence of alcohol. Most of the African and Indian participants reported that they did not use condoms to protect themselves because they were too intoxicated.

The other thing is that guys who like to drink alcohol when they go to parties. In that party you find that the boys are drunk and the girls are drunk and everyone is drunk. When they go for sex the condom is not used. They do not even think of condoms they just have sex. (African Male)

Some adolescents are purposefully practicing unsafe sex in order to infect others. The African participants explained that some youth who are either infected or consider themselves as infected deliberately avoid using condoms so that they can spread the disease to others because they do not want to die alone, as illustrated in the following comments:

You know that they are infected and their intention is to spread AIDS to innocent ones (African Female)

And some guys have got partners who have died of Aids and they think they got AIDS too and just want to spread it. They will say I do not want to die alone. (African Male)

Some adolescents are at risk of contracting HIV because they do not use condoms with girls that they judge as 'safe'. Some adolescents believe they can judge by physical appearance whether the girl is infected or not. According to some of the African male participants a

number of boys in their communities do not use condoms with girls that look healthy and attractive, as illustrated in the following comments:

A dozen of them and a million of them. They will say so and so is gorgeous, they are clean, they do not have Aids. And then ... He is not using a condom because he can see they are clean, and they are gorgeous. ...but later he finds out that he did not know what his girlfriend was doing at the time. Maybe whilst he is at work they are busy doing their own things and they also sleep with him. (African Male)

Some guys use condoms with only some kinds of partners. You see some people just look at the girl and have that trust that maybe this one does not have HIV/AIDS. (African Male)

Boys are more likely to use condoms with girls that they do not trust. Condoms are not used in relationships that are deemed 'safe'. Boys do not use condoms with girls who are regarded as trustworthy.

Ja, Rabbit. Jumping from that hole to that hole. Like, they like to trust the girl by just seeing what she is doing. They just say, Ah, I won't use a condom with that one, I will use it with that one because she is a bitch. They judge girls from what they see. She is beautiful, she has got nice legs etc. (African Male)

The younger teenagers felt that they are unable to use condoms because they are usually too big. One African participant explained that it would be difficult for him to use a condom, as the size of his genitals is smaller than the condom.

Such a kid like me, as I am in this age, if I want to have sex, I take a condom and just by looking that thing I say Awu, how can I fit here? There is no use for me to use this. How can it fit me. There is no use for me to use this because it is not going to fit. It is for adults. I cannot use it because it does not fit. If I use it will remain in the woman's womb, ... And that is why young people end up having Aids because they see that it does not fit. (African Male)

Some African participants complained that condoms are not suitable for adolescents because they are not producing small sizes. Some adolescents complained that adolescents are not engaging in sexual activity.

What I think is that the people who are making condoms, they must make them even in our sizes. They must not only make big sizes. (African Male)

I do not think they will make small sizes for them because they know that they are still under age. That's the problem. I think they won't make condoms of your sizes because they think you are still young to have sex. (African Male)

Some girls are at are at risk of contracting HIV infection from older men. Some girls engage in sexual activities with men that are much older than them for money, gifts etc. These older

men are often referred to as sugar daddies because they are often older and wealthy. Girls in these relationships are not able to insist on condom use or negotiate safer sexual practices.

And the other people who are spreading AIDS are old people, our fathers, you know. They like these young ladies. You find that a man is married but he has got another girlfriend outside and they do not know what kind of lives these girls are living.
(African Male)

5.4. Perceived severity of AIDS

Many of male and female participants knew that AIDS is a fatal disease and many people have died of AIDS. However, a number of African participants admitted that some adolescents do not take prevention messages seriously. As a result, AIDS is seen as a vague and distance threat.

Some even make jokes about it. They say, Aids will not hunt us we must hunt it.
(African Male)

What I know is that youth are so ignorant. Instead of making each other aware they tease each other about it. They are making into a joke. (African Male)

5.5. Perceived Benefits of Condoms

Participants were aware of the benefits of using condoms. They knew that condoms protect against the risk of pregnancy and STIs (including HIV/AIDS). However, there was a greater

tendency to associate condoms with STIs than pregnancy. Participants felt that more effective methods should be used to protect against pregnancy.

It is just to prevent contracting HIV, because most of the girls are using injection to prevent pregnancy. (African Male)

Men recognise the role of condoms in preventing pregnancy but they see pregnancy as the female's responsibility. As a result, boys who do not perceive their partners to be at risk of STIs (including HIV/AIDS) and are therefore unlikely to use condoms.

I think it is to prevent ... If she is preventing ... Others will tell you I do not go sleep around I am always at home and in that time you won't use a condom. And you will say what is the use of a condom because this person is using an injection and she stays at home always. (African Male)

The pregnant part – I reckon that's the girls problem, she should be on the pill or she should have an injection. (White Male)

5.6. Perceived Barriers to Condom Use

There are a number of barriers to condom use. A variety of factors may prevent condom use including fear of partner's reactions, lack of confidence, reduction in sexual pleasure and access to condoms.

5.6.1. Trust

Condoms are less likely to be used in regular relationships. The use of condoms is likely to suggest lack of trust between partners. Condoms are more likely to be used in casual relationships. However, once trust develops in a relationship, condom use is terminated. This is largely because they feel that the threat of HIV infection declines. Individuals in regular relationships are more likely to be concerned about pregnancy than disease.

In that case the one you see to have proved himself to be faithful to you is the one with whom you will not use a condom. It all depends on whether you trust that person or not. (African Female)

There is the aspect of trust. The girls are so much in love with the boys that they trust them and therefore there is no need for using condoms. (Indian Female)

I think that once you are in a serious relationship you are not worried about transmitted diseases – because you trust – you are more worried about pregnancy and depends how safe your pill is. (White Female)

It is sometimes difficult to introduce condoms in a regular relationship because condoms are associated with a lack of trust. Introducing condom use in a long-term relationship is suggestive of lack of trust, as illustrated by the following comments:

If you started with a condom continue with it. Otherwise it is difficult, because you will find that you have already built trust between yourselves. (African Female)

Some participants felt that their partners would become suspicious if they insisted on condom use because they had already informed their partner that they had never had other sexual partners. If they suggested condom use their partner may become suspicious and accuse them of having other sexual partners.

Yes it does happen, for instance in some cases if you are proposing love to a girl you will tell her that you had never had any relationship before and she will say the same. Now if you start picking up a condom she will say now, it means you do not trust me, I told you I had never had any sexual relationship before and so you said, now why do you want to use a condom? (African Male)

A distinction is made between girls who live in their neighbourhood and girls who do not. Girls outside neighbourhood are likely to be viewed with suspicion and unlikely to be trusted. Male participants explained that these girls are unlikely to be trusted because the boys did not know if they [the girls] had other boyfriends. The boys usually know girls from the neighbourhood and as a result, they are able to judge their behaviour. Boys are more likely to trust girls who did not have other boyfriends. These girls are seen as 'safe' and therefore not at risk of HIV infection.

It depends where I found her and how. You cannot find a girl for instance in areas, which are unfamiliar like KwaMashu and did not grow up with this person, and only to find that I can trust her so much. (African Male)

You can trust a person you grew up with and not the person you do not know how did she grow up. (African Male)

5.6.2. Reduction in Sexual Pleasure

The reduction of sexual pleasure is one of the major barriers to condom use. Sex is not fully enjoyed if the condom is used. The adolescents stated that they prefer flesh-to-flesh sex, which is seen as more enjoyable. The phrases like “you cannot eat the sweat with its wrapper”, “you cannot eat the banana with its cover”, “you cannot eat the pig in the sack” etc, were often used to describe their lack of pleasure.

We do not enjoy sex with a condom (African Female)

One African female respondent said that they had to remove the condom during sexual intercourse because they experienced a lack of sensation while using condoms. In general, participants preferred condoms that they purchased than condoms they obtain from the clinic. Some participants were likely to perceive condoms that they obtain from the clinics as reducing sexual pleasure. A number of African participants also felt that these condoms were of poor quality and therefore not effective.

Yes, I once used one of those condoms that you get from the clinic with a girlfriend but she did not like it. I then bought a condom from the chemist and she really enjoyed it.

In my view there is a difference (African Male)

Some participants who had prior experience with condoms expressed more favourable attitudes to them. They were very comfortable with using condoms and they did not feel that condoms reduced sexual pleasure, as illustrated in the following comments.

There is no difference if you are used to it. (African Female)

If you have already used a condom you won't experience any problems (African Male)

A commonly held complaint was that condoms interrupt sexual activities. The condom has to be used with every sexual act. Some participants felt that condoms did not allow for spontaneity. Some female participant also explained that it is difficult to introduce the topic of condoms when one is ready to have sex.

But I would not say in the heat of the moment – hang on a minute lets discuss this. (White Female)

The other thing is that ... Stubborn. Its just that if you want to have sex with the girlfriend sometimes you have to cheat her in order to make love. So that time you won't have enough time to put the condom. So you will just do it. Because sometimes they say no I do not feel like having sex today at the same time that no means yes. (African Male)

5.6.3. Effectiveness of Condoms

Some participants were concerned about the reliability of condoms. They were afraid that condoms may burst during sexual intercourse.. Some African male adolescents reported that that some girls are suspicious of the lubricating oils in condoms and that they are afraid that these oils may cause them to become ill. The girls feel condoms may create some discomfort during sexual intercourse.

And the other thing is that a condom has got these oils in it you see. Other girls are afraid of such things and the girls think that these oils are the ones that will make them sick. (African Male)

Some girls even questioned the quality of the condoms and resisted using condoms because of concern for their health.

Some they do not trust condoms. They will say, how would you know that this thing is working? They will ask questions like that and will say what is it made of? How can you put something that you do not know what is it made of? You must know what is this thing made of first. (African Male)

5.6.4 Access to Condoms

The youth are embarrassed to go to the clinics to obtain condoms. The attitudes of providers may act as a barrier to condom use. Some of the participants explain that the providers are not very friendly. Moreover, some providers chastised them for engaging in sexual activities.

And there are guys who are afraid of going to the clinic and take condoms, they are afraid of the nurses there. (African Male)

Yes, if you go there sometimes they will scorn you saying, "why are you engaging in activities that are for adults? (African Male)

The adolescents are ashamed of going to the clinics to request condoms because of the fear of being recognised. They are concerned that providers might be acquainted with their parents and as a result, their parents will find out about their sexual activities. These sorts of concerns are evident in the following comments:

Condoms are supposed to be all over, all over, in all corners. No one will go to the clinic and say I am looking for condoms. Because other people are ashamed of going to the clinic and ask for the condoms there. For instance you find that the nurse is my mother's friend and is going to tell my mother that I am asking for condoms.

(African Male)

Some adolescents may be embarrassed to be seen buying condoms. As a result, they may engage in sex without a condom. Some are not able to afford to buy condoms and as a result, they engage in unprotected sexual activities.

In the pharmacy there are so many people there and you may be the only one buying condoms. (White Female)

My friend would rather say to me come buy condoms with me, than go by herself (White Female)

5.6.5. Economic dependence of women

The poor financial situation of girls may sometimes compel them to engage in unprotected sex. Girls who are financially dependent on their male partners are not able to negotiate sex with their partner for fear of abandonment. These girls are therefore forced to have sex in

exchange for financial security. Some girls feared that their partner would desert them if they did not have sex with them.

Only to find that ... you get forced to abandon the condom. I can't even imagine losing so much money. (African Female)

The man is going to run away from you if at all times you use a condom, married or not. (African Female)

Some girls may deliberately engage in unprotected sex in order to fall pregnant. These girls believe that the child will cement their relationship with their partner and give them greater security.

Ya, it depends what kind of life you are living. Here in townships when you are working you have money, and you got everything, usually what girls like, they like to get pregnant and have a child, you see. When you are using a condom its like: Oh man!! How am I going to get this thing?. So she is going to come with a lot of questions that will make you feel guilty. Like, you do not trust me why don't you trust me? (African Male)

But most of them ... they want to get pregnant and have his kid because he has got a lot of money. (African Male)

Some Indian and African female participants pointed that some young female adolescents get manipulated by taxi drivers into having sex with them. Girls often engage in sexual relationships with taxi drivers in return for free transportation.

Once the girls sleep with them then they get free taxi rides (Indian Female)

*Some other times you will find that taxi drivers are manipulating young girls.
(African Male)*

5.6.6. Peer Influence

Some studies (MacPhail and Campbell, 2000; Harrison et al, 2001) have found that peers may often discourage condom use, particularly, in African communities. On the contrary, the focus group participants felt that their peers were supportive of condom use. They often encouraged each other to use condoms and sometimes pooled money in order to buy condoms.

We do talk about using condoms when we are sitting in the street. We tell the guys that we must use condoms. Sometimes you will find that a guy comes with a condom and gives it to us. (African Male)

No, they do not tease you. For instance if you do not have condoms you will say to your friends: please give me some condoms and he will give you. (African Male)

5.7. Cues to action

5.7.1. Knowing someone with AIDS

Research has shown that people who know someone with AIDS are more likely to adopt protective behaviour. Participants who knew someone who died of AIDS were more likely to use condoms consistently. Some of the African participants and White participants admitted that they knew somebody who is suffering from or has died of AIDS. The Indian participants said they had no knowledge of a person who has died of AIDS, perhaps, because of HIV/AIDS stigma (which was discussed earlier) in their communities.

I know somebody from F-section, he has come to the open, and people know him.

Another guy at school is also suffering. (African Male)

The perception of the African participants was that youth who are practicing unprotected sex have not witnessed how people who are infected suffer. The youth believed that if there could be a close friend or a family member who is infected that can drive them to begin using condoms, as illustrated in the following comments:

If there can be a friend amongst them who is infected, this can put pressure on him to use it. (African Female)

Or if someone in the family is infected that can scare her. (African Female)

If they see infected people, then they realize that AIDS is there and it kills. (African

Male)

5.7.2. Communication about AIDS

Communication is important to promote health seeking behaviour. Some of the African participants felt that they were able to convince their peers to use condoms by talking to them about HIV/AIDS.

Yes. We can talk to those people and ask them whether they know for instance that so and so died of AIDS. Basically tell them about the number of people that they know who have died of AIDS. (African Female)

5.8. Perceived self-efficacy

People are more likely to engage in the health enhancing behaviour if they believe they know how to correctly engage in the behaviour and that it can actually enhance their health. The high incidence of rape in South Africa has led some adolescent girls to conclude that avoiding HIV/AIDS is impossible. These perceptions are evident in the following comments:

You cannot escape Aids family. Sexual intercourse ...marriage. So its not very easy to escape AIDS because if I get raped this afternoon I won't have time to go and find a condom. (African Female)

You cannot say: wear a condom please before you rape me. (African Female)

It's the same even if one can stop using a condom. (African Female)

Some of the female participants felt that the high rate of rape leads them to conclude that using a condom is a fruitless exercise. The adolescent girls stated that it is better not to use a condom. They felt that they would rather enjoy sex. They felt that their risk of being raped in South Africa and therefore they are at risk of HIV infection.

Chapter Six

Conclusion

The aim of this study was to explore adolescents' perceptions of risk of AIDS and condom use. The findings from the focus groups may not be generalised to the entire population of KwaZulu-Natal because they are based on relatively small sample. However there are important findings revealed by the study, which warrant some attention. It is hoped that the study will enhance existing knowledge and understanding of adolescents' sexual behaviour in the era of HIV/AIDS.

The findings of this study are consistent with the results of other studies (Varga, 1997; MacPhail and Campbel, 2001; Tillotson and Maharaj, 2001). Awareness of AIDS is high. Almost all the participants had heard of AIDS. This suggests that prevention programmes have been successful in raising awareness. Levels of knowledge about causation, modes of transmission, prevention and treatment of HIV and AIDS are relatively good. Numerous studies have shown that high levels of knowledge and awareness of HIV/AIDS is not always translated into behaviour change (Friedland et al, 1991; Swart-Kruger and Richter, 1997).

Most of the participants perceived the consequences of AIDS as severe. However, some participants do not believe that AIDS exists. Other studies have found that some of the adolescents who do not believe in the existence of AIDS often harbour the suspicion that the disease is the ploy by the governments to control Africans fertility and a conspiracy by the White population to eliminate the African population (Leclerc-Madlala, 1997; Tillotson and Maharaj, 2001). This study did not find any evidence to support these findings.

Africans are more likely to perceive themselves at greater risk than other race groups. They are more likely to perceive themselves at risk because of their own sexual behaviour. African adolescents are more likely to engage in multiple sexual partnerships, which is likely to increase the risk of contracting the HIV/AIDS. Some adolescents are at risk because they either do not use a condom or they use a condom inconsistently. A tendency of some African girls to become involved in sexual relationships with older men place also places them at greater risk to contract HIV/AIDS. In these relationships, girls have less power to negotiate safer sexual practices. Consumption of alcohol is likely to lead to irresponsible sexual behaviours including sex without a condom. Some adolescents also feel that once they are infected they must infect others. Leclerc-Madlala (1997) also found that there is a tendency for Zulu youth to infect others once they have been infected.

In South Africa, there exists a high level of violence. Some of the adolescent girls expressed their fear of being raped. They felt that they are in danger of being raped and in this way, become infected with HIV/AIDS. These adolescents feel that they are at risk of being raped by a HIV positive person at anytime and as a result they do not see the need for protection. The adolescent girls feel defenceless against rape. Jewkes et al (2001) found that two thirds of adolescent girls had been beaten by a boyfriend and that one in ten of teenagers had been raped. This signifies the blatant failure by government to ensure law enforcement and crime prevention in our communities.

There are currently many barriers to condom use amongst adolescents. As has been shown elsewhere (Varga, 1997) trust is the major barrier to condom use amongst adolescents. Condom use is interpreted as a sign of lack of trust. This is because of the association of condoms with illicit sex. This is hardly surprising because prevention programmes have in

the past promoted condoms as a method of preventing STIs. Prevention programmes have an important role to play in promoting condoms as a method of dual protection against pregnancy and disease.

The study also found that most of the adolescent boys tend to trust girls who live in their neighbourhood. This is because they are more likely to assess their sexual behaviour and determine if they have other sexual partners. These results concur with the findings of the study by Tillotson and Maharaj (2001), which found that girls from the boys' neighbourhood are more likely to be trusted than girls from other neighbourhoods.

Condoms are also less likely to be used because they are associated with a lack of sexual pleasure. Other studies have also found that the belief that condoms reduce sexual pleasure is likely to contribute to the non-use of condoms (Abdool Karim et al, 1992c; Varga, 1997). Most of the adolescents complain that sex with a condom is seen as less pleasurable.

Some participants felt that certain condoms were more likely than other condoms to reduce sexual pleasure. In their exploratory qualitative study to identify barriers to condom use, Abdool Karim et al (1992c) found some adolescents were concerned that the condom would burst during sexual intercourse and this acted as a major barrier to condom use.

Some participants also expressed concern about the quality of condoms. Some participants felt that condoms that are freely available in clinics are of a lower quality and therefore they were less likely to be accepted. However, some participants were not able to afford to purchase condoms and as a result, they were more likely to engage in unprotected sexual activity. Some participants also expressed the fear that condoms may break or burst during

sexual intercourse. MacPhail and Campbell (2001) also found that poverty was a powerful factor that prevents young people from purchasing condoms (p.1623).

Some participants experienced difficulty in obtaining condoms from health facilities. Sometimes providers may act as a barrier to condom use. Some participants complained that providers often scolded them for engaging in sexual activities. The study by Abdool Karim et al (1992a) and Abdool Karim et al (1992b) found that adolescents who requested condoms from health professionals were often subject to rude and unfriendly treatment.

The poor socio-economic status of female participants also increased their risk of HIV infection. As has been found in other studies, women with low socio-economic status are less likely to insist on condom use (Worth, 1989; Campbell et al, 1998). These women are often financially dependent on their partners and are therefore unable to refuse to have sex with their partner if their partner did not want to use a condom. It was noted by some African participants that some girls are financially supported by their boyfriends and as a result, they are unlikely to object to sex without a condom.

Some participants also complained that the condoms were too big. Other studies (MacPhail and Campbell, 2001) for example have found that there is an objection by peers to condom use. Young men using condoms are jeered at, belittled and accused of being stupid by their friends (1620). In contrast this study found that there is a strong support for condoms among their peers. Most of the adolescents said that they had discussed condoms with their peers and they encouraged each other to use condoms. In some cases the adolescent boys pooled resources to purchase condoms.

Many African adolescents in this study vehemently stated that knowing somebody who is infected or has died of AIDS could induce adolescents to practice safe sex. This suggests that it is important to create an environment where people living with AIDS are not afraid to disclose their status, without fear of stigma. This is also likely to impact positively on sexual behaviour. Unfortunately, there is a high level of stigma that is attached to AIDS. There is an urgent need to eliminate stigma surrounding HIV and AIDS.

The study shows that there is a severe lack of communication between parents and the adolescents. Other studies (Myekiso and Twaise, 1993; Blake et al, 2001) have shown that where good parent-child communication exists, the adolescents tend to live health promoting sexual lives. In this study most of the adolescents said they are afraid of discussing sexual matters with parents. For the African participants it was considered as against African culture to discuss sexual matters with parents. In instances where communication takes place it is often a unidirectional- from parent to child in form of instructions without detailed explanation. As a result most of the adolescents turn to their friends for sexual advice. However, sometimes this information may not be correct and may lead to to risk taking behaviour. There seems therefore to be a need for national educational programmes to encourage communication between parents and children on sexual health matters.

The level of HIV infection is reaching pandemic proportions in South Africa. The devastating consequences of the epidemic, particularly on demographic factors and socio-economic factors, are well documented. Considering these negative effects of the epidemic it is clear that HIV/AIDS is the biggest challenge facing our country today. Most of the people who become infected are young people during their productive and reproductive ages. There is

therefore a need, in this country and around the world, to build and reinforce concerted efforts towards promoting safer sexual practices among the youth.

References

Abdool Karim, Q.A., Preston-Whyte, E., and Abdool Karim, S.S.A. (1992a). Teenagers seeking condoms at family planning services. Part I. A user's perspective. *South African Medical Journal* 82:356-359.

Abdool Karim, Q.A., Preston-Whyte, E., and Abdool Karim, S.S.A. (1992b). Teenagers seeking condoms at family planning services. Part II. A provider's perspective. *South African Medical Journal* 82:360-362.

Abdool Karim, S.S., Abdool Karim, Q., and Preston-Whyte, E., Sankar, N. (1992c). Reasons for lack of condom use among high school students. *South African Medical Journal* 82:107-110.

Ajzen, I. and Fishbein, M. (1980). *Understanding attitudes and predicting behaviour*. New Jersey, Prentice Hall.

Akwara, P.A., Diamond, I. and Madise, N. (2001). *Perception of Risk of HIV/AIDS and Sexual Behaviour? Is there a casual link?* Paper prepared for the Population Association of American Conference, Washington DC, USA. 29th March – 31st March 2001.

Alan Guttmacher Institute (2001). Teenage Sexual and Reproductive Behaviour in Developed Countries: Can More Progress Be Made? [On Line].

Available: http://www.guttmacher.org/pubs/euroteens_summ.pdf. Downloaded, 14 November 2002.

Blake, S.M., Simkin, L., Ledsky, R., Perkins, C. and Calabrese, J.M. (2001). Effects of a Parent-Child communications Intervention on Young Adolescents' Risk for Early Onset of Sexual Intercourse. *Family Planning Perspectives* 33(2): 52-61.

Blanc, A.K., and Way, A.A. (1998). Sexual Behaviour and Contraceptive Knowledge and Use among Adolescents in Developing Countries. *Studies in Family Planning* 29(2): 106-116.

Campbell, C., Mazaidume, Y. and Williams, B. (1998). Gender as an obstacle to condom use: HIV prevention amongst commercial sex workers in a mining community. *Agenda*. 39: 50-57.

Campbell, C. and Mzaidume, Y. (2002). How can HIV be prevented in South Africa? A social Perspective. *British Medical Journal* 324:229-232.

Campbell, C.M. and Williams, B.G. (1996). Academic research and HIV/AIDS in South Africa. *South African Medical Journal* 86(1): 55-60.

Cook, T.D. and Reichardt, C.S. (1979). *Beyond Qualitative Versus Quantitative Methods in Qualitative and Quantitative Methods in Evaluation Research*, Cook, T.D., and Reichardt, C.S (1979). California, SAGE.

Dallimore, A., (2001). *Adolescent risk-taking behaviour in an era of HIV/AIDS infection*. Unpublished Masters Dissertation. Durban, University of Natal.

Department of Health (1998). *South African Demographic and Health Survey*. South Africa National Department of Health. Pretoria: Government Printers.

Department of Health (2000a). *National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa*, Pretoria: Government Printers.

Department of Health (2000b). *South African Health Review*. South Africa National Department of Health. Pretoria: Government Printers.

Department of Health (2001). *National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa*. South Africa National Department of Health, Pretoria, Government Printers.

Department of Social Development (2000). *The state of South Africa's Population Report*. National Population Unit. Pretoria, Government Printers.

Eiser, J.R., (1986). *Social Psychology: Attitudes, cognition and social behaviour*. Cambridge, University Press.

Filstead, W.J., (1979). *Qualitative Methods: A needed perspective in Evaluation Research* in (Eds) Cook, T.D., and Reichardt, C.S. (1979). *Qualitative and Quantitative Methods in Evaluation Research*, California, SAGE.

Flisher, A.J., Ziervogel, C.F., Chalton, D.O., Leger, P.H., Robertson, B.A. (1993). Risk taking behaviour of Cape Peninsula high-school students. *South African Medical Journal* 83:495-497.

Friedland, R.H., Jankelowitz, S.K., De Beer, M., De Klerk, C., Khoury, V., Csizmadia, T., Padayachee, G.N., Levy, S. (1991). Perceptions and knowledge about the acquired immunodeficiency syndrome among students in University residences. *South African Medical Journal* 79:149-154.

Gage, A.J. (1998). Sexual Activity and Contraceptive Use: The components of the decision-making process. *Studies in Family Planning* 29(2):154-166.

Gibbs, A. (1997). *Social research update*. London. SAGE.

Hall, D. and Hall, I. (1996). *Practical Social Research- project work in the community*.

Harrison, A., Xaba, N., Kunene, P., and Ntuli, N. (2001). Understanding young women's risk for HIV/AIDS: Adolescent Sexuality and vulnerability in rural KwaZulu-Natal. *Society in transition* 32(1): 69-78.

Heisie, L.L., Raikes, A., Watts, C.H and Zwi, A.B (1994). Violence against women: a neglected public health issue in less developed countries. *Social Science and Medicine* 39(9): 1165-1179.

Herek, G.M. and Capitanio, J.P. (1999). AIDS Stigma and Sexual Prejudice. *American Behavioral Scientist* 42:1126-1143.

Hulton, L.A., Cullen, R., and Khalokho, S.W. (2000). Perceptions of the risks of sexual activity and their consequences among Ugandan adolescents. *Studies in Family Planning* 31(1):35-46.

Jewkes, R., Vundule, C., Maforah, F., and Jordaan, E. (2001). Relationship dynamics and teenage pregnancy in South Africa. *Social Science and Medicine* 52:733-744.

Jiwani, Y. (1999). *The 1999 General Social Survey on Spousal violence: an analysis*. [On Line]. Available: <http://www.harbour.stu.ca/treda/reports/gss01.htm> Downloaded, 06 March 2002.

Kalunde, W. K., (1997). HIV/AIDS and sexual behavior among youth in Zambia. *Health Transition Review*, Supplement 3, 7:91-95.

Kasprzyk, D., Montano, D.E, and Fishbein, M. (1998). Application of an Integrated Behavioural Model to predict condom use: A Prospective Study among High HIV Risk Groups. *Journal of Applied Social Psychology* 28 (17-24): 1557-2304.

Kaufman, C.E, De Wet, T., and Stadler, J., (2001). Adolescent Pregnancy and Parenthood in South Africa. *Studies in Family Planning* 32 (2):147-160.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal* 311:299-302.

Krueger, R.A. (1994). *Focus Groups – A practical guide for applied research*. 2nd edition. SAGE. California.

Langer, L.M., Zimmerman, R.S., and Katz, J.A. (1994). Which is more important to High school students: Preventing Pregnancy or Preventing AIDS? *Family Planning Perspectives* 26(4):154-159.

Leclerc-Madlala, S., (1997). Infect One, Infect All: Zulu Youth Response to the AIDS epidemic in South Africa. *Medical Anthropology* 17:363-380.

Loewenson, R. and Whiteside, A. (1998). HIV and AIDS in Southern Africa. in (Whiteside, A. Eds. (1998). *The implications of AIDS for Demography and Policy in Southern Africa*. Pietermaritzburg, University of Natal Press,

Loewenson, R. and Whiteside, A. (2001). *HIV/AIDS Implications for Poverty Reduction*. United Nations Development Programme Policy Paper (UNDP).

Maart, B. (2000). Risky Business: Issues Affecting Adolescent Sexual Health in South Africa. *Development Update*, 3(2): 144-158.

MacPhail, C. and Campbell, C. (2001). "I think condoms are good but aai, I hate those things": Condom use among adolescents and young people in a Southern African township. *Social Science and Medicine* 52:1613-1627.

Maharaj, P., (2001). Male attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. *Journal of Southern African Studies* 27(2): 245-257.

Manzini, N., (2001). Sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa. *Reproductive Health Matters* 9(17):44-51.

Mayekiso, T.V. and Twaise, N. (1993). Assessment of parental involvement in imparting sexual knowledge to adolescents. *South African Journal of Psychology* 23(1):21-23.

Nichols, P. (1991). *Social Survey Methods*. Fieldguide for Development Workers. Oxford, Oxfam.

Nzioka, C. (2001). Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya. *Reproductive Health Matters* 9(17)108-117.

Oliver, P.D, Leeming, F.C, and Dwyer, W.O (1998). Studying Parental Involvement in school-based sex Education: Lessons learned. *Family Planning Perspectives* 30(3):106-153

Preston-Whyte, E. and Zondi, M. (1991). Adolescent sexuality and its implications for teenage pregnancy and AIDS. *VMO.CME* 9(11)1388-1397.

Preston-Whyte, E.M. (1999). Reproductive Health and the condom dilemma: Identifying Situational Barriers to HIV protection in South Africa. In *Resistances to Behavioral Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries* 139-155. (Eds) John C. Caldwell, Pat Caldwell, John Anarfi, Kofi Awusabo-Asare, James Ntozi, I.O. Orubuloye, Jeff Marck, Wendy Cosford, Rachel Colombo and Elaine Hollings. Health Transition Centre, NCEPH. The Australian National University.

Rutenberg, N., Kehus-Alons, C., Brown, L., Macintyre, K., Dallimore, A., and Kaufman, C. (2001). *Transitions to Adulthood in the context of AIDS in South Africa*. University of Natal, Population Council and Tulane University.

Robinson, A., Brown, L., and Macintyre, K. (2001). *Focus Group Discussions among adolescents in KwaZulu Natal Province, South Africa*. Draft Report.

Rotherman-Borus, M.J., Futterman, D. (2000). Promoting Early Detection of Human Immunodeficiency Virus Infection Among Adolescents. *Archives of Paediatric and Adolescent Medicine* (5):435-9.

Shedlin, M.G., and Shreiber, J.M. (1995). *Using Focus Groups in Drug Abuse and HIV/AIDS Research*. In E. Lambert, R Ashley, R. Needle (Eds) *Qualitative Methods in Drug Abuse and HIV Research*. Washington DC, National Institute of Drug Abuse.

Statistics South Africa (1999). *Census' 1996*. Pretoria, Government Printers.

Stewart, D.W., and Shamdasani, P.N. (1990). *Focus Groups- Theory and Practice*. Newbury Park, California.

Stroebe, W. (2000). *Social Psychology and Health*. 2nd Edition. Buckingham, Open University Press.

Swart-Kruger, J., Ritcher, L.M. (1997). AIDS-Related Knowledge, Attitudes and Behavior Among South Africa Street Youth: Reflections on Power, Sexuality and Autonomous Self. *Social Science and Medicine*, 45(6): 957-966.

Tamang, A., Nepal, B., Puri, M., and Shrestha, D. (2001). Sexual Behavior and Risk Perceptions among Young Men in Border Towns of Nepal. *Asian-Pacific Population Journal*, 16 (2): 195-210.

Tillotson, J., and Maharaj, P. (2001). An exploratory study into the barriers to HIV/AIDS protective behavior among African Zulu-speaking adolescent males in township secondary schools in Durban, South Africa. *Society in Transition* 32 (1): 83-101.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 1999. *Sexual Behavioral Change for HIV: Where have Theories taken us?* [On Line]

Available: <http://www.unaids.org/publications/documents/epidemiology/surveillance/CDROM/Surveillance%20Guidelines/Behavioural%20Surveillance/Behavioural%20Background%20docs/sexl%20behavioural%20change.pdf>. Downloaded, 16 October 2002.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 1998. *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2000a. *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2000b. *AIDS epidemic update*. December 2000. Geneva, Switzerland.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2002. *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland.

Varga, C.A. (1997). Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal, South Africa. *Health Transition Review*, Supplement 3 to 7: 45-67.

Venier, J.L., Ross, M.W., Akande, A. (1998). HIV/AIDS-Related social anxieties in adolescents in three African countries. *Social Science and Medicine* 46 (3): 313-320.

Whiteside, A., Wilkins, N., Mason, B., and Wood, G. (1995). *The impact of HIV/AIDS on planning issues in KwaZulu Natal.*: Town and Regional Planning. Pietermaritzburg

Whiteside, A. and Sunter, C. (2000). *AIDS – The challenge for South Africa*. Cape Town: Tafelberg.

Witte, K. (1999). *Theory Based Interventions and Evaluations of Outreach Efforts*. [On Line]. Available: <http://nlm.gov/pnr/eval/witte.html>, Downloaded, 01 October 2002

Wood, K., Maforah, F. and Jewkes, R. (1998). “He forced me to love him”: Putting violence on adolescent sexual health agendas. *Social Science and Medicine* 47 (2): 233-242

World Health Organisation (WHO). 1995. *The narrative research method: Studying behaviour patterns of young people by young people. A guide to its use*. Geneva: Adolescent Health Programme, Division of Family and Reproductive Health.

Worth, O. (1989). Sexual Decision-Making and AIDS: Why condom promotion among vulnerable women is likely to fail. *Studies in Family Planning* 20(6): 297-307.