

**UMBUMBULU TAXI DRIVERS' ATTITUDES CONCERNING CONDOM USE AND
DUAL CONTRACEPTIVE USE BY THEIR FEMALE PARTNERS**

Zamashandu Jeanette Mbatha

Student Number: 971162604

Supervised by Dr Emma Durden

**Dissertation submitted in fulfilment of the Degree of Master of Social Science
The Centre for Communication, Media & Society,
School of Applied Human Sciences,
University of KwaZulu-Natal, Durban**

January 2015

DECLARATION

I, Zamashandu Jeanette Mbatha declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
 - a) Their words have been re-written but the general information attributed to them has been referenced
 - b) Where their exact words have been used, then their writing has been placed inside quotation marks, and referenced.
5. This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the References sections.

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to my supervisor Dr. Emma Durden, who has patiently supported me throughout my thesis, for the useful comments and remarks. I am grateful to Prof. Keyan Tomaselli for the support throughout the course of the work. It has been a remarkable privilege to do my MA thesis with CCMS. I would also like to thank Umbumbulu Taxi Association, the rank manager and taxi drivers who gave generously their time to share their knowledge and experiences. I will not forget to thank all the fellow CCMS students for their invaluable contributions during our Friday morning seminars – much appreciated.

I would also like to thank my lovely daughter Asanda; my dear friends Prestage Murima and Musara Lubumbo, for your love and continued support. Words cannot express how grateful I am.

My sincere appreciation also goes to my dearest husband Xolani Zindela, for his warmth, love and support and ongoing motivation. I will be grateful forever for your love. Your prayers for me are what have sustained me thus far.

Above all, I thank the Lord who always makes me to triumph in Christ Jesus.

ABSTRACT

Sub-Saharan Africa remains most severely affected by HIV/AIDS, with nearly one in every 20 adults living with HIV and accounting for 71% of people living with the disease worldwide. However, according to UNAIDS at least 86% of people living with HIV in the Sub-Saharan know their status. And in the past three years alone, new HIV infections fell by 13%. (UNAIDS, 2014; WHO, 2012). An abiding concern in the HIV and AIDS narrative has been the relative absence of men in interventions and responses to the disease. This study seeks, among other things, to unearth whether patriarchy or hegemonic masculinity influences dual contraceptive use.

While there is a wealth of information around condom use and the knowledge, attitudes and perceptions that prevail thereof with women, little is known about the same from a male perspective. This study therefore explores the attitudes of taxi drivers who in male circles are considered the ‘other’, and by academics as risk populations.

The conceptual bases of this study are the Social Ecology Model and the Health Belief Model. The study reveals that despite knowledge of STIs, HIV and AIDS transmission, many individuals do not feel personally vulnerable to contracting and transmitting a disease to their sexual partners. Findings of this study highlight the need for research to be conducted with the taxi drivers’ female partners on the use of dual contraceptive methods.

Table of Contents

DECLARATION	i
ACKNOWLEDGEMENTS	ii
ABSTRACT	iii
CHAPTER ONE: INTRODUCTION	1
Problem Statement	4
Locating the study	5
Objectives of the study	7
A note on terminology	8
Thesis structure	9
CHAPTER TWO: LITERATURE REVIEW	11
Drivers of the epidemic	12
Key Drivers	13
Multiple and Concurrent Sexual Partnerships.....	13
Condom Use.....	16
Medical Male Circumcision	19
Contributing Drivers	19
Knowledge and Attitudes of Males.....	19
Age-Disparate Sex	20
Low contraceptive use by women	21
Social and Structural Drivers	23
Poverty	23
Gender dynamics and power relations.....	25
TAXI DRIVERS IN SOUTH AFRICA	26
CHAPTER THREE: THEORETICAL FRAMEWORK	30
The Health Belief Model	31
Perceived Susceptibility	34
Perceived Severity.....	34
Perceived Benefits	35
Perceived Barriers	35
Cues to Action	36
Self-Efficacy	37
Critique of the HBM	37

The Ecological Perspective	39
The Social Ecology Model	41
Individual/Intrapersonal level	42
Interpersonal Level	42
Institutional Level.....	43
The Community Level	43
Policy Level.....	44
Applications and limitations of the SEM	44
<i>Application of these theories in this study</i>	45
CHAPTER 4: METHODOLOGICAL OUTLINE	47
Interpretive Paradigm	47
Research Design	49
Research Preparation Processes	49
Selection of participants	50
Data gathering methods	51
Focus Group Discussion	51
Structured Interviews	52
Enacted reflexivity	53
Data Analysis	54
CHAPTER FIVE: DATA ANALYSIS	59
Perceptions of Contraceptive use among Umbumbulu Male Taxi Drivers	59
Attitudes Towards Condom Use	59
Multiple and Concurrent Sexual Partnerships	63
Transactional and Intergenerational Sexual Relationships	68
STI Spread at the Taxi Rank	69
Male Attitudes towards Contraceptive Use by their Female Partners	72
Negative Perceptions on Contraceptive Use	74
Negotiation of Contraceptive use in Relationships	76
Communication Strategies around contraceptive use in relationships	80
Perceptions around HIV Testing	80
Religion and Contraceptive use	81
Intrapersonal Level	87
Interpersonal Level	88

Organisation Level	89
Community Level	89
CONCLUSION	91
A Summary: Findings, Recommendations and Conclusions	91
<i>Recommendations</i>	95
BIBLIOGRAPHY	96

CHAPTER ONE: INTRODUCTION

HIV and AIDS remain a global problem and continue to claim more lives every day despite numerous protective methods and strategies that have been put in place to control and manage the disease and its effects. According to the World Health Organisation in 2012, 35.3 million people across the world were infected. Of these, adults aged between 15 and 49 years constitute 0.8%. Sub-Saharan Africa remains most severely affected by the disease with nearly one in every 20 adults living with HIV and accounting for 71% of people living with the disease worldwide. However, according to UNAIDS at least 86% of people living with HIV in the Sub-Saharan know their status. And in the past three years alone, new HIV infections fell by 13%. (UNAIDS, 2014; WHO, 2012). The burden of the epidemic continues to vary considerably from country to country.

In 2012 a total of 6.1 million South Africans were living with the disease. Of these 17.1% were individuals between the ages of 15 and 49 (UNAIDS, 2012). Over two million South Africans are on treatment (Shisana, 2013). The KwaZulu-Natal remains the leading province in terms of disease prevalence with 28% of its population living with the disease (ibid.). Shisana et al., (2014) also point out that condom use has declined in South Africa, thus lending weight to this study.

In the absence of a cure, efforts to mitigate the impact of the epidemic have largely focused on prevention. “Prevention demands the integration of health promotion strategies, which not only break the silence surrounding HIV and AIDS but also vicariously, sexuality” (Kunda, 2008:29). These strategies largely consist of communication back and forth between these affected communities and public health specialists. It is while communicating that social interactions are aptly captured, and in the process interactions are negotiated – meanings are challenged, changed and circulated – and discourses are reproduced (ibid.). It is also through talking to individuals that an understanding of their lives and day-to-day experiences can be gleaned. From a public health perspective, this is crucial, as it enables the development of strategies and interventions to best deal with public health issues at hand. In addition, there is an opportunity to better understand how communities are affected and influenced by their environments and how these environments in turn affect and influence these communities. This is important again where intervention design is concerned, especially in the case of HIV and AIDS where the only salvation at the moment is to prevent infection by barrier methods

and abstinence (Jensen, 2012).

An abiding concern in the HIV and AIDS narrative has been the somewhat absence of men from interventions conducted by health communication agencies. While men are involved in health communication campaign strategy, they rarely participate in such programmes as participants. This is the experience of those of us who work for DramAidE and why this organisation deliberately targeted (male) taxi drivers as a vulnerable community at risk of infections. Men have thus found themselves in a spectator's role while women, due to their biological function, have become centre-stage in HIV and AIDS conversations. The absence of men from the rank and file discussions, so to speak, is worrying simply because men are also actors and have their own urgency when it comes to the coping with epidemic.

Hegemonic masculinity has over the years allowed men to claim and sustain a leading and dominant position in the social hierarchy. This masculinity is known to spill over to the sexual domain where women's sexual choices are mostly influenced by their male partners. Women shape the contours of their heterosexual relationships, their acquiescence and or resistance to this hegemony loosely based on their interactions and association with these males. This study seeks, among other things, to unearth whether patriarchy or hegemonic masculinity influences dual contraceptive use (Stern & Buikema, 2013).

The study was conducted under the auspices of the Centre for Communication, Media and Society (CCMS) which is directly linked to its officially affiliated partner, Drama for AIDS Education (DramAidE), on whose work this study is based. Integrating the theoretical skills taught at CCMS which, according to Lubombo (2014), emphasises social agency in the study of the world, and which applies action research in changing it (Durden & Tomaselli 2012). My study explores how taxi drivers make meaning of contraceptive use within their specific cultural contexts. This study integrated with ongoing workshops conducted by DramAidE (2012ff) with taxi drivers to assess why they fail to access health services and to encourage them to communicate with their partners on the advantages of contraceptive use.

While this study appears to be a product of the usual CCMS – DramAidE partnership where the latter provides a research site for the former (DramAidE, 2010), it is important to note that I am personally involved in the DramAidE projects as a Facilitator responsible for the Gender

Challenge project in Umbumbulu district mobilising men to curb the spread of AIDS using the Brothers for Life campaign that promotes the health and wellbeing of South African men with a focus on HIV (Myers et al, 2013).

The project took the pattern of the *'See you at 7: Mobilising Young Men to Care'* project which is about developing gender responsibility, drawing men into the process of social change towards healthy sexual behaviour (CADRE, 2001). When interviewed on 14 November 2014, Gumede, (DramAidE Director), a project concept was developed in two rural schools in KwaZulu Natal involving 100% pupil and teacher participation, in interactive performative engagements with the local community and parents also. The project started with research and after that a series of workshops were developed and tested. The outcome of the workshops led to the development of plays that were raising questions about 'men taking responsibility'. In one of the plays a boyfriend sets a date with his girlfriend and he then says, "I'll see you at 7 O'clock, thus the title of the book is *'See You at 7'* (Gumede, 14, 11, 2014, Interview).

The main aim of the *'See you at 7: Mobilising Young Men to Care'* project was for young men to become involved in the promotion of healthy lifestyles and safer sex practices. For example, there is a play that shows a stereotypical way in which young people behave in relationships. The theme of the play is: Does 'No' mean 'Yes. This play explores the communication barriers that prevent young people from successfully respecting and supporting each other's right to have control over their bodies (CADRE, 2001). The project encouraged young men to understand the needs of women's sexual reproductive rights (ibid.). Theories of behaviour change, participatory action research, interactive participatory learning, and strategies for health communication and life skills were applied in the *'See you at 7: Mobilising Young Men to Care'* project (Tomaselli & Chasi, 2011).

The Gender Challenge project that has been conducted since 2007 in Umbumbulu area, gave me an opportunity to work with men encouraging them to talk openly about their sexuality as well as to explore gender stereotypes and behaviours. The Gender Challenge project also encourages taxi drivers to develop new thinking and show that there is equality between genders. Although working with men (young and old) was challenging, it also taught me that being a facilitator and working in the community with people from different backgrounds

requires devotion.

My work at DramAidE has undoubtedly influenced my interest in the topic of this study in two significant ways. Firstly, being a Facilitator of the DramAidE travelling theatre group that visits communities to raise awareness about HIV/AIDS prevention through promotion of healthy behaviours including contraceptives use by women, I was privileged to learn the challenges that women face when they want to use contraceptives. What I discovered is that regardless of their knowledge about, and willingness to use contraceptives for different purposes such as preventing pregnancy and STIs, more often than not they are discouraged by their male partners.

Secondly, as a woman, I have a personal understanding of the extent to which male partners can influence our decisions about health and other matters. It is in the context of the foregoing that this study attempts to explore taxi drivers' attitudes concerning condom use and dual contraceptive used by their female partners.

Problem Statement

Dual contraception, commonly known as 'the Double Dutch method' (Gregson & Kirkman, 1999:45), has been over the years promoted as an important means of family planning as well as a method of prevention of infection with HIV and other sexually transmitted infections (STIs). However, little is known about current levels and predictors of dual method use in South Africa or about interventions that might promote dual protection (Myer et al., 2002). "The predominance of hormonal contraceptives, particularly injectables, means that the simplest approach to dual protection is through the combination of a barrier method, most commonly the male condom, with a non-barrier (primarily hormonal) contraceptive" (Myer et al., 2002:119). This study seeks to understand, from a male taxi driver's perspective, the attitudes that prevail towards dual contraception.

While there is a wealth of information around condom use and the knowledge, attitudes and perceptions that prevail thereof with women, little is known about this from a male perspective. This is mainly because men are most often the 'other' in the HIV and AIDS narrative. This study aims to explore beyond men and delve into the attitudes of taxi drivers who, in broader male circles are considered the 'other' and as 'at risk' (Ncama et al., 2013).

Mchunu et al. (2012) observe that the transport sector in South Africa enables a high-risk population mainly because of drivers' mobility, social dislocation, the high-risk environment within which they operate.

It is therefore important to study male taxi drivers' attitudes because taxi drivers fall prey to unsafe and promiscuous sexual practices as a result of being away from their families for prolonged periods of time. The taxi industry in South Africa employs about 65% of economically active people in South Africa (Manzi, 2004). Unlike other industries, the nature of the industry – being non-regulated and mobile – makes it difficult for government and other stakeholders to implement health and safety regulations, and to implement HIV and AIDS interventions.

Conceptually, the study draws from the Social Ecology Model and the Health Belief Model (Sallis et al., 2008). The Health Belief Model is used to understand, at an individual level, male taxi drivers' attitudes towards dual contraception. The Social Ecology Model, on the other hand, is used to understand attitudes while taking into account the environment that taxi drivers come from and operate within. These theories assist in unpacking certain phenomena throughout the study and also enable the researcher to understand certain behaviours and attitudes.

Locating the study

HIV and AIDS and all its complexities have challenged the government and other stakeholders to develop and initiate an appropriate response to the pandemic. While strategies such as the Abstain, Be-faithful and Condomise (ABC) have been employed across the continent together with various other strategies and campaigns, in South Africa's KwaZulu Natal, a need arose to address the disease via a different response. According to Moodley (2007), these three behavior change elements forms the A (Abstain), B (Be Faithful) and/or C (Condomise) message today.

The response was to appropriately manage the effect and impact of the disease, and also raise awareness of the disease amongst the youth and the old. Using 'participatory action' research methodologies with the "aim of facilitating awareness, providing information and developing skills to build a social movement", a response was created at the University of Zululand in

1992 (DramAidE, 2008; Durden & Tomaselli, 2012; Tomaselli & Chasi, 2011). DramAidE is a direct response to the problems that HIV and AIDS bring with them and aims to engage society to think critically about their behaviours and how these affect and influence their sexual health. “DramAidE facilitates a participatory process where participants are challenged to question their beliefs and negotiate new meaning for themselves and the world around them” (DramAidE, 2008).

DramAidE’s methodology is anchored in Freirean Pedagogy (Freire 1972; Botha, 2009) and Boleyn dramaturgy (Boal, 1979; Durden, 2010) in terms of raising awareness and changing attitudes and belief (Dalrymple, 1995; Sondergaard, 2000; Kelly, 2002; 2001). Participatory Action Research (PAR), one of the underpinning methodologies that informs DramAidE, states that research must be action-oriented and, for the programme to have impact on behaviour, must involve communities as active participants (Nduhura, 2004). Melkote and Steeves (2001) posit that PAR draws from the philosophy that endogenous knowledge and narratives of the oppressed are key assets to liberation. As such, the approach aims to “establish existing cultural beliefs and practices identify emerging themes and modifications and then further develop the intervention in order to initiate change” (Dalrymple, 1995: 265).

It is against this background that DramAidE conducts community dialogues. These dialogues are platforms that bring together all stakeholders such as government departments, other non-governmental organisations (NGOs), community based organisations (CBOs) among others together with affected communities to address the social drivers of HIV (Figueroa, et al., 2002). When conducting community dialogues, DramAidE’s facilitators follow Figueroa et al’s (2002) 10 steps. These are: ‘Recognition of a Problem’; ‘Identification and Involvement of Leaders and Stakeholders’; ‘Clarification of Perceptions’; ‘Expression of Individual and Shared Needs’; ‘Vision of the future’; ‘Assessment of Current Status’; ‘Setting Objectives’; ‘Options for Action’; ‘Consensus on Action’ and ‘an Action Plan.’ Community dialogue therefore emphasises equal participation and community empowerment by horizontal interaction (Gazu et al., 2008:12).

It was while conducting community dialogues in semi urban and rural KwaZulu-Natal that I discovered that contraception use and condom use was particularly problematic for women in committed relationships. The conversations around dual contraception revealed that in as

much as women are unable to openly discuss their contraceptive needs with their partners, men's attitudes towards condom and contraceptive use are central to the fight against HIV and AIDS. Taxi drivers were studied because there was lot of talk from the women around the sexual behaviours of men, and taxi drivers in particular. The research location is in Umbumbulu District in KwaZulu Natal (KZN) where some of the community dialogues were conducted. That the community had been exposed to DramAidE projects was the reason why this area was chosen as an ideal research location.

Objectives of the study

The overall aim of this study is to assess male taxi drivers' attitudes to condom use and dual contraceptive use by their female partners, using male taxi drivers in KwaZulu Natal (KZN), Umbumbulu District as a case study. This is particularly important because from a social ecological perspective, the success of DramAidE projects aimed at raising awareness about HIV/AIDS prevention through promotion of healthy behaviours including contraceptive use by women is undoubtedly impacted by the cooperation of their male partners.

In order to achieve the above objective, the study intends to answer the following key questions:

1. How do male taxi drivers perceive their risk of contracting HIV and AIDS?
2. What is the understanding of male taxi drivers of dual contraceptive use in sexual relationships?
3. How do male taxi drivers perceive their role, as well as their partner's role, in HIV prevention and pregnancy prevention?
4. What implications does this have for public health communication with regard to contraceptive use?

Having a dialogue with taxi drivers around contraceptive and condom use (dual protection) to answer the above questions is significant in that it helps establishing effective ways through which HIV and AIDS can be managed and controlled in at-risk populations like taxi drivers and their female partners. It is thus important that male taxi drivers give their own accounts, as they are considered to be an at-risk population (Mchunu et al., 2012). Their narratives open windows on what their daily lives are like and offer an opportunity for the public health worker to design interventions that best speak to their plight. It is important that male taxi

drivers be actively involved in the design and development of interventions that focus on their circumstances. This ensures the adoption of messages and practices as they take ownership of the intervention (cf. Parker, 1994).

The above is consistent not only with the cultural studies approach at CCMS which values research that listens to the voices of affected communities, but also with DramAidE's community engagement or participatory approach which seeks to empower communities. Sustainability of DramAidE programmes, as with the rationale for this study, is essentially premised on the assumption that if stakeholders are involved in finding solutions to their social development challenges, success is likely (Lubombo, 2011; Bessette, 2004; Figueroa et al., 2002). The argument for involving male counterparts as stakeholders in female contraceptive use is therefore based on the rationale that if they support their women, contraceptive use is likely to be successful. Conversely, if they do not cooperate, it comes to naught. However, men's support of their female partners' use of contraceptives is unarguably dependent on their understanding of contraceptive use.

From the community dialogues, it emerged that men have myths and beliefs associated with contraceptive use by women. For example, some men think that injectable contraceptives make their women too wet, also believing that it is not proper to 'eat sweets while they are wrapped in a plastic.' Some of these myths are counter progressive as they negatively affect the desired use of contraceptives. As such, the need to improve knowledge and change men's attitude towards contraceptives requires foremost an appreciation of their understanding and perceptions about contraceptives. This is the task that this study attempts to achieve.

Study findings shed more light on how male taxi drivers' attitudes affect dual contraception use by their female partners, thus contributing to wider policy-making at community levels. The study also contributes to existing literature on male taxi drivers and their sexual health behaviour. This study does not focus on private sexual behaviour but explores sexual behaviour and sexuality; and how sexuality affects and implicates the individual and society (Murima, 2013).

A note on terminology

In this study, some important terms and concepts have been used. These need some

clarification for the benefit of the reader. These are as follows:

Contraceptives: The World Health Organisation (WHO) defines contraceptives as devices, techniques, drugs or surgical procedures that are used to prevent conception. There are many forms of contraceptives which include hormonal contraception (birth control pills, skin, patches, vaginal ring and implants); intrauterine devices (IUDs) usually containing hormones or copper; barrier methods (condoms, diaphragm); withdrawal method; and finally sterilisation (vasectomy and tubal ligation). The methods can be used independent of each other but barrier methods can be used in combination with any other methods. In cases where this happens, the process is called dual contraception. In this study, the term contraceptive is used to refer to male condoms, pills and injectables used by male taxi drivers and their female partners in Umbumbulu.

Dual Contraceptive use: Barrier methods can be used in combination with any other methods. In cases where this happens, the process is called dual contraception.

Stakeholders: These are people and organisations without whose interests programmes are doomed to fail. Stakeholders in this study refer to male taxi drivers, their women counterparts and other government and non-governmental organisations interested in health. From a social ecological perspective, individual health behaviours are affected by their environment including one's network of friends, family and community at large. In the case of this study, contraceptive use by women is believed to be affected by their male counterparts. As such, males are stakeholders whose interests must be considered if a woman's sexual and reproductive health is to be improved.

Taxi drivers: The term refers to participants in this study. They are all adult males who work as commuter minibus drivers in Umbumbulu district of KwaZulu-Natal. Most taxis in South Africa are 16 seater commuter Toyota minibuses which take passengers between cities into rural areas, small settlements and remote villages.

Thesis structure

Structurally, the dissertation is arranged into six chapters that address pertinent issues that arise in the attempt to answer the research questions. These are arranged as follows:

Chapter One outlines a broad overview of HIV prevalence in South Africa, with a particular reference to KZN. The chapter is essentially an introduction to the study and provides a background of the study and also provides a brief context for the study. An overall map of the thesis is offered by a snapshot of what each chapter encapsulates.

Chapter Two is a review of studies that have been conducted on contraceptive use in the context of HIV and AIDS in South Africa. The chapter investigates the body of literature on dual contraceptives, which is a combination of barrier methods, most commonly the male condom, with non-barrier contraceptives such as pills and injections. The chapter further examines the issue of gender relations and multiple concurrent sexual partnerships as they relate to HIV transmission, while highlighting the condition of HIV and AIDS among taxi drivers on the national and international level.

Chapter Three is comprised of theories and approaches that underpin my study. The Health Belief Model is employed to understand influences and determinants of health behaviour. The Social Ecology Model is used to understand how the environment affects and is in turn affected by male taxi drivers' attitudes.

Chapter Four provides the research paradigm, the design and methodological outline that was applied in the execution of the study. The chapter wraps up with a review of the validity and reliability of the strategies used to generate data and the ethical issues that were considered during research.

Chapter Five covers a presentation of the collated data transcribed from focus group and interviews conducted at Umbumbulu taxi rank. It also covers a discussion of the factors that encourages sexual risk behaviours. Key research questions are addressed and considerations for public communication programmes are addressed.

Chapter Six presents the conclusion of this thesis by summarizing the key findings and stating the key theoretical contributions of the study. It also includes recommendations for the taxi drivers' health programmes.

CHAPTER TWO: LITERATURE REVIEW

Sexual health over the years has been at the core of discussions that affect everyday lives globally. This is because sex and sexuality and the effects thereof affect and influence everyday behaviour and lifestyle. Therefore it becomes important and crucial to understand attitudes, perceptions and knowledge of communities, especially of at-risk populations. At the core of sexual health is dual contraceptive use as protection against STI infection and unwanted and unplanned pregnancies. This study argues that decisions to use contraceptives do not lie entirely with the concerned individual as there are many factors that affect health decisions people make (see Sallis, et al., 2008). Sub-Saharan Africa has not been spared from the challenges that come with sex and sexuality. This region is the global epicentre of HIV and AIDS, with a high of 11% adult prevalence, compared to the global 1% adult prevalence (UNAIDS 2009). 63% of the world's 33.4 million people living with the disease reside in Sub-Saharan Africa. Every day in Sub-Saharan Africa at least 6,000 people become infected (ibid.).

Inquiry into sexual health behaviour has enabled researchers to come up with interventions that target specific behaviours. While some interventions have been successful, others have fallen short because of their narrow focus and exclusion of critical populations within the community. Men in general are a 'special' research population when it comes to sexual behaviour, mainly because of their reluctance to seek medical help, patriarchal values associated with men's sexual health, their egos, and attitudes towards sexual health. Taxi drivers become an even more special research population simply because they are considered the 'other' by other men. This is because taxi drivers are notorious in communities for their risky behaviours (IOM, 2003).

This chapter examines literature on male driver's attitudes towards contraceptive and condom use by their female partners. The literature review is important as it assists in providing rationale and context for this study. Traditional studies that analyse attitudes take the form of knowledge, attitudes and perception studies that isolate individuals from social, cultural and economic contexts that influence and shape their lives (Murima, 2013). Knowledge, attitude and perception studies (KAP) do not acknowledge the effect of culture, economics and societal factors on human behaviour in particular sexual health behaviour. This study is different from the few studies on taxi drivers in South Africa in that it is not merely

descriptive but makes an effort to account for the gap that exists between knowledge and action.

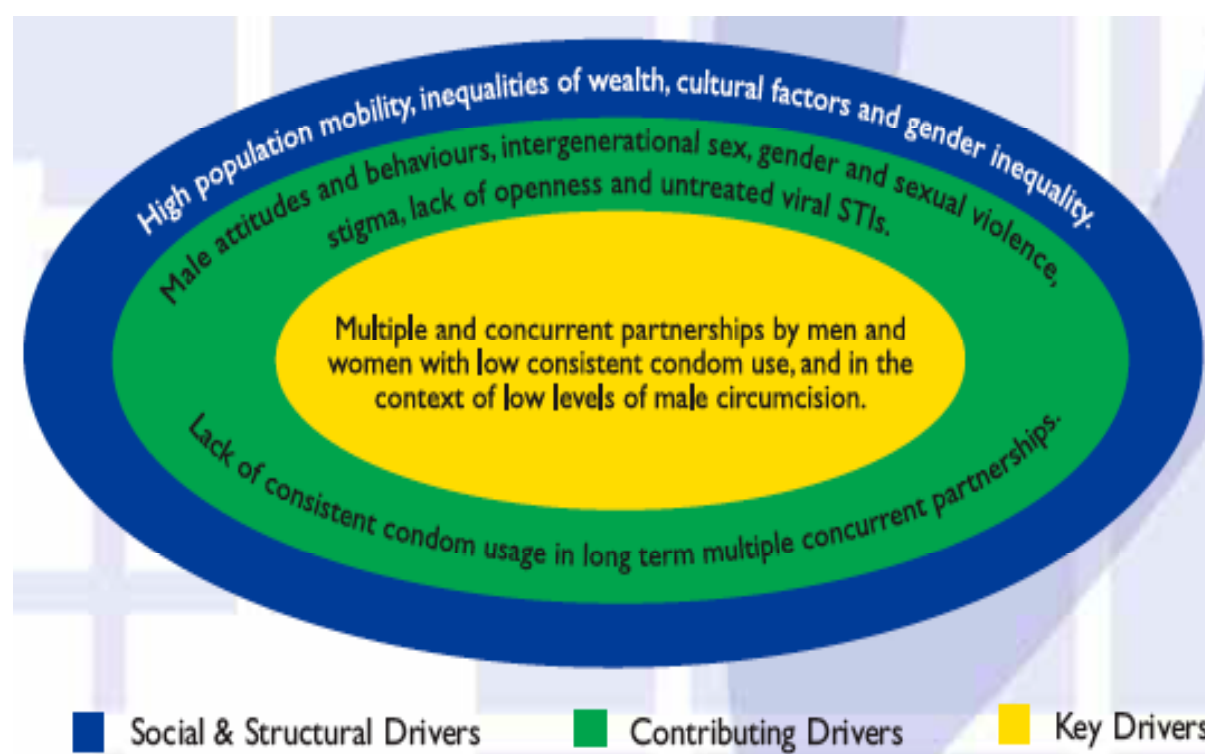
Ncama et al. (2013) assessed the level of knowledge, beliefs and practices regarding HIV Infection and AIDS amongst mini bus taxi drivers. Other studies have focussed on taxi drivers' perceptions on HIV/AIDS relating to transmission and prevention (Mchunu et al., 2012). Others also describe risky sexual behaviours and associated factors among taxi drivers (Lakew & Tamene, 2014). There is thus a need to shift in focus, to understand the phenomenon of taxi drivers' sexual risk behaviour by exploring their attitudes towards HIV prevention, for example condom use and dual protection use. Protection unlike prevention keeps HIV from being transmitted by reducing the likelihood of sexual risk (Mutinta, 2012). The conceptual framework that guides the study takes cognisance of the fact that behaviours and attitudes of these taxi drivers which result in risky health decisions are impacted by different factors. Below is a discussion of the different drivers of the HIV epidemic.

Drivers of the epidemic

The spread of HIV and AIDS and STIs in South Africa is attributed mainly to low levels of condom use. This is due to people's negative attitudes to condom use which result in non-condom compliance (Shisana, 2014). In addition, women's inability to negotiate safe sex as a result of multiple and concurrent sexual partnerships (MCPs) and other structural factors influence this inability (Parker et al., 2007; Lurie & Rosenthal, 2007). In the context of South Africa, power and control disparities in relationships create a context for men to have multiple, concurrent partners and fuel their reluctance to use condoms. It is therefore important for this study to discuss drivers of the epidemic in the light of male taxi drivers' attitudes towards condom use.

From the above, it is evident that the drivers as they affect individuals are compounded by different factors that play out at different levels of society such as individual attitudes, power relations between sexual partners and other structural factors such as poverty. Setswe (2010) aptly divides these drivers of the Sub-Saharan HIV epidemic into three categories namely (i) key drivers, (ii) contributing drivers, as well as (iii) social and structural drivers. As shown on Figure 1 below, the different drivers belong to, and are indeed discussed below, under each of these categories.

Figure 1: Key Drivers of the HIV epidemic in South Africa. Adapted from Setswe (2010: 10)



Key Drivers

Key drivers are those risk factors that are most likely to put people at-risk of HIV infection.

As shown on Figure 1 above, key drivers of the Sub-Saharan epidemic include the following:

Multiple and Concurrent Sexual Partnerships

Multiple, concurrent partnerships can be broadly described as relationships where an individual has two or more sexual relationships that overlap in time. These relationships can be long or short term and vary in nature and meaning. There are different forms of MCPs and it is important for the purposes of this study that these be explored. This is because in their many forms, these MCPs characterise the reality of what is happening in the lives of many individuals, particularly in Sub Saharan Africa. These kinds of relationships may be a reflection of the reality of which Umbumbulu male taxi drivers are a part.

According to Jana et al. (2008), steady and other 'side' partners are one of the forms of MCPs; this is characterised by an individual who has a steady partner and has another 'on the side'. The 'other' partners are often kept a secret and this type of relationship exists to satisfy

sexual, material or emotional needs. Intergenerational relationships are also another form of MCP; these involve young people, especially girls who are involved with older men. Transactional sexual relationships are again another form of MCP, and these are characterised by using sex as a currency for transaction. Sex work and ‘one-night stands’ are classified in this context (Jana et al., 2008). The last form of MCP is polygamy; polygamy is an institution that is viewed in the context of culture and social norms. Polygamy is a traditional economic institution that allows multiple partners, with men using this practice to justify multiple relationships. These various forms of MCPs leave individuals vulnerable and at risk of infection since the multiple and concurrent partners begin to form what is known as a sexual network (SAFAIDS, 2011). According to the Recognition of Customary Marriage Act No. 120, (1998), in South Africa, polygamy is allowed by legal matrimony and by common law, and it is practised by the current president of South Africa Mr Jacob Gedl’eyihlekisa Zuma.

The Monarchs of KwaZulu-Natal and Swaziland also practice polygamy (Nyathikazi, 2013). In their study about women’s perspectives on the reasons for HIV and AIDS prevalence in rural areas of KwaZulu-Natal, Mogotlane et al. (2007) found that polygamy remains culturally acceptable. However, having multiple sex partners for a male is not culturally encouraged. Nyathikazi (2013) argue that women who are not married are belittled by the society and then they resort to polygamous marriages to avoid being concubines. Her findings revealed that polygamy is influenced by socio-economic reasons and one has to earn a higher income in order to practice it (Nyathikazi, 2013). Concurrency is defined as “overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner” (UNAIDS, 2012:18). Multiple sexual partnerships are defined as non-exclusive relationships where an individual has more than one sexual partner at any given time. Concurrent sexual partnerships are widely believed to be one of the main drivers of the HIV epidemic in Sub-Saharan Africa. A 2006 survey in South Africa found that “risk of exposure to HIV is linked to having numerous sexual partnerships, with higher risk of HIV acquisition being closely associated with having concurrent sexual partnerships” (Parker et al., 2007:42).

MCP is a practice that accelerates the growth of the HIV epidemic (Jana et al., 2008; SAFAIDS, 2011; UNAIDS, 2011). Suzanne Leclerc-Madlala (2009:103) notes that multiple and concurrent partnerships is a “normative partnering pattern” in Southern Africa. She adds

that MCPs have the potential of putting a number of people at risk for infection through the “sexual network” that is created by engaging in MCPs. This is also because MCPs are characterised by low condom use due to the complexities that exist in every form of MCP (ibid.).

The Women’s Health Research Unit (2013) conducted a study in Cape Town and discovered that men involved in MCPs stated that they used condoms constantly (not consistently) with their side partners in an effort to protect their main partners, and go for regular HIV tests. The study indicates that men are likely to have unprotected sex with their ‘established’ partners and test regularly, while having protected sex with their side partners. The dynamics of this is evident in that the ‘established’ female partner has no power to negotiate safe sex; if she does she is deemed unfaithful, while the side partner has agency in demanding protected sex, and it’s accorded to her as her due.

The 2012 South African National HIV Prevalence, Incidence and Behaviour Survey, notes that MCPs in the past 12 months were more common in males than females (Shisana et al., 2014). In 2012 alone, five times more males (16.2%) reported having more than one sexual partner in the previous 12 months than their female counterparts (3.3%), although it is unclear whether those sexual partners used protection or not. However, Tanser et al. (2011:247), argue that “having concurrent partners is not expected to change an individual’s risk of acquiring HIV, provided that partner concurrency does not increase an individual’s cumulative number of unprotected sex acts.

“The level of connectedness of individuals to the broader sexual network, rather than the number of overlapping relationships, may be a more important determinant of the spread of HIV in communities” (Delva et al., 2011:2). In a study that was conducted in a high prevalence, rural South African population, Tanser et al. (2011), found that there was no evidence to suggest that concurrent partnerships are an important driver of HIV incidence in the rural African population (2011). As the ‘First HIV and AIDS National Communication Survey in Gauteng’ findings indicate, the “risk of HIV infection is dependent on the overall exposure to sexual contacts and unprotected sex with different partners” (2006:11). Evidently, the above arguments contradict mainly because of the meanings attached to the reasons behind being involved in MCPs and these shall be discussed below. Individuals

engage in MCPs for different reasons and among them are notions of sexual dissatisfaction. Where one partner feels sexually disadvantaged, they tend to look for satisfaction outside the confines of the existing relationships (Shisana et al., 2014). Sexual dissatisfaction may be due to lack of communication among the partners, according to Jana et al.'s (2013) study of MCPs in greater Gauteng in South Africa. Furthermore, attitudes and perceptions towards MCPs encourage the perpetuation of the practice. Some individuals regard MCPs as normal and attribute this to social and cultural norms that validate and normalise such relationships.

In addition, cultural norms celebrate men who are in MCPs while on the other hand condemning women involved in the same. The financial gain that comes with being involved in transactional and intergenerational sex is motive enough for a woman to be involved in MCPs. Some women are driven by poverty while others are driven by a desire for material gain (Jana et al., 2013). Finally, alcohol consumption and drug abuse increase the chances of MCPs; in Jana et al.'s study participants noted that sexual activity was high in bars and in environments where patrons are under the influence of alcohol and drug abuse.

Condom Use

Condoms are a key component of comprehensive HIV prevention as part of other sexual prevention approaches that include: reduction in the number of sexual partners, HIV testing and counselling, delayed sexual debut, treatment of STIs and male circumcision. When used consistently and correctly, condoms offer the best prevention there is when abstinence and delayed sexual debut have failed. The condom use script can never be complete without mentioning the dynamic involved in condom use as a form of prevention. Condoms come in two generic forms: the male condom and the female condom. The male condom, by virtue of popularity, accessibility and ubiquitousness, remains the preferred condom choice, while the female condom is less likely to be chosen despite offering the same potential as the male condom. This is because the female condom is not easily accessible. Macleod (2011:55) contends that in South Africa, "female condoms (Femidom) are not widely available – an unavailability that has the potential to lessen the ability of women to negotiate safe sex as the power is taken away from them by mere unavailability of the Femidom. Indeed, access to the Femidom seems especially difficult for women who have to negotiate the negative attitudes of nurses at local clinics, while social norms prevent them from carrying condoms."

Gallo (2014) reviewed published data on the effectiveness and acceptability of the female condom for protection against pregnancy and infection and found that overall in South Africa, and in Durban in particular, use of the female condom is low and several barriers hinder the wider adoption of the use of the method. Some of these barriers include acceptability and cost (Vijayakumar et al., 2006; Peters et al., 2010). Despite the obvious challenges, the female condom remains the sole female-initiated method of dual protection against unintended pregnancy and sexually transmissible infections (STIs), including HIV. The government of South Africa has also stepped up efforts to distribute the female condoms while raising awareness.

In June 1998, the South African National Department of Health (DOH) launched the 'National Introduction of the Female Condom Programme' to make female condoms available at selected sites in all provinces. The programme has ultimately led to female condoms being distributed in over 300 select public sector facilities across the country (Beksinska et al., 2012). While this is a noble exercise, it is not without its challenges, as there have been reports of health care providers lacking the knowledge, tools, and professionalism to effectively communicate proper female condom use and prevent product stock outs (ibid.). This is a cause of concern because women remain vulnerable and are short-changed when it comes to safe sex negotiation and protecting themselves against unwanted pregnancies.

In a study by Mantell et al. (2011) in South Africa, KwaZulu Natal, of male students' perceptions of the female condom, 74% of the study population indicated that they knew of the female condom but did not have enough information to be able to safely and confidently encourage their partners to use them; this also hampered their efforts to talk about the female condom. Others also indicated that the female condom was very expensive, thus preferring to using the male condom; this is despite the fact that the female condom and the male condom are distributed free of charge on campuses. It is against this background that this study endeavours to explore attitudes towards dual contraceptive use by male taxi drivers' partners.

The male condom on the other hand is more popular, and the preferred condom (Kulczycki et al., 2004). Male condoms, if used consistently and correctly, are highly effective at preventing the sexual transmission of HIV. However, in South Africa, while condom use is

increasing, it remains low and inconsistent. The HSRC household survey with data from 2008 put condom use 'at last sex' at 62% of those over 15, while the 2005 survey data showed this was 35% (Shisana et al., 2009). Despite this increase, male condom-use is typically erratic, particularly with primary sexual partners. Male condom use patterns usher in discussion around non-condom use; this is vital for this study because an understanding of the factors that influence and affect condom use and non-use enables the researcher to understand and appreciate attitudes that affect and influence sexual health behaviour.

Pullum et al. (2005) note that in established relationships, condoms become phased out as they become associated with trust. This is because partners believe that the significant other is also faithful, thus there is no need for protection. In most cases such laxity renders both parties vulnerable to HIV infection and other STIs. Women, on the other hand, are bound to suffer more because they no longer have the power to negotiate safe sex. The condom is considered a barrier to trust and love, sex in its basic form is seen as an expression of love for another person, and the condom is then used with those individuals one does not like, love or trust.

In her study of MCPs in Swaziland, Ruark (2013) concludes that in most cases condoms are used more as contraception rather than as a method of HIV prevention. This she says happens in most established relationships. Ruark (2013) further contends that the condom is considered to hamper spontaneity and sexual pleasure. This is because condom users put forward that the male condom hampers sexual pleasure and inhibits the naturalness of sex. On the other hand the narratives of the male condom reinforce gender stereotypes and notions of sexuality (ibid.). Mumtaz et al.'s (2005) study on condom use in Uganda and Zimbabwe note that women who report low control in their relationships are more likely to report inconsistent condom use.

The high burden of HIV and unplanned and unwanted pregnancy amongst South Africans has led to an increased promotion of the use of dual method so as to prevent STIs, including HIV, and pregnancy. Encouraging the use of contraceptive services is also important for meeting HIV prevention goals. Thus, contraception services should be recognized as contributing significantly to HIV prevention, in and of themselves (MacPhail et al., 2007).

Medical Male Circumcision

Male circumcision is an important additional health-sector HIV prevention intervention that reduces the risk of heterosexually-acquired HIV infection. Male circumcision is embedded in culture and has various meanings both culturally and socially. Circumcision affirms a man's self-worth, shows generosity, expresses love/appreciation, helps restore pride, validates manhood, and asserts and establishes power and authority in relationships (Luke & Kurz, 2002; Kelly et al., 2003; Hallman, 2004; Lary et al., 2004; Luke, 2005). On the other hand, for a woman, it affirms her value, an expression of love/appreciation, boosts her self-esteem and social status (ibid.). However, for medical reasons, circumcision lowers the chances of infection. It is against this background that medical male circumcision (MMC) has been introduced, in an effort to manage prevalence rates. However, low uptake of MMC is a driver of the HIV and AIDS.

While MMC has been hailed for its protective efficacy, recent studies have shown that the procedure has brought confusion among men as some circumcised men consider it as a natural condom which allows them to be promiscuous having a feeling that they are immune to HIV infection (see Mathews, 2012). This myth among men presents challenges to condom use and defeats the purpose of other prevention efforts. It is the task of this study to find out whether their perceptions to the use or non-use of condoms and contraceptives are related to MMC.

Contributing Drivers

Contributing drivers are those factors that compound key drivers discussed above. Under this category, as shown on Figure 1, are factors such as male attitudes towards condom and contraceptives by their female partners, lack of consistent condom use, gender dynamics, intergenerational or age-disparate sex, HIV- related stigma among others. Due to limited space, only male attitudes, gender dynamics and intergenerational sex are discussed under this section. Condom use has already been discussed. However, this does not suggest that other drivers that have been left out are less important. While all are equally important, only those related to the objectives of the study are pertinent here.

Knowledge and Attitudes of Males

The HIV epidemic has always been viewed as gendered, and this is not without basis.

Statistics show that women are the most affected. It is from this perspective that the gender perspective and engaging men and boys are recognised as important in addressing the HIV epidemic (CADRE, 2001). The World Health Organisation (WHO, 2007) acknowledges need for male involvement in response to the pandemic encouraging them not only to work with women for gender equality but also to question harmful definitions of masculinity and end all forms of violence against women and girls that may be a result of lack of knowledge or negative social attitudes towards women (Barker et al., 2007). Men are known for their negative attitudes towards condom use (Shisana, 2013; Maharaj & Cleland, 2005) and patronising attitudes towards women as most are known for dating younger women (Leclerc-Madlala, 2008). The DramAidE community dialogues conducted in KwaZulu-Natal found that men have negative attitudes towards contraceptive use by their women. As with men in other communities, taxi drivers in Umbumbulu tend to dominate their female partners who are often younger than them. This unarguably put both men and women at risk of HIV as women do not have a say in sexual decisions (MacPhail & Campbell, 2001). It is therefore imperative that negative attitudes can be transformed. As such, changes in the attitudes and behaviours of men as well as unequal power between women and men are important to prevent HIV. The Health Belief Model and the Social Ecology Model employed as a framework for this study may be useful tools in this endeavour.

Age-Disparate Sex

Leclerc-Madlala (2008) defines Age-Disparate Sex (ADS) relationship as a relationship where the male partner is five or more years older than the female partner. This form of relationship includes multiple concurrent partnerships and transactional sex. For young women, especially school girls, money and the promise of consumption motivates them to be involved with older men. In a study conducted in Cape Town, South Africa, Beauclair et al (2012), found that the increasing average age difference between men and their partners have important implications for transmission of HIV and other STIs. However, Pinkerton et al., argue that the risk of STI acquisition is largely determined by the probability of STI infection in the partner, the frequency of sex acts and the level of condom use in a relationship (2011). In rural KwaZulu- Natal, Harling et al. (2014) tested whether age disparities affect HIV incidence in young women using data from one of Africa's largest population-based HIV incidence cohorts. Their study revealed that partner age disparity did not predict HIV acquisition.

Studies have also indicated that, while many young women are prey to the sexual coercions of older men, many are also active in seeking and exploiting partners for gain (Beauchair et al., 2012; Leclerc-Madlala, 2008). In ADS, some girls do not perceive themselves to be victims. As demonstrated by the findings of a study that was conducted in Cape Town, where Strebel et al., (2013) provided evidence that girls in relationships with older men (taxi drivers) were seen as promiscuous in that they moved from one taxi driver to another, often sleeping with a number of drivers at the same time. For some taxi drivers being involved in this type of a relationship is a way to “affirm his self-worth, restore his pride & manhood, demonstrate generosity, express love/appreciation, and socially validates manhood” (Leclerc-Madlala, 2008:22). This practice of ADS is considered widespread and it is largely regarded as a relationship based on material transactions in exchange for sex and also occurring mainly between young women, “particularly of school-going age, and older men” (Strebel et al., 2013:78).

Low contraceptive use by women

South Africa has the highest level of contraceptive use compared to other Sub-Saharan African countries, with 65% of women reporting current use of a method, mostly injectable (Gutin et al., 2010). Like in any other country, contraceptive use in South Africa is influenced by socio-cultural and personal factors. Efficacy, adverse effects, accessibility or convenience are frequently cited by women as important features when choosing a method (De Irala et al., 2011). Sociocultural factors such as religious teachings or cultural norms about sexuality and family and availability of contraceptive methods in individual countries may influence the different patterns of contraception (ibid.).

There are many forms of contraceptives and these include hormonal contraception (birth control pills, skin patches, vaginal ring and implants); intrauterine devices (IUDs) usually containing hormones or copper; barrier methods (condoms (both male and female), diaphragm, cervical cap and the sponge); withdrawal method; and finally sterilisation (vasectomy and tubal ligation). Cultural values, beliefs, communication with partners, availability and accessibility of contraceptive methods, nurses’ attitudes, level of education and self-efficacy affect women’s use of contraceptives. Better communication by women with their partners has the potential to increase contraceptive use while lack of

communication results in the exact opposite (Wood & Jewkes, 2006).

Morrell et al. (2008) state that women are left vulnerable to unwanted and unplanned pregnancies mainly because their partners state that continued use of contraceptives, in particular hormonal contraception, results in ‘vaginal wetness’: a condition men complain decreases male sexual pleasure or even turn men off. In an effort to please their partners, women tend to forgo contraceptive methods, thus exposing them to unwanted and unplanned pregnancies and HIV infection. Studies have indicated that women use different methods to dry their vaginas. Vaginal tightening is also a common practice (Epstein, 1997). Vaginal drying has been defined as “the removal of vaginal secretions prior to sex, and vaginal tightening as the insertion into the vagina of any substance or material to constrict the vaginal walls and create friction and heat during sex” (Braunstein & van de Wijgert, 2003:22).

Braunstein and van de Wijgert (2003) used qualitative data to obtain a better understanding on norms, preferences, and practices regarding lubrication during sex. Findings from that study revealed that vaginal dryness during intercourse increase male sexual satisfaction. In Zimbabwe, vaginal dryness is reported to increase sexual satisfaction for both partners. The informant from Zimbabwe explained that Zimbabwean women who fail to achieve the “right” amount of lubrication for sex can face divorce or be sent back to their families or village by their husbands for further “education” from female relatives on how to be an appropriately dutiful wife (Braunstein and van de Wijgert, 2003). This finding corresponds with that of a study exploring various theoretical approaches to health education media in an attempt to identify a model appropriate for sexually transmitted disease education media in Hlabisa, KwaZulu Natal (Epstein, 1997). The study showed that men prefer that the vagina be “tight” during sexual intercourse. Consequently, women insert substances to try and keep their vaginas tight. Epstein (1997:69) lists the methods actually used: Piong Tong, Snuff and Alum.

Vaginal drying practices may affect women's risk of HIV infection and other STIs (Kun, 1998). This study, while not focusing on women *per se*, will explore how men view contraceptive use, with the intention of informing policy and intervention design.

Social and Structural Drivers

These drivers relate to those factors characterising one's environment and are beyond an individual control. UNAIDS acknowledges that the HIV epidemic unfolds along contours of poverty, power dynamics related to inequalities of wealth distribution and gender (Shisana, et al., 2014).

Poverty

Like any other communicable disease, HIV and AIDS is linked to poverty. The relationship between poverty and HIV and AIDS is central to understanding of the impact of the epidemic on urban and rural livelihoods. The relationship becomes bi-directional in that poverty is a key factor in transmission and on the other hand, the disease can impoverish communities in a way that intensifies the epidemic itself (Shisana et al., 2014).

Poverty has severe effects on individuals' and communities' vulnerability to the spread of HIV, their ability to handle risks, and opportunity to participate in prevention and care activities. The experience of HIV and AIDS by poor individuals, households and communities is likely to lead to an intensification of poverty, and push some non-poor into poverty and some of the very poor into destitution. In turn, poverty can accelerate the onset of HIV and AIDS and tends to exacerbate the impact of the epidemic (Shisana et al., 2014). Poor communities struggle to make ends meet, thus devise other way of eking out a living. Usually the most affected in such communities are women and girls who are left with the burden of caring for and nurturing families. Bearing this burden leads women and girls to engage in intergenerational and transactional sex.

Transactional and intergenerational sex fosters behaviours that include risk-taking, and usually involve unprotected sex. People with low economic status are likely not use condoms, thus increasing their risk to infection; this is mainly because they have no access to health facilities, reproductive health information and proper support structures from other social institutions (Manzini, 2001; Murima, 2013).

Women and girls in transactional sexual relationships find themselves unable to negotiate for safe sex for fear of endangering their economic goals (Panday et al., 2009). Like transactional sex, intergenerational sex creates unequal power distribution and lack of negotiation skills for

safe sex (Murima, 2013). In such relationships, young girls and women cease to have a choice when it comes to pregnancy protection resulting them in having back-door abortions which can prove to be fatal. Intergenerational relationships are characterised by violence leaving women vulnerable to abuse (emotional and physical) and unable to negotiate for safe sex. Wood et al., 1998) put forward that women are wary of safe sex negotiations for fear of violent reactions by their partners. Use of other ‘invisible’ methods of contraception may be interpreted by their partners as indicators of unfaithfulness, causing ‘wet vaginas’ and reducing sexual pleasure (ibid.). Men clearly have an upper hand when it comes to sexual matters as women are constrained by their subordinate position in gender and social hierarchy, forced and coerced sex, and inaccessibility of contraception (Jewkes et al., 2001; Wood & Jewkes, 2006).

In Kampala, Uganda, Mbonye et al. (2012) used qualitative data to obtain a better understanding of how gender inequities may have played a role in facilitating the entry of women into sex work by looking at the life histories of women who are at high risk of HIV infection. They clearly explain how inequities in gender and power relations reduce economic and social opportunities for better lives among women, and increase risky sexual behaviour. Their work aptly describes why women remain and engage in transactional and intergenerational relationships.

As Fourie and Schonteich (2002) argue in the context of HIV/AIDS and poverty.

“It [HIV and AIDS] changes family composition and the way communities operate, affecting food security and destabilising traditional support systems. By eroding the knowledge base of society and weakening production sectors, it destroys social capital. By inhibiting public and private sector development and cutting across all sectors of society, it weakens national institutions. By eventually impairing economic growth, the epidemic has an impact on investment, trade and national security, leading to still more widespread and extreme poverty. (Cited in Fourie & Schonteich, 2002:32)

This quote encapsulates how HIV and AIDS increase poverty in already impoverished communities. While this study does not focus on drivers of the epidemic, it is important to

understand these drivers in relation to male taxi drivers' attitudes towards condom and contraceptive use.

Gender dynamics and power relations

Socially constructed expectations about masculinity and gender-roles that encourage male promiscuity make women vulnerable to violence and restrict their ability to discuss or negotiate sex. Power inequalities in sexual relationships put women and men at risk of HIV as women in most cases cannot insist on the use of dual contraceptives (Woodsong & Koo, 1999). The 'South African HIV and AIDS and STI Strategic Plan' (2007-2011) goes so far as to suggest that "power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms" (DoH, 2007:32).

According to the Department of Health's Strategic Plan, qualitative studies in South Africa show that "men believe they are more powerful than women and that men are expected to control women in their relationships" (DOH, 2007:32). This invites Kempe Ronald Hope's (2001) argument, based on gender inequality that much of that inequality can be attributed to traditional cultural values and beliefs that influence the way women behave. He notes that in some African cultures there are restrictive laws and traditions that compel women and young girls seek their husbands' or partners' approval for using contraceptives (Hope, 2001). This has been found to impact negatively on the effective use of contraceptives by women. Studies have also shown that in families where a man's opinion is dominant, women do not discuss contraceptive issues with their husbands. Furthermore, in relationships where the female partner is very young and has no decision-making powers, safer sex practices, especially the use of condoms, may not be easy every time (MacPhail & Campbell, 2001).

Male resistance to condom use and women's inability to negotiate safer sex due to the socioeconomic and cultural conditions faced by women such as poverty, economic dependence, socio-sexual subordination and power inequity have been attributed to the increased vulnerability to HIV infection (Hope, 2001). "Men's sexual behaviour places women at great risk of acquiring HIV infection, and contributes to HIV infection in women who often have less power to determine when, how and even where sex takes place" (Ncama et al., 2013:5).

HIV and AIDS have compounded the context in which social and economic marginalisation, and the erosion of ‘masculinity’ combine to render women subject to oppressive social structures and to gender-based violence. HIV and AIDS have exacerbated the economic and social insecurity of women, and women’s social and economic insecurity, in turn, makes them vulnerable to infection with HIV and AIDS. Fear of violence, stigmatisation, exclusion and destitution dominates the lives of many women in South Africa. Women’s fear of a violent response from their partner may prevent them from: negotiating safe sex, seeking voluntary testing and counselling, seeking STI treatment, reporting rape and receiving post-exposure prophylaxis, disclosing their HIV status, taking *nevirapine* to prevent vertical transmission, and formula-feeding their babies. It is such behaviour that exacerbates increased prevalence rates and renders HIV and AIDS more than just a medical condition. It is important to note that these attitudes and fears that women harbour as a result of the environment they live within and also a product of societal expectations.

TAXI DRIVERS IN SOUTH AFRICA

The taxi industry in South Africa is part of the informal economy, according to Jane Barrett (2003). She points out that the majority of taxi owners “do not register as tax payers and do not register their employees with labour legislation” (2003: ix). This industry plays a critical role in the lives of a number of people, particularly in black dominated communities. However, the industry has had a violent history. Taxis account for at least 65 per cent of all public transport commuter trips, as the majority of people in South Africa are poor and dependent on taxis as mass transit. This makes the industry to be ubiquitous as it provides service to millions of South Africans and also creates employment for the majority of the urban and rural marginalised poor people (see Fobosi 2013). A number of mini taxis are not driven by their owners. Taxi owners claim that up to half of daily takings are stolen by drivers; however taxi drivers say that the scale is smaller than the owners claim (see Barrett, 2003). Taxi drivers’ work is “less controlled than of workers within formalised public transport” (Barret, 2003:29).

The South African taxi industry remains the critical pillar of the country’s public transport sector: not only is it the most available mode of transport, it is affordable to the public (Fourie, 2003). The issue of HIV infection and AIDS in the minibus taxi industry in KwaZulu-Natal is different from that of truck drivers. Taxi drivers in South Africa are a

unique and under researched population and merit research because the transport industry, and in particular, long distance drivers, are at risk due to their geographical mobility. Research has been done around minibus taxi drivers as ‘sugar daddies’ and school-going girls. Porter et al. (2010) in their study conclude that minibus taxi drivers appeal sexually to the schoolgirls due to the nature of their work, and therefore contribute to the spread of HIV infection. Girls in the study expressed the convenience of having a taxi driver as a sugar daddy, noting that these taxi drivers provide free transport. It is these sexual behaviours that narrate the trajectory of taxi drivers in South Africa. The minibus taxi drivers entice the schoolgirls by giving them money and allowing them to ride in their taxis.

Ncama et al. (2013) in their study of taxi drivers and their knowledge of HIV and AIDS found that taxi drivers were concerned with condom use and self-efficacy in as far as condom use is concerned. Concerns with condom use revolved around condom safety and breakage, condom ineffectiveness, disappearance of the condom into the vagina, decreased sexual pleasure, and condom use signifying infidelity or having a sexually transmitted infection. Tackling such misperceptions remains a challenge for programmes and policies aimed at increasing condom use amongst sexually active men (MacPhail & Campbell 2001; Rauf et al. 2010).

Elsewhere, in the West Indies for example, Orisatoki and Oguntibeju (2010), in their study of taxi drivers operating at a major airport in St Lucia, reported high knowledge of HIV infection (78.3%), but affirmed that misconceptions still exist amongst them. They also stated that less than half of the minibus taxi drivers used condoms consistently and identified affordability and availability as constraints to condom use.

Despite extensive efforts by the South African health system and non-governmental organisations in promoting safe sex, condom use amongst the minibus taxi drivers is relatively low, with many still engaging in unprotected sexual activities. Multiple sexual partners are relatively common amongst the minibus taxi drivers, thus increasing the likelihood of transmitting HIV and other sexually transmitted infections to their partners. Of the participants, 74.3% admitted having more than one sexual partner (ibid.).

Ncama et al. (2013), in their study of taxi drivers in Durban, South Africa, found that most

minibus taxi drivers are young unmarried men who have received little education and little information about HIV. They are further vulnerable to infection because they travel throughout the city during their work, encounter many different people, receive money, and sometimes find themselves pursued by women who hope the drivers will spend money on them. There is a need for intervention programmes with a focus on minibus taxi drivers and similar high-risk groups.

Studies published to date demonstrate that although taxi drivers do have knowledge of HIV and AIDS, this knowledge is not consistent or comprehensive, and furthermore, that knowledge and practice frequently do not go hand in hand. Despite general awareness of HIV and AIDS and its dangers, taxi drivers do not uniformly report multiple partners. High awareness of HIV and AIDS amongst drivers also does not imply they always have the necessary knowledge of transmission routes and prevention methods.

Taxi drivers also seem to have a problem translating the knowledge they do have into perception of individual risk, and denial is a part of their attitudes to HIV and AIDS (Ncama et al., 2013). Furthermore, the working context of truck drivers is an all-male environment that encourages machismo behaviour, adventurousness, risk-taking and exaggerated virility – resulting in a feeling of entitlement to lots of sex with lots of partners (ibid.). This study therefore seeks to understand their attitudes to dual contraception by their female partners.

This chapter presented the literature review on the risk factors that are most likely to put people at-risk of HIV infection, including social and structural drivers of HIV epidemic. The literature reviewed is on male attitudes towards contraceptive and condom use, with special reference to male taxi drivers in South Africa. The literature examined focused on male attitudes concerning contraceptive use; multiple and concurrent sexual partnerships; gender dynamics and intergenerational sex as the contributing drivers of the HIV epidemic in South Africa. The literature review has shown that there is dearth of studies that specifically explored (male) taxi driver's attitudes concerning condom use and dual protection use by their female partners.

In order to analyse taxi drivers' attitudes concerning condom use and dual contraceptive use by their partners, a theoretical framework is provided to explain how male taxi drivers

are influenced with regard to their decisions to use condoms or other contraceptives and also explain how the environment affects and is in turn affected by male taxi drivers' attitudes, particularly with regard to their partners' use of dual contraception.

CHAPTER THREE: THEORETICAL FRAMEWORK

The consequences associated with sexual behaviour are a major concern the world over. Sexual decisions are influenced by a cocktail of factors including alcohol and drug abuse, peer norms, religion, misinformation, ignorance, beliefs, attitudes and values (WHO, 2006). Preventative behaviour is therefore called for, although uptake of preventative behaviour is also influenced and affected by various factors which are key in designing interventions (Glanz & Rimer, 2005). Condom use is recognised as an important strategy in the prevention of sexually transmitted infections and pregnancy.

Since the condom is not 100% effective in preventing diseases, and taking into account that the male condom is more readily available than the female condom, dual protection is often advised and encouraged. This enables a woman to at least have control over her own sexual health and have power to negotiate for safe sex. Condom and dual contraceptive use is “a contested terrain often negotiated and mediated within contexts of culture, gender dynamics (power relations), and religion” (Mutinta, 2012:56). An understanding of these is only possible when health theories are applied, and no single theory is sufficient to explain human behaviour.

According to Glanz & Rimer (2005), three key concepts are cross-cutting in all of these health theories. The first concept is that behaviour is mediated by thought processes: people’s knowledge base and their thoughts affect their decisions and how they act. The second concept is that knowledge is necessary for, but not sufficient to produce, most behaviour changes. Lastly, they assert that perceptions, motivations, skills, and the social environment strongly influence behaviour. For example, if taxi drivers believe that women who carry condoms are promiscuous, they are more likely not to take them seriously for a relationship. In other words, the woman will be used only for sex.

The purpose of this study is to investigate male taxi drivers’ attitudes concerning condom use and dual contraceptive use by their female partners. At an individual decision-making level, the Health Belief Model is employed to understand influences and determinants of health behaviour, and how male taxi drivers are influenced with regard to their decisions to use condoms or other contraceptives. The Social Ecology Model is used to understand how the

environment affects and is in turn affected by male taxi drivers' attitudes, particularly with regard to their partners' use of dual contraception.

The Health Belief Model

The Health Belief Model (HBM) (Becker, 1974) is one of the oldest and most used theories in health communication. Developed in the 1950s by a group of American public health service social psychologists, and subsequently expanded, the HBM aims to explain the lack of interest by the public in preventing and detecting diseases. The model attempts to explain the thought processes that drive an individual in making health decisions. One premise that the HBM evolved from is that each individual's perception of the world determines what that individual will do. For this reason, the HBM acts as a framework that enables the designing of health behaviour interventions. The HBM basically states that before undertaking any health behaviour, individuals conduct a cost-benefit analysis (CBA) of their health behaviour and the choices that they make are driven by the cost-benefit analysis conducted. "Cost-benefit analysis purports to be a way of deciding what society prefers. Where only one option can be chosen from a series of options, CBA should inform the decision maker as to which option is socially most preferred" (Dasgupta & Pearce, 1978).

The cost-benefit analysis process firmly places the HBM under the value expectancy theory group. Hanan (referring to Melkote and Steeves (2001:132) states that value expectancy theories assume that:

Individuals will take preventative actions (risk reduction behaviours) when they are susceptible to a disease (self-perception of risk) and acknowledge the consequences as severe; they believe that taking preventive actions will be beneficial in reducing the threat of contracting the disease (e.g., condoms are effective against HIV infection), and that its perceived benefits will be sufficient to overcome perceived barriers such as cost or inconvenience of undertaking the actions.

Value expectancy also means that attitudes are developed and adjusted based on individual evaluations about belief and values. For example, if individuals endorse condom use as contributing to the value of their lives, this may add to the number of individuals who practice safe sex. For the purposes of this study, the model is apt as it provides policy makers

with guidelines for programme development, allowing them to understand and address the reasons for non-compliance with contraceptive use (Julinawati et al., 2013) and can also explain male taxi drivers' attitudes. HBM is a rational cognitive model and assumes a rational decision maker (Freimuth, 1992). The theory assumes that an individual's behaviour is influenced by six constructs and these are (1) perceived susceptibility; (2) perceived severity; (3) perceived benefits; (4) perceived barriers; (5) cues to action; and (6) self-efficacy.

The table below presents definitions and applications for each of the six concepts of the Health Belief Model.

Table3.1: Key Concepts of the Health Belief Model

Concept	Definition	Application in campaigns (dual contraceptive use)
PERCEIVED SUSCEPTIBILITY	<p>One's opinion of chances of getting a condition</p> <p>CAN THIS REALLY HAPPEN TO ME?</p>	<p>Define populations at risk</p> <p>Personalise/relate risk to individuals in target population</p> <p>Heighten perceived susceptibility</p> <p>Make people feel threatened (fear appeals)</p> <p>e.g find an HIV+ taxi-driver speaker to tell their story</p>
PERCEIVED SEVERITY	<p>One's opinion of how serious the condition and its consequences are.</p> <p>CAN THIS REALLY HURT ME?</p>	<p>Specify consequences of the risk and condition.</p> <p>Make the taxi drivers see what HIV can do to them</p>
PERCEIVED BENEFIT	<p>One's belief that there is benefit in changing/adapting a new health behaviour</p> <p>CAN DOING (X) ACTUALLY HELP ME</p>	<p>Clarify the positive effects to be expected, show what has been proven/research.</p> <p>E.g. dual contraceptive use to prevent infection</p>
PERCEIVED BARRIERS	<p>One's opinion of the tangible and psychological costs of the advised action.</p> <p>IT MIGHT BE DIFFICULT TO DO (X). CAN I ACTUALLY DO (X)?</p>	<p>Taxi drivers identify their personal barriers to using condoms (i.e. condoms limit the feeling, injectibles make their women watery)</p> <p>Demonstrate that barriers are easily broken.</p> <p>Inform them about resources, make tools available.</p>
CUES TO ACTION	<p>Individual assessment of external forces promoting the desired change / activate readiness</p> <p>WHAT CAN I DO TO CHANGE</p>	<p>Provide how-to information, promote awareness, reminders.</p> <p>Taxi drivers receive reminder cues for action in the form of incentives (e.g. key rings with the printed message "no glove, no love") or reminder messages</p> <p>(Brothers for Life campaign).</p>

SELF EFFICACY	Confidence in one's ability to take action and sustain it.	Promote Taxi driver's ability to succeed in changing behaviour
	I THINK I CAN DO I	Provide training, guidance in performing action so that they become confident in using a condom correctly in all circumstances.

Perceived Susceptibility

An individual's chance of contracting a disease is referred to as perceived susceptibility (Glanz et al., 2008). Susceptibility is realised when individuals ask themselves questions like 'can this really happen to me'. The ability to be aware of their vulnerability towards certain diseases is then referred to as perceived risk (ibid).

Uptake of certain behaviour can be predicted using perceived susceptibility and risk (Burak & Meyer, 1997). For instance, an individual who believes that they are not at risk of contracting HIV will most likely not practise safe sex, while the opposite is also true. Therefore an increase in perceived susceptibility also translates to higher chances of uptake of health affirming behaviour. An interesting and often unexplored feature of perceived susceptibility is that an individual may feel susceptible to a disease or condition but still continue to behave in a certain manner (ibid.). For people to see need for changing risky behaviours, the model posits that levels of perceived susceptibility must be high. In programmatic interventions, the at-risk population has to be defined, and the risk has to be personalised to individuals in target population as a way of heightening perceived susceptibility levels. This makes people feel threatened. This study explores how taxi drivers perceive condom and contraceptive use by their partners. In addition it investigates their perceptions and determinants that influence and drive their health decisions. Findings may be useful in designing interventions framed within the HBM.

Perceived Severity

Champion and Skinner (2008:35) define perceived severity as "the belief in the seriousness of the consequences incurred if affected by the condition both medically and socially." In other words, this refers to one's opinion of chances of getting a condition. In most cases high levels of perceived severity increase chances of uptake of health affirming behaviour and so the opposite is also true (ibid.). Where perceived severity is low then chances of taking up

positive behaviour are also low. For instance, an individual who perceives having an STI as being something small does not attach any importance to ways of practising safe sex, such as using a condom. In the same vein, an individual who perceives condom use as unimportant has lower chances of using condoms. To gauge severity of an illness, people ask themselves questions like, 'can this really hurt me'. As such, interventions using this aspect of the model clearly specify consequences of the risk and condition to make the target population see what disease can do to them. The targeted population must believe that the disease or health condition can actually hurt them.

Perceived Benefits

The next construct of the HBM is the perceived benefits that are attached to following certain health behaviours. This is where one believes that there is benefit in changing/adapting new health behaviour after asking themselves if the doing or practicing a certain behaviour can actually help them. If the perceived benefits are low then there is "no inclination to practise healthy behaviours on the part of individuals" (Mattson, 1991:345). Perceived benefits are directly linked to perceived severity and susceptibility in that perception of these benefits may lower perceived susceptibility as well as perceived severity (Glanz & Rimer, 2005).

Perceived benefits can be defined as "the individual's beliefs regarding the effectiveness of strategies designed to decrease vulnerability or reduce the threat of illness" (Brown, DiClemente & Reynolds, 1991:51). Perceived benefits are usually specific but can take a general form as in living more healthily and for longer. Perceived benefits are affected by attitudes and information among other factors. For instance, an abundance of information on the benefits of knowing your HIV status is likely to encourage an individual to use a condom and to be faithful to one partner, while an absence of the same results in ignorance. As such, interventions seek to clarify the positive effects to be expected, showing what has been proven by research, for example, dual contraceptive use to prevent infection. Perceived benefits of dual contraceptive use will be explored in the study from the perspective of the male taxi drivers.

Perceived Barriers

Contrary to the perceived benefits these are one's opinions of the tangible and psychological costs of the advised action where people feel that it might be difficult to do certain practices.

Here they can ask themselves questions like ‘can I actually do it’. Perceived barriers thus act as deterrents to practising healthy lifestyles, as individuals are more likely to focus on the barriers than on perceived benefits (Chew, et al., 2002). Barriers take various forms including cost, social values and norms, pain, inconvenience and peer pressure and can also be found in the physical, emotional and physiological realm (ibid.). Perceived barriers can be defined as “the assessment of potential negative consequences that may result from taking particular health actions” (Brown, DiClemente & Reynolds, 1991:51). For example, with the use of a condom (the preventive action) to avoid HIV (the illness), the barriers could include inability to apply the condom (physical barrier), the religious or moral beliefs forbidding the use of birth control (psychological barrier), the embarrassment associated with discussing the use of condoms (emotional barrier), or even the inability to afford condoms (financial barrier) (Mattson, 1999).

Perceived barriers act as the single most powerful predictor for decision making (Rosenstock, 1974; Sharma & Romas, 2008), thus they merit exploration in this study. Understanding and identifying barriers can be used to enhance participation rates in prevention programmes even when offered free of charge (Farooqui et al., 2013). Addressing perceived barriers will help reconcile negative attitudes towards contraceptive and condom use among partners (Burak & Meyer, 1997). The researcher will seek to find out from the participants their perceived barriers to condom and contraceptive use. If taxi drivers identify their personal barriers to accepting dual contraceptive use by their female partners, it becomes possible to find ways of breaking these barriers. Only then can information about resources relevant tools to break these barriers be made available to them.

Cues to Action

Cues to action are external factors that prompt an individual to change their behaviour (Mattson, 1999). They act as the stimuli that encourage an individual to take steps towards making a change. Cues to action can be defined as “specific stimuli necessary to trigger appropriate health behaviour” (Mattson, 1999: 243). The cues can take many forms including mass media advertisements, posters, or witnessing someone dying or suffering from a disease, as all these elicit action for taking preventative behaviour. Cues to action can be grouped into two specific categories – internal and external.

Internal cues to action focus more on interpersonal aspects and include perceptions, social cognition, and physical cues such as symptoms of the illness (Glanz & Rimer 2005). External cues to action on the other hand are more public, such as messages found in mass media and through interpersonal interaction. External cues are often positive in nature and have goals to change individual and community health behaviours (Mattson, 1999). In this study, a focus on cues to action is vital as Mattson (1999:243) states that “individual beliefs and perceptions about health and illness are socially constructed and contingent upon social interaction.” The importance of communication in cues to action cannot be overstated as it plays an important role of informing individuals, especially where mass media is concerned. This study therefore attempt to account for male taxi drivers’ attitudes towards dual protection use by their partners and identify gaps which can be addressed using cues to action. In essence the study does not probe on cues to action but uses cues to action as an intervention based on the responses the taxi drivers give concerning the topic under study. The study serves as a foundation upon which the how-to information, as well as awareness promotion and reminder messages to taxi drivers can be based.

Self-Efficacy

Central to HBM is the concept of self-efficacy which has been incorporated into the HBM (Rosenstock, Stretcher & Becker, 1988). Self-efficacy refers to an individual’s perception of competence and capability in completing certain tasks (Bandura, 1997). This is when one gains confidence in their ability to take action and sustain it, confident that they can do it. Thus self-efficacy can be viewed as predictive of preventative behaviour. For instance, if an individual feels that they are able to practice certain behaviour, then they most likely able to do it. The opposite is also true; where self-efficacy is low then chances of uptake of positive behaviour is low. In this study, self-efficacy will mean the taxi drivers’ confidence in using condoms and being comfortable with their partners’ use of dual contraception. As shall be shown in Chapter Five, promoting taxi driver’s ability to succeed in changing behaviour may be done through providing training, guidance in performing action so that they become confident in using a condom correctly in all circumstances.

Critique of the HBM

The HBM has been one of the most useful paradigms for investigating health-related behaviours (Janz & Becker, 1984). However, there have been criticisms levelled against it

and these should be noted. The relationship between perceived severity and susceptibility is not clear, and a number of other authors (Chew, Palmer, Slonska & Subbiah, 2002) state that perceived susceptibility may depend on level of severity. The emotional component of decision making is left out in the HBM, such as fear. According to Talvitie (2012:9), “fears should be considered as constructs.” The HBM focuses on perceptual factors such as beliefs and fails to account for variance in behaviour that might be due to such salient factors as personal habits and social cultural norms (Noh et al., 1994: 379). Therefore, the underlying principle that health behaviour is ‘rational’ and that people usually attempt to maximise “value expectancy function” (Cleary, 1986:344), is problematic. Health behaviours such as smoking consist of a habitual component that cannot be explained by rational processes of decision-making (Rosenstock, 1990). It is also possible that sexual behaviour does not lend itself to interpretation as “a rational behaviour as it is associated with impulsivity” (Loewenstein & Furstenberg, 1991:961). For example, in the heat of passion, some people often behave in ways that they later regret (ibid.). This makes sexual-decision making more difficult to predict using the HBM.

Existing research points out to various myths about HIV/AIDS. For example, some still believe that AIDS is an American’s plot to reduce South Africa’s black population while others believe that South African government is withholding a cure for AIDS (Niehaus & Jonsson, 2006:182). Research shows that individuals who hold these beliefs are less likely to protect themselves from HIV infection (Bogart et al., 2011). Kunda’s study (2008) indicated that people create myths to justify health inappropriate behaviour, for instance, in the case of Jacob Zuma’s alleged rape of a young woman known to him to be HIV positive, his initial explanation about why he did not use a condom rested on what he identified as Zulu culture. He explained that –“if a man did not have intercourse with a woman who wanted intercourse, the woman might become so angry that she might falsely accuse the man of rape” (Skeen, 2007:39). When asked why he took a shower, Zuma explained, “I wished to take a shower because it is one of the reasons that would minimise the risk of contracting the disease (Skeen, 2007:32-33). This idea of ‘taking a shower’ has sent the wrong message to other men, thinking that taking a shower after engaging into unprotected sex will automatically prevent one from contracting the virus. Further, given the Big Man culture of many Africans, presidents and leaders can do no wrong, they set examples to be followed, and not to be criticised (Bourgault, 1995). Similarly, when President Thabo Mbeki denied the link between

HIV and AIDS, many fellow dissidents refrained from safe sex practices justifying this on the basis of the authority of ‘the president’.

Health behaviour has been changing over the past years and it will continue to change, simply because life is not static and nor are other facets of life, such as diseases. Changes in health behaviour therefore necessitate changes in the theories and models used to understand and interpret health behaviour. Individual level theories thus become inadequate, as they focus on the individual and overlook the influence of other factors that influence and determine health behaviour such as family, policy and community. In addition, individual level theories are also found wanting in group settings such as drug users, deprived populations, and teenagers and other sensitive issues like sex (McLeroy et al., 1988).

Green (1984:238) recognises that the use of individual level theories for social problems creates a counterproductive ‘victim blaming’ culture which not only is unrealistic but also counterproductive to the bigger picture of promoting positive health behaviour. Hastings and Donovan (2002) encourage the use of a broader perspective that not only focuses on the individual behavioural influences but also the social, physical and determinants of that behaviour.

Rosenstock (1990) also notes that social norms established within a culture or subculture can exert an important influence on behaviour. This means that male taxi drivers may adopt certain behaviour (concurrent and multiple sexual partnerships) because of a desire to gain social approval or popularity rather than improve health behaviour. The Social Ecology Model is used to complement the Health Belief Model, thus some of the shortcomings of the HBM with relation to the influence of the context or society on the individual such as the social and structural drivers of the HIV epidemic discussed earlier are addressed by the Social Ecology Model.

The Ecological Perspective

Ecological approaches to health behaviour target multiple levels of health behaviour influences and, like individual level theories, contribute to the development of public health communication strategies and interventions. The basic premise of the ecological theories is that health, behaviour and their determinants are interrelated (Sallis, Owen & Fisher, 2008).

The use of the ecological perspective is ideal for this study, as the phenomenon under study – male taxi drivers’ attitudes concerning condom use and dual contraceptive use by their female partners – is too complex to comprehend relying on the individual level theories. It is important to note that the primary function of the ecological perspective is to understand all potential means that ultimately lead to people making decisions regarding long lasting positive health behaviour.

Stokols (1992, 1996) describes and defines the term ‘ecology’ as a biological science term that refers to relationships and transactions between organisms and their environments. The ecological perspective, as it has evolved in behavioural sciences and public health, emphasises the interaction between, and interdependence of, factors internal to and externally across all levels of a health issue. It is a “systems” approach, highlighting people’s interactions and connections with their physical and socio-cultural surroundings (Glanz & Rimer, 2005).

Two key concepts underpin the ecological perspective; (1) behaviour affects and is affected by multiple levels of influence, and (2) individual behaviour shapes and is shaped by the social environment (reciprocal causation) (Glanz & Rimer, 2005; Sallis & Owen, 2002). The first key concept makes the ecological perspective very attractive to health promotion programmes and interventions, as the multiple levels of influence are acknowledged.

The second key concept of the ecological perspective is reciprocal determinism, which describes the interaction between the person’s behaviour and the environment. Individual behaviour shapes, and is shaped by, the social environment. The interaction between individuals and environments and their conjoined influence on each and HIV-related outcomes is often ignored in studies (Tan et al., 2013). For instance, behavioural control is a dimension of power at the individual level (Fisher & Fisher, 1992) while availability of resources is a dimension of power at the environmental level (Larios et al., 2009). Thus, an individual’s power is not only dependent on his or her behavioural skills, but also on whether his or her environment affords the behaviour to be enacted. However, one’s environment may also facilitate and limit behavioural potentials and, in turn, the individual's behaviours may change environmental features over time.

The success of using the ecological approach in addressing the multiplicity of social problems cannot be overstated. The ecological perspective has been used to address alcohol use among college athletes in America (Williams et al., 2006), it has also been used to understand eating habits and obesity in America (Edensor, 2004). Use of mosquito nets in rural Africa has also been analysed and understood through the ecological perspective and in Switzerland it has been used to understand the anti-litter campaign (Elder & Stern, 2009). In South Africa, studies around sexual health decision making have been made and these also use the ecological models to unpack decision making behaviour (Karim & Karim, 2010; Rohleder et al., 2009; Harrison et al., 2011; Matthews et al., 2013).

It is against this background that this study employs the ecological perspective in an attempt to understand male taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners.

The Social Ecology Model

No single factor on its own can lead to behaviour change and as such behaviour change is a result of a cocktail of factors that have been harnessed together to achieve behaviour change. The Social Ecology Model (SEM) recognises individuals as embedded within larger social systems and describes the interactive characteristics of individuals and environments that underlie health outcomes (Sallis, Owen, & Fisher, 2008; Stokols, 1992). The SEM not only assumes that multiple levels of influence exist but also that these levels are interactive and reinforcing. Stokols (1992, 1996) argues that the social, physical, and cultural aspects of an environment have a cumulative effect on health. He further contends that the environment itself is multi-layered, since institutions and neighbourhoods are embedded in larger social and economic structures, and that the environmental context may influence the health of individual people differently, depending on their unique beliefs and practice. The SEM is divided into five levels of influence and these are (1) intrapersonal; (2) interpersonal; (3) organisational; (4) community and (5) public policy. These levels are diagrammatically described and explained by Glanz and Rimer (2005) as follows:

<i>Concept</i>	<i>Definition</i>
Intrapersonal Level	Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
Interpersonal Level	Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
Community Level	
Institutional Factors	Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors
Community Factors	Social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations
Public Policy	Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management

The Ecological Perspective: Levels of Influence (Glanz & Rimer, 2005: 11)

Individual/Intrapersonal level

This is the most basic level of the model as it focuses on the individual and the individuals' beliefs, knowledge and attitudes. This level of influence is critical as the individual is the most important unit of a group, thus an understanding of how an individual behaves is key in understanding how a group behaves. Central to the individual level of influence is the concept of self-efficacy, which has been already discussed with regard to the HBM. The individual characteristics that influence behaviour within the individual level are well within the control of the individual, though they can be influenced by other factors. For instance if a woman delays going for HIV testing, at the individual level her beliefs and attitudes towards HIV testing and counselling may come into play, thus influencing her decision to delay having the test done. Fear that she may have the disease may also influence her behaviour to delay. This level of the model will be investigated by exploring the drivers' attitudes towards dual contraception while at the same time the line of question and discussions shall be guided by the HBM as it encompasses the individual level of the SEM in its entirety.

Interpersonal Level

The second level of the SEM is the interpersonal level; this level is based upon the concept that the social environment has the potential to influence individuals who exist within the same environment. Social norms operate within this realm, although they are generated in the institutional and community levels (Sallis & Owen, 2000; Smedley & Syme, 2000). Family members, friends, health professionals and peers provide social identity and play a major role

in helping create and affirm identity and health behaviour. These people provide an individual with advice, and can reinforce or destroy beliefs and encourage an individual to behave in a certain way. In turn, the individual has the power to also influence these same people to change their behaviour. The interpersonal level contains individuals who are key decision makers and sometimes opinion leaders. In an effort to facilitate behaviour change it is important therefore to identify these individuals, for instance interventions targeting children would require the cooperation of parents as key decision makers. Again a man who has an attitude towards his partner using birth control injections or pills, at the interpersonal level may be getting the influence from his friends who do not realise the importance of using contraceptives. For the purpose of this study, this level will be investigating by probing the social networks that these men have and how these affect and in turn influence their health seeking behaviour.

Institutional Level

“Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviours, make up the institutional level” (Glanz & Rimer, 2005:11). Schools and churches have the ability to influence behaviour; so do policies and regulations put in place by these institutions. For instance, certain buildings have no smoking policies in place such that these restricted areas are smoke free. This affects and influences the behaviour of smokers, in particular those who stay or work within those buildings. In the same vein, it may be that the attitudes of male taxi drivers are influenced by their institutional environment, which is the taxi rank.

The Community Level

The fourth level of the SEM is the community level and according to Glanz and Rimer (2005) social networks and norms make up this level; so do groups and organisations. The community is viewed as a result of interconnected relationships that have an influence on an individual's health (McLeroy et al., 1988). The community acts as the link between the individual and the world and doubles up as a source of support, especially during periods of adopting positive health behaviour (ibid.). In addition, interconnectedness of groups in the community level is ideal for improving and promoting health behaviour in society. For instance, if an individual tests positive for one disease they can be referred to another health institution for further assistance and there too they get information on groups and

organisations that support and help them. On the negative side, organisations within a society may give conflicting statements on health behaviour. For example, teenagers who need contraception may be told by their parents or partners to use one type of contraceptive and yet the South African government departments promote dual contraceptive methods. These methods are promoted for protection against pregnancy, HIV and STIs. Other structures such as churches ignore contraceptives and call for abstinence. This disconnect between organisations leads to misinformation thus exposing the teenager not only to pregnancy but also to diseases.

Policy Level

The final level of the SEM is the policy level, which includes laws and policies that regulate behaviour. For instance the woman who delays using contraceptives at the policy level may not have enough access to these contraceptives, especially at the clinics, where nurses' attitudes are not friendly (Wood & Jewkes 2006). The policy level incorporates the local and national level policies that regulate or support healthy actions and practices for the prevention, care or support, detection and treatment of a condition (McLeroy et al., 1988). This level will not be explored in this study as this study is mainly focusing on the attitudes of the individuals.

The SEM can be explained in full using the following example. For example, a person who engages in unprotected sex may do so because of his beliefs related to condom use (individual level), the power dynamics within the relationship (interpersonal level), a lack of available condoms (organizational level), norms for condom use in his social network and community (community level), and policies that do not allow for condom distribution in schools or prisons (structural/policy level).

Applications and limitations of the SEM

This study aims to understand male taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners through the Social Ecology Model lens. These attitudes will be interrogated at every level of the model, making the SEM an ideal model to use in this study. Not only does the SEM take into account the environment as part of health behaviour but it is multi-disciplinary in nature thus allowing for the application of other disciplines to interpret and explain health behaviour. This interdisciplinary nature of the SEM

is essential when it comes to intervention design and implementation.

It is important to note that the SEM comes with its own shortcomings that need to be addressed. One of the biggest shortcomings of the model is its interdisciplinary nature. This is particularly difficult when it comes to intervention design and implementation, especially at policy level, given the red tape and much dreaded bureaucracy involved (McLeroy et al., 1988).

Application of these theories in this study

My study uses the Health Belief Model to investigate taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners. The HBM provides a framework for understanding taxi drivers' perceived risk of HIV and AIDS/ STIs. The questions for my research were influenced by the HBM theory and the SEM. The HBM theory and the SEM will allow the researcher to understand how susceptible participants feel to health problems such as HIV and AIDS or STIs. Slowing the spread of infection requires that "people adopt safer sexual practices such as condom use and dual contraceptive use" (UNFPA; WHO & PATH, 2005:1). By questioning participants about how they perceive their role as well as their partner's role in HIV prevention as well as pregnancy, some of the HBM variables will be questioned. This study seeks to understand male taxi drivers' attitudes concerning condom use and dual contraceptive use by their partners. The HBM and SEM will help the researcher to examine the relationship between the participants' attitudes concerning condom use, and dual contraceptive use by their partners. Furthermore, the theories and the model will allow the researcher to interrogate the participants' decision-making processes and also HIV and AIDS-related knowledge, attitudes, beliefs, behaviours and interpersonal skills.

In conclusion this chapter discusses the Social Ecology Model and the Health Belief Model; these two models will be used in this study to inform data analysis. The Social Ecology Model bears great relevance for this study as it recognises individuals as embedded within larger social systems and describes the interactive characteristics of individuals and environments that underlie health outcomes. The Social Ecology Model will thus be used to understand taxi drivers, their environment and how both affect the other in terms contraceptive use knowledge, attitudes and perceptions.

The Health Belief Model, an individual level theory, attempts to explain the thought processes that drive an individual in making health decisions. This model will thus be used to interrogate knowledge, attitudes and perceptions of taxi drivers concerning condom use and dual contraceptive use by their female partners. The HBM theory and the SEM will allow the researcher to understand how susceptible participants feel to health problems such as HIV and AIDS or STIs.

CHAPTER 4: METHODOLOGICAL OUTLINE

This study is an investigation of the attitudes of taxi drivers in Umbumbulu District, concerning condom use and dual protection use by their partners. Men's participation in contraceptive usage by their sexual partners is quite significant in any concerted effort to address health issues such as unwanted pregnancy, high STI rate, and HIV transmission. Insight into what men feel, think and know about dual contraceptive use therefore key as the beginning point towards addressing these problems. This chapter provides the methodological outline that was applied in the execution of the study. Aspects presented relate to the research design, sampling techniques, data collection and analysis methods.

Grounded in cultural studies for its usefulness in providing some tools that “enable one to read and interpret one’s culture critically” (Kellner, 2009: 10), this study is located within the qualitative paradigm of research precisely because it aims to achieve a deep understanding of people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles. This is what Wright (2009) claims to be the main purpose of qualitative research. Qualitative research was favoured over more quantitative approaches, as the study dealt with a fairly small sample and endeavored to “get an in-depth opinion from participants” (Dawson, 2002:14).

Denzin and Lincoln (2003:15) note that qualitative research “involves an interpretive, natural approach to its subject matter, it attempts to make sense of, or to interpret, phenomena in terms of the meaning people bring to them”. Qualitative research therefore enables the researcher to have a better understanding of the study population’s world view thus making research easier, especially in under researched areas (Creswell, 2003). Qualitative research makes use of various data collection methods, and this study makes use of the focus group discussions which will be discussed in depth later in the chapter.

Interpretive Paradigm

The aim of this research is to understand male taxi drivers’ attitudes towards dual contraceptive use and condom use by their partners. It aims to unearth and understand the factors that affect and influence their attitudes towards condom use and contraception use by their female partners. The study fits with the strategies and intentions of the interpretive research paradigm. Higgs (2001) states that under interpretivism, knowledge is a product of

social construction and as such encompasses various research approaches, all of which have the goal of interpreting the social world. Interpretivism is more about understanding the participants' world view as opposed to explaining and predicting their behaviour.

Crotty (1998) states that meanings are constructed by human beings in unique ways, depending on their context and personal frames of reference as they engage with the world they are interpreting. "Our knowledge of reality is a social construction by human actors. As a result, value-free data cannot be obtained because the enquirer uses his or her preconceptions in order to guide the process of enquiry, changing the position of both parties" (Bryman & Bell, 2003:203). Interpretivism is therefore ideal for the purposes of this study, as it unpacks taxi drivers' attitudes. "This is because "Interpretivism emphasises the ways that people being studied make sense of and how they talk about, their world or experiences" (Mutinta, 2012: 104).

There are multiple and large-scale factors and processes that influence taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners; taxi drivers may be aware or not of the existence of such forces and their influence on their interpretations and behaviour. It is against this background that Interpretivism is ideal for this study. With this research approach, the idea of "reality" is determined by people rather than by objective factors. In this type of research, findings emerge from the interactions between the researcher and the participants as the research progresses (Creswell, 1998). Therefore, subjectivity is valued; there is acknowledgement that humans are incapable of total objectivity because they are situated in a reality constructed by subjective experiences. In choosing this particular paradigm, certain assumptions and perspectives are accepted. Male taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners are cognitive and interactive processes that are tacit and sometimes subconscious and occur in context.

The Interpretive paradigm was viewed as the most suitable for this research because of its potential to generate new understandings of complex multidimensional human phenomena, such as those investigated in this research. Specifically, practical knowledge was sought, which is embedded in the world of meanings and taxi drivers' interactions. It is also ideal as it enables the researcher to understand the web within which taxi drivers act, and how this web influences and affects their sexual behaviour.

Research Design

This study employed a descriptive case study research design. Twelve Umbumbulu male taxi drivers were selected, from which data were collected to help answer the main research questions. It is termed a descriptive case study because the information about the research problem was gathered from one area, Umbumbulu taxi rank, which is the only taxi association in Umbumbulu. Thus the collected information represents Umbumbulu male taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners. The study is descriptive in that it answers the question of "what" is the male taxi driver's understanding of dual contraceptive use in sexual relationships (Berg, 1995).

A research design, according to Kumar, (2011:94) is "a procedural plan that is adopted by the researcher to answer questions validly, objectively, accurately and economically". This is a descriptive cross-sectional study of taxi drivers in Umbumbulu District, KwaZulu Natal, whose aim is to take a onetime stock of their attitudes, knowledge and behaviour about dual protection. Cross-sectional study is "a study design in which data are collected for all the variables of interest using one sample at one time" (Adler & Clark, 2007:160).

A combination of qualitative techniques was employed in order to develop a clear understanding of the phenomena under study. Focus group discussion (FGD) and interviews were designed to generate textual, experiential narratives to give nuance to the findings.

Research Preparation Processes

The first stage of study was the development of data collection instruments. Interview and FGD questions were designed based on the HBM and SEM constructs. All the questions were open-ended; they were designed in such a way that participants would give supporting explanations as well as answers. Interviews and FGD were filled with open-ended questions that were designed to receive participants' HIV and AIDS-related knowledge, attitudes, beliefs, behaviours, and their interpersonal skills. Questions about participants' attitudes concerning condom use and dual contraceptive use and their decision making processes were also developed. The second stage involved the sampling procedures for the respondents for the case study. This study involved twelve Umbumbulu male taxi drivers. The findings of the study were then analysed to identify information gaps and questions that were either repetitive or misunderstood.

Selection of participants

The sample population for this study was a group of 12 male taxi drivers in Kwa-Zulu Natal, Umbumbulu District. In order for the researcher to gather data from the male taxi drivers, purposive sampling was used. Purposive sampling suggests that “members are chosen with a purpose to represent a location or a type in relation to a key criterion” (Ritchie & Lewis, 2003:79). Taxi drivers were identified purposively as they can provide the best information to achieve the objectives of this study. Participants are usually sampled purposively to reflect population variations that are particularly relevant to the research topic (Fisher et al., 2002; Kumar, 2011). As Kumar posits, as a researcher “you only go to those who in your opinion are likely to have the required information and be willing to share it with you” (2011:207).

Since the request of conducting research with Umbumbulu taxi drivers had been granted by Umbumbulu Taxi Association, the rank manager was very cooperative. Also, he assisted the researcher in selecting drivers who were known to be cooperative. Potential biases for sampling were discussed with the chairperson of the taxi rank. He mentioned that a number of taxi drivers were only interested in making money, and nothing else, so he was going to pick from different cliques, but only the ones who were cooperative and respectful. Twelve taxi drivers were ‘hand-picked’ by the chairperson of the taxi association and they were requested to participate, after which informed consent was obtained from them.

The aims and objectives of the study were discussed first with the association executives and the taxi drivers. An informed consent form was provided to all the participants to sign. The form included the freedom to withdraw at any point. As per the tradition of human sciences research, participants were informed about the level of confidentiality, which was guaranteed in this study. Participants were informed that all data would be used for research only, and that at no stage would their identity be disclosed. They were also informed that all information would remain confidential, with no association to the participants.

Taxi drivers were given a platform to share their knowledge, attitude and experiences.

Data gathering methods

Qualitative data was collected through use of focus group discussions (FGD) and structured interviews. The FGD and structured interviews were conducted by the researcher in the home-language of the respondents, which is isiZulu. The researcher is a Zulu language speaker, with experience in conducting and facilitating workshops and has a “firm grasp of the issues being studied” (Yin, 2003:59). The other reason for using isiZulu was because the taxi drivers would be more conversant in the language which was also their first language; they were more receptive in speaking in their language than conversing in English.

A (FGD) was conducted to generate qualitative data to address the research questions, with first a discussion on STIs, HIV and AIDS. A FGD is defined as a “carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment” (Krueger, 1988:18). This method allowed the researcher to ascertain the participants’ opinions and attitudes related to condom use and dual contraceptive use. The FGD was recorded with the participants’ permission, using a voice recorder.

Focus Group Discussion

Focus groups have a long history in market research; however, they are under used in social research (Morgan, 1998). As Barbour and Kritzing (1999:70) point out, the aim of FGD is to “provide opportunities for a relatively free-flowing and interactive exchange of views, it is less amenable to the researcher’s influence, compared to a one-to-one interview.” Due to the time constraints, and considering that taxi drivers are very busy people, the researcher conducted only one focus group discussion, although it lasted for over an hour. A focus group of twelve purposively selected taxi drivers was conducted and a topic guide was used for the FGD. The guide included general questions and a focus on personal experiences and the participants showed that they were willing to be part of the FGD. The enthusiasm was high, as the participants repeatedly laughed.

Open ended questions were asked in order to allow participants to tell their stories in their own words. These questions focused on HIV and AIDS-related issues and encouraged the participants to share their views and experiences. This method allowed for further probing to achieve deeper understanding of their experiences. For example, the researcher would

encourage the participants to provide examples where necessary. This form of research also allowed groups of peers to express their perspectives.

The FGD was participatory and dialogue was encouraged. Participants felt comfortable to share their personal experiences, considering the fact that the researcher is a female. However, there were some limitations to the recording of the discussion as we could hear other taxi drivers talking out loud and cars passing by. These sounds disturbed the recording, but the researcher encouraged the participants to be audible and not to speak at once. Participants were seated in a circle and the aim was for them to be able to see each other as well as to be audible for the recording, as the audio tape recorder was placed in the middle of the circle to record the responses of the participants. However, in retrospect this could have been avoided if the researcher had a co-facilitator, it would have helped to control the flow of the FGD.

Focus groups are a “culturally sensitive data collection method” (Hart et al., 1999:690). During the FGD respondents mentioned that they come from similar socio-cultural background. All the participants were born and bred in Umbumbulu. A number of them still practice traditional way of living. For example, their families have cattle and their great-grandfathers, even some grandfathers, still practice polygamy. These participants come from sub-tribal areas whereby each sub-tribal area is administered by different chiefs – *iziNdunas* – and different ward councilors.

A criticism of a FGD is that “there is more control over the emerging perspectives but less spontaneity and richness in the quality of discussion” (UNAIDS, 2007:94). To mitigate against this challenge, less vocal participants were encouraged to share their views and structured interviews were then employed.

Structured Interviews

Interviews serve very specific purposes. First, they are used as a means for investigating and gathering of narratives of lived experiences. Second, it is a vehicle by which to develop a conversational relationship with participants about the meaning of experiences. This may be achieved through reflection with participants on the topic at hand (van Manen, 1997). Interviews also allow participants to share their experiences in their own words. There are

various ways of conducting research interviews. Structured interviews were conducted after the FGD. This form of interviewing utilises “standard questions and optional probes” (Marshall & Rossman, 2011:145). In order for the facilitator to obtain maximum amount of data, the probing strategy involved starting with general questions and then followed up by asking more detailed questions. Three structured interviews were used to solicit information regarding participants’ feelings towards and knowledge of dual contraceptive use. Interviewing taxi drivers gave the researcher an opportunity to get to know them as individuals, so that the researcher could understand how they think and feel (Terre Blanche et al., 2006). An interview schedule was used in the facilitation of these structured interviews. The three respondents who were interviewed were purposively selected from those who participated in the FGD by the researcher. Only those who were more vocal during the FGD were selected for the interviews. However, the researcher prompted particular individuals for their opinions thus ensuring that everyone spoke more or less equally.

Open-ended questions were used to explore issues related to HIV and AIDS, multiple and concurrent partnership and dual contraceptive use. The focus of the interviews was on finding out about the respondents’ knowledge on the spread of HIV and AIDS, their opinions on condom use as well as dual contraceptive use by their partners and also about their behaviour in relation to HIV prevention. These interviews were carried out in the taxi rank’s office whilst the taxi drivers were waiting for the passengers.

Structured interviews were conducted at the Umbumbulu taxi rank with the Umbumbulu male taxi drivers, in the first language for the taxi drivers. Taxi drivers were comfortable to express themselves in isiZulu. The length of the interviews varied from two to three hours. The researcher first read the questions in English and then translated them in isiZulu. The responses were recorded with the participants’ permission.

Enacted reflexivity

To ensure that this study was reliable and valid it was critical that the researcher took time to reflect on who she is, before, during and after every research. The researcher is a senior facilitator with an organisation that uses interactive methodologies as a way of implementing public health communication interventions. Umbumbulu is one district that the researcher works in, thus it was easy to gain access to the taxi association. As a woman, it is perceived

hard by society to talk about sex, especially to taxi drivers who already are viewed negatively by society. However, the years as a facilitator came into play as the researcher was able to apply various skills in an effort to overcome her gender and any other awkward instances that occurred during the process of data gathering. The researcher problematized her position as a senior facilitator at DramAidE, she did not just accept views that reflected her preconceived ideas. All data received were interrogated in a reflexive aware manner (Tomaselli, 2008).

Data Analysis

Data were analysed using thematic analysis. Thematic analysis is a qualitative method of analysis used for identifying, analysing and reporting themes within data (Braun & Clarke, 2006:80). It allows for qualitative data to be understood and described by quantitative means (Boyatzis, 1998), if this is desired by the researcher. It involves a process of encoding qualitative information, and the creation of an explicit code. A code is “the most basic segment of raw data that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998: 63). The process of coding can be described as a way of relating the data to ideas about the data (ibid.). It allows researchers to think about their data, and make the categories themselves points of analysis. As part of the analytical process, it involves the decision that a category is relevant to the project; and the choice of which data segments “belong” in a category (Ely et al., 1997).

The coding process may result in the formation of a list of themes, organised in either a complex or simple fashion. A theme is “a pattern identified in the data, at minimum it organises and describes your observations” (Braun & Clarke, 2006:79), and at maximum “interprets aspects of the phenomenon” (Boyatzis, 1998:4). Coding is an active process, and even if the researcher chooses to make their analysis a data-driven one, concentrating on the data when creating themes rather than theoretical expectations dictating what they should be looking for, this is still the case. The researcher’s theoretical framework, as well as the context in which the data were created and analysed, cannot be ignored. Themes do not naturally emerge out of the data; there is often a misconception that “themes reside in the data, and if we look hard enough they will emerge. If themes ‘reside’ anywhere, they reside in our heads from thinking about our data and creating links as we understand them” (Ely et al., 1997:205).

Analysis involves, at the very least, “drawing together and comparing discussion of similar themes and examining how these relate to the variation between individuals and between groups” (Barbour & Kitzinger, 1999:16). There are many ways of analysing FGD data: for example, content, narrative, conversation analysis. In this study thematic analysis was preferred for its usability in identifying, analyzing and reporting patterns (themes) within data. For Braun and Clarke (2006:79), thematic analysis “minimally organizes and describes the data set in rich detail”. This method was employed to compare and contrast the data obtained from the FGD and structured interviews. The thematic analysis was guided by the following six phases described by Braun and Clarke (2006). As Boyatzis, (1998) put forward, this six phase process allows the researcher to interpret various aspects of the research topic.

The table below aptly describes the steps taken in the analysis process of this study.

Phase	Description
1.Familiarizing yourself	Familiarizing yourself
2.Generating initial	Generating initial
3.Searching for themes	Collating codes into potential themes, gathering all data
4.Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5.Defining and naming	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6.Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Figure Four: Adapted from Braun and Clarke (2006:87).

The themes that were used to code and understand the data were drawn from the responses of the participants.

The results of this study need to be considered in relation to its limitations. First, the study cannot be fully generalized within the Durban, KwaZulu-Natal taxi industry because the sample was small: the results were only obtained from the taxi drivers of one taxi association, which is Umbumbulu Taxi Association. However, the demographics of the group of taxi drivers who participated in the study were similar to those of the general population in Umbumbulu with regard to ethnic groups. Therefore, the findings seem to be partially generalizable to the wider population of male taxi drivers in Durban, Kwa-Zulu Natal. It could have been better if the researcher conducted at least two FGDs with different groups.

Second, the absence of the taxi drivers' female partners is another limitation in this study. The researcher relied on the participants' reporting of their female partners' use of contraceptives. Participants may have under-reported non-hormonal (pills and injectables) contraceptive use among their female partners because they may not have known about their use.

Third, the fact that the researcher was female was a bit of a challenge as she figured out that some other topics could have been explored in greater depth. For example when the participants discussed how when females use hormonal injectables, they become 'cold'. Also, participants might have behaved differently from how they behave when they are not observed.

Fourth, it is possible that peer pressure influenced the outcome of the data collected as it was noticed that the participants were more open in the interviews and their responses were not the same as the ones in the FGDs.

Fifth, group dynamics: some participants were quiet and others were very open. The researcher ensured that no one person dominated the group by encouraging everyone to contribute.

Finally, the literature review of taxi drivers in South Africa was limited, there is dearth of studies focusing on the sexual behavior of taxi drivers in South Africa.

Despite these limitations, the study has offered useful information for designing men's health interventions to promote use of dual contraceptive methods among taxi drivers and their female partners.

In conclusion this chapter discussed the research methodology used to conduct the study and also shows how qualitative methods were used to collect data. Based on the study's general objective to understand male taxi drivers' attitudes concerning condom use and dual contraceptive use by their female partners, the qualitative research approach was considered the most fitting one. The study took the form of a descriptive case study research design. Data was collected using interviews and focus group discussion and thematic analysis was used to analyse data. The collection of data did not go without its limitations.

CHAPTER FIVE: DATA ANALYSIS

Perceptions of Contraceptive use among Umbumbulu Male Taxi Drivers

The purpose of this study is to understand how male taxi drivers in Umbumbulu district perceive condom use and dual contraceptive use by their partners. Insights from the reviewed literature as well as the theoretical framework underpinning this study are used to provide the lenses for analysis of these findings. In light of the study objectives, findings are discussed under the following themes: (i) how taxi drivers perceived their susceptibility to HIV, (ii) how they perceived the severity of HIV, the benefits of using contraceptives and barriers that affect contraceptive use by their partners, and (iii) how all this affects their attitudes towards contraceptive use.

Attitudes Towards Condom Use

“Condom is not nice, it’s not really nice to have sex with a condom.”

The study examined how participants perceived their risk of HIV and STIs, and their attitudes towards condom use and dual contraceptive use by their female partners. The HBM posits that an individual who believes that they are not at risk of contracting HIV will most likely not practise safe sex (Janz & Becker, 1984). In order to reduce the spread of HIV transmission, for instance, people need to recognize that their behaviours are risky (Catania et al., 1990). In this study, perceived risk was used to understand participants’ attitudes to their chances of contracting HIV and STIs.

Taxi drivers were asked if they thought that they were susceptible to HIV. Participants had a lot of knowledge about the risk of HIV and they revealed that as with any other people, they were also susceptible to contracting the virus. For Thabo, *HIV kills, and I’m scared to die*. Susceptibility to HIV could also be inferred from the fact that the participants reported that they use condoms particularly during intercourse with casual partners for fear of contracting the virus.

When I meet someone for the first time, I make sure that I wear a raincoat [meaning a condom], (Sizwe, non-cohabitating, 2013).

Another participant echoed the above statement, saying:

Condom use is important when you hardly know each other, I mean [short pause] we have to get used to each other, trust each other, then I'll see if she's a good person thereafter decide whether I use protection or stop using it, (Ben, non-cohabitating, 2013).

This perception illustrates that it is important to negotiate condom use at first intercourse. The majority of the participants in the focus group discussion argued that they would use condoms with new partners, but would stop once they have begun to trust them. Kwethaba explained, *it's only important to negotiate condom use at first intercourse*. The participant was asked what happens on the second and the third time and he responded *well it depends on how you click* [meaning feeling comfortable around that person], (Kwethaba, co-habiting, 2013).

The statement suggests that the participants' level of susceptibility as well as how they perceive the risk of HIV when it comes to HIV and AIDS prevention is high. Participants understood that if they get HIV they can infect others and eventually themselves fall ill and die. However, it was noted that participants kept on emphasising the importance of 'trust' and 'feeling comfortable' with their female partners, but no one mentioned the importance of getting tested.

Another respondent who has an *ingoduso* [fiancée] explained:

Yes, I'm sexually active and I condomise, hey sisi [sister], I'm getting married next year January, I don't have time to play, I come a long way nomuntu wami [with my woman], (Bra Darkie, non-cohabitating, 2013, interview).

In Bra Darkie's experience, consistent correct condom use is perceived as a benefit. The statement suggests that even if one is in a 'steady' relationship, regardless of the length of that particular relationship, it is vital to use protection when engaging into sex. The above statement explains the perceived benefits of consistent condom use against HIV/AIDS, STIs and unwanted pregnancy. It is important to note that some men choose to be trustworthy and

monogamous partners, who also protect their loved ones rather than exposing them to HIV infections and other health risks. This is in agreement with self-efficacy. Self-efficacy is predictive of preventative behaviour. The above findings clearly explain that the participants' attitudes towards condom use and dual protection by their partners have developed based on their evaluations about what they value and in Bra Darkie's case, his 'woman'. This perception also illustrates that Bra Darkie's perception of the severity encourages him to want to live a healthy lifestyle and practice safe sex.

My study also found that the perception of condom use is viewed by the participants as a sign of infidelity or lack of trust. It is also vital to note that some women oppose the use of condoms, as Pro explained:

Some women don't like it when we use condoms; they just ask you 'what are you doing? Oh so you think I'm a whore, I sleep around?' (2013).

Another participant elaborated: *Others say they don't like to use a condom because it causes them rash, so we take it off.*

The above statements clearly demonstrate that some taxi drivers' female sexual partners resist using a condom and claim that they are on a pill or injectables. The chances of this individual negotiating condom use in the future would be very slim, as low self-efficacy affects decision making. The statements also suggest a lack of responsibility and commitment among participants and their sexual partners. Findings show that participants know what role to play in preventing HIV infection; however, their self-efficacy is low as they are not able to carry out positive behaviour. It was noteworthy that for some participants, condom use remains inconsistent, although they do consider their behaviour as risky. Participants with a high level of perceived severity were significantly more likely to strongly agree with consistent condom use than those with a low level of perceived severity.

While taxi drivers claimed to have information on HIV transmission, and also perceived non-condom use to be a risky behaviour, they still admitted that they continue to practice unsafe sex. The statements suggest that inconsistent use of condoms has been suggested as one of the key reasons for the high rates of HIV prevalence among South Africans.

Contrary to the above statements, the findings also revealed that whilst some participants believed that they were susceptible to HIV and STIs, their casual sexual behaviour demonstrated very low perceived risk. For example, Kwethaba (2013) said: *Condom is not nice, it's not really nice to have sex with a condom*; this suggests that Kwethaba's benefit – of sexual pleasure – outweighs the perceived risk of getting HIV. The same sentiments are echoed by the majority of participants. One participant even said: *It feels like you're masturbating, I use it and take it off (during sex) and my partner doesn't say anything* (Kay kay, non-cohabitating 2013). This statement brings to light the issue of communication between couples. The fact that Kay kay states that his partner does not say anything when he takes the condom off prior to ejaculation may mean that women fear to negotiate safe sex.

I don't use a condom, wena wake wawudla uswidi ugoqwe ngephepha [meaning, 'have you ever had sweets wrapped in plastic']? (Thabo, non-cohabitating, 2013).

Similarly, said another respondent whose response is quite common: *We do use protection, but sometimes we don't, we forget. In other cases it's a matter of where you find yourselves in, you look around and you don't find any protection, and you find that it's a quickie, only to find that you've put yourself into trouble*, (Thabang, non-cohabitating, 2013).

It is reasonable to argue that the majority of participants do not act responsibly when it comes to STI, HIV and AIDS prevention. The knowledge and information they possess does not translate to healthy and safe behaviours. The maximum protection explained the notion of a “quickie” as sex that happens fast and is not even planned, therefore they do not even think about protection, as the action is spontaneous. This explanation suggests that even though men know that they should use condoms, this knowledge is overridden by the “luck” of having a “quickie” which they also admit is satisfying. Participants' responses seem to suggest that their attitudes affect and influence sexual health behaviour.

Previous studies in KwaZulu-Natal have also shown that men have negative attitudes towards public sector condoms. In a study that examines perceptions of public-sector condoms and their impact on condom use among university students, Mulwo et al. (2009) found out that public-sector condoms are perceived as ineffective and are widely seen to be of a poor quality

and lower status as compared to the commercial brands. Similar findings were reported by Mattson et al. (2004) in a study of condom-related calls to the National AIDS Helpline, who discovered that national AIDS Helpline callers were concerned about the public sector condoms – dismissed as “government condoms” - as having an unpleasant smell. Communication campaigns were proposed by the National AIDS Helpline as one of the solutions that should give more information on the availability of public sector condoms as a result of a large contribution of funds from the government.

Male attitudes have been discussed in Chapter Two as contributing drivers of the HIV epidemic. From the foregoing, it can be argued that these attitudes are contributing to the taxi drivers’ low perceived risk of HIV. According to the HBM, for people to adopt safer behaviours, there must be a high perception of risk. There is need therefore for interventions aimed at heightening perception of HIV risk among taxi drivers in Umbumbulu. Some of the ways through which this can be achieved, is to use some of their colleagues who are infected and publicly living with HIV to sensitise them. Alternatively, others who are using condoms and are encouraging their partners to use dual contraceptives may be used as models to encourage their peers.

Multiple and Concurrent Sexual Partnerships

“There are so many of us who have omakhwapheni [meaning ‘side chicks’]”

Participants in this study demonstrated high levels of knowledge regarding HIV and AIDS, and awareness of the risks associated with multiple sexual partners and unprotected sex. The study found that concurrent multiple sexual partnerships are accepted as a common and normal behaviour at the taxi rank. For Mkhize, *There are so many of us* [taxi drivers] *who have omakhwapheni* [‘side chicks’].

When asked about the risks involved when engaged in multiple concurrent sexual partnerships (MCSPs), the drivers admitted that it is risky and also places their partners at risk. Participants admitted that men who are in multiple sexual partnerships were more likely to be infected with HIV infections. They also explained that they do get involved in multiple sexual partnerships, and they do not use condoms consistently. Mkhize put the practice of multiple sexual partnerships into context:

Participant: *Things happen here at the rank.*

[When asked why they engage in MSP, the participant explained:] *Well, what can I say? It's good fun, I've slept with other women and I don't get caught, it's very nice to be able to sleep with different women.* (Mkhize, married, 2013)

Researcher: Do you use protection though?

Participant: *Sometimes I do and sometimes I don't.*

According to the HBM (Becker, 1974), for people to see the need for changing risky behaviours, the model posits that levels of perceived susceptibility must be high. Data from study shows high levels of knowledge and very low levels of perceived susceptibility. The statements also demonstrate low perception regarding taxi driver's severity to the outcomes associated with multiple sexual relationships and unprotected sex. The study findings also recognised the relationship between taxi drivers and their environment. As the Social Ecology Model posits, friends and peers provide social identity and play a major role in helping create and affirm identity and health behaviour (Sallis & Owen, 2000). Lack of sexual communication, has been noted to be predictive of condom use (UNAIDS, 1999).

Imbalances in power within sexual relationships often favour men. Such imbalances arise from social and cultural expectations around male and female. Also, many participants felt that having many sexual partners displayed a sign of real manhood. The statements relate to issues of masculinity in the sense that some men have no reason for having MCSPs apart from wanting to fulfil and prove their manhood. Also, MCSPs are a major factor contributing to the rise in HIV infections. The data thus suggests that taxi drivers do not use condoms consistently.

With my stable partner I don't use it consistently, I'm not too worried even if she gets pregnantwith other partners it's also a problem, sometimes I use it sometimes I don't, especially when you've been wanting to get into that person's pants for a long time and the condom isn't there, you just don't even think about the virus, you think after the action (Ben, non-cohabitating, 2013).

The above statement is associated with lower perceived risk at the individual level. A lower

perceived severity of HIV increase the likelihood of being diagnosed with an STI or HIV. In spite of the knowledge about the risks of multiple sexual partnerships, taxi drivers still practice unsafe sex. This is in agreement with Mutinta (2012) who found that students engage in high-risk sexual practices including multiple and concurrent sexual partnerships. Delving deeper into Ben's comment helps reveal that some participants do not think about their own susceptibility to the virus, as well as unplanned pregnancy; they engage in risky behaviour whilst remaining fully aware of HIV risks.

Participants describe a straight partner as a main lover, the one with whom the relationship is most serious and which might one day lead to marriage (Hunter, 2010:191). Men's expectation is that this type of a woman will always avail herself whenever needed by him. According to Kay, taxi drivers who seem to get involved in multiple sexual partnerships are the ones who do not have "straight partners". Thus their perceived severity is low as they do not take into consideration the benefits of having one partner and of using a condom consistently. Kay's response suggests that he does not see himself susceptible to HIV and yet data of this study in the FGD shows that he does not like to use a condom as it feels like "masturbating". This justifies the Social Ecology Model because it evokes that regardless of how an individual may perceive the severity of contracting the virus, the social and cultural aspect of an environment may have an effect on health (Stokols, 1992).

Taxi drivers admitted having multiple and concurrent sexual partnerships. This kind of a relationship was explained by the participants as a type of a sexual relationship where an individual is engaged with more than one person at the same time. Concurrent sexual partnerships link taxi drivers together in sexual networks; when a taxi driver with HIV is introduced into a network where other people engage in overlapping sexual partnerships, it makes the virus spread rapidly between partners (Mah and Halperin, 2008).

It is interesting to note that a number of cohabitating taxi drivers were reported to have additional relationships with younger girls. These taxi drivers were said to be involved in relationships with youth: out-of-school girls, and others who are still in school. Due to power inequalities in these relationships, taxi drivers would inform the younger girls about their "straight" female partners. This then meant that the taxi drivers would not have any intention of marrying these girls. Power inequality then plays a big role in these relations, as

the taxi drivers' partners sometimes find out about these young girls.

We don't hide our straight girlfriends, but we do hide 'others', everybody knows that I have 'ingoduso' [meaning 'fiancee'], so it's not a secret, you tell them that look I have my woman, and everything is fine; the problem starts when they call in the wee hours of the morning, I mean they know you're not alone. (Kwethaba, cohabitating, 2013)

Kwethaba's response seems to suggest that he takes advantage of younger girls and does not show them any respect. According to DoH, (2007:32) "power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms." Kwethaba's statement also suggests that power and gender inequality may be a barrier to contraceptive use, as it leaves men to decide on how to handle the relationship. Touching on masculinity, most participants indicate that they were expected by their partners to be decision makers. This attitude could be caused by the patriarchal culture, which puts men in the authoritarian position and relegates women to subordinate positions. Kwethaba's response signifies that he feels that he is entitled to have multiple partners while avoiding the responsibilities of permanent relationships. These gender stereotypes, according to Hawkins et al, (2009:178) present "an image of women, and particularly girls, as sexual objects and commodities". Competition for sexual partners at the taxi rank was said to be very common.

Findings validate the three concepts of the health theories that knowledge is necessary for, but not sufficient to produce, most behaviour changes (Glanz & Rimer, 2005). Thus there is a need in providing taxi drivers with small group workshops that will communicate health messages to encourage reduction of sexual partners.

Research has also shown that there is a close link between alcohol and multiple sexual partners.

Jana et al's (2008: 29) study on multiple and concurrent sexual partnerships in Southern Africa found that alcohol is a contributor to multiple and concurrent sexual partnerships. They argue that people are more likely to engage in casual sex when drunk. Data from my FGD from Umbumbulu, taxi drivers show that the majority of the taxi drivers have engaged in sex without using condoms under the influence of alcohol. Alcohol was recognized as a

risk factor to non-condom use, as some participants admitted that they have engaged in sex while under the influence of alcohol and protection was not used. As is suggested by this statement:

When we drink alcohol with women, you find that they want to have sex and when you're drunk what you thought was not attractive becomes attractive and you forget about protection, then when you're done you see a box of condoms and you say eish, I should have started there, (Stout, married, 2013).

After careful analysis of the data, evidence indicated that almost all participants had high knowledge about the risks associated with contracting HIV as well as other STIs. However, most of the participants were of the view that alcohol relaxes them to the point that their perceptions about the severity of this risk were altered, and they were no longer concerned about the risk. Lack of sleep is another mitigating factor mentioned by most respondents given their sexual and driving activities, possible ill-health, all of which place passengers at risk. Another participant explained:

There are different types of people, the ones who are shy and the confident ones, so here there are people who can be very shy around ladies, but once they've had one or two glasses of alcohol, hey, I tell you, they relax, then they start approaching the ladies, (Kwethaba, 2013).

Stout's response seems to suggest that there is connection between alcohol and risky behaviour which creates networks of sexual relation making taxi drivers susceptible to HIV infections. Alcohol helps to socialise better and is a factor in creating opportunities for casual liaisons.

The definition of perceived susceptibility refers to one's opinion of the chances of getting a condition. It is found that despite the knowledge many participants possess, a number of taxi drivers are involved in multiple and concurrent partnerships; do not use condoms consistently, and others do not use protection at all. For a significant number of participants, the above mentioned factors may contribute to the prevalence of HIV and AIDS. Findings in this account are supported by a qualitative study by Morojele et al. (2006) that suggests that

there is a relationship between the use of alcohol and risky sex, especially among casual sexual partners. Therefore there is a strong need to encourage men to use condoms, especially when drunk and also to develop intervention strategies to address the issue of consistent condom use among taxi drivers.

Transactional and Intergenerational Sexual Relationships

“Some girls intentionally want to get pregnant”

Data from my study shows that taxi drivers do get involved into transactional sexual relationships with young women. The ten country study conducted in Southern Africa showed that in some relationships couples do not overtly agree to exchange sex for material gain, but the man gives the woman material rewards as a norm (Jana et al., 2008). These gender stereotypes position men as having the power to manipulate young women and might make men less likely to take responsibility and more likely to take risks.

Some girls intentionally want to get pregnant because they think we're loaded [meaning they have lots of money], since we buy them airtime, streetwise two, and some other goodies, (Spha, non-cohabitating, 2013).

Taxi drivers' perception that girls want to get pregnant because they think they have lots of money presents cause for concern as they do not mention any method of contraception that is used in order to prevent pregnancy and any other infections that might result. In KZN, Mutinta (2012) found that transactional sexual relationships on campuses are defined by the exchange of goods or money for sexual services and propel the risk of HIV/AIDS on campuses. His findings showed that most young women hold the weaker negotiating positions for their relationships as partners who have money, also have power over women who are mostly on the receiving end. This according to Mutinta's observation suggest that many students do not realise that transactional sex makes particular people attractive as sexual partners who given the current distribution of HIV are at high risk of HIV infection for instance, older partners (2012).

Another participant explained:

We have sex in the car [taxi] and when it's a rush rush situation, nobody has time to look for a condom, you'll waste your time looking around for a condom and the person changes her mind, so uvula iwindi ungene [meaning 'you slide the panty and penetrate'], (Ben, 2013).

The above statement highlights the vulnerability of young women in relation to older, more resourced men, potentially facilitating risks of pregnancy and HIV infection (Potgieter et al., 2012; Shisana et al., 2009). This statement suggests that the type of relationships taxi drivers have with these women is based on transactional sex (Leclerc-Madlala, 2003; Shisana et al., 2009). The statement suggests a lack of responsibility and commitment among participants and their sexual partners. Findings show that participants know what role they need to play and what behaviours they need to adopt in preventing HIV infection; however, their self-efficacy is low as they are not able to carry out positive behaviour as their perceived severity is low.

STI Spread at the Taxi Rank

“Almost everyone has had STI here at the taxi rank”

Analysis showed that although participants demonstrated high knowledge of issues around HIV and AIDS, nevertheless their responses suggest that there are basic gaps in knowledge about the common STIs that can be easily treated and cured in contrast to the infections that cannot be cured. Participants reported their perceptions of STIs, including whether they had heard of STIs; they mentioned the specific ones they knew about. They were also asked if they knew of anyone who had had an STI, if they had had any of them themselves, and how they treated them. One participant responded:

I do not get that scared when I hear the word STI, because it is curable. There is one that can be treated by medical doctors and the one that can only be treated by traditional medicines, (Stout, 2013).

Traditional healers seem to be consulted by the taxi drivers for the treatment of STIs. Despite the fact that taxi drivers contract STIs which is a result of unprotected sex, participants did not demonstrate the knowledge that STIs increase the risk of HIV infection, as they believed

that there is no connection between STIs and HIV.

Another participant said:

Almost everyone has had STI here at the taxi rank, it's not something that you can be ashamed of if you're suffering from it because it's easily cured and we've got very good traditional healers here in Umbumbulu, sisi [sister], there is one who is well known, that's where we go when we have STIs (Pro, non-cohabitating, 2013).

The above statements suggest a high level of STIs amongst the men, which suggests that some participants consciously practice risk behaviours, such as having unprotected sex, that may put them at risk of HIV infection, and the findings show a very low level of condom use. The statements also bring to light the participant's limited in-depth knowledge about STIs. Stout, a married middle aged man said that:

Doctors fail to treat STIs, especially pubic lice, yes they do treat 'cornflower' [cauliflower, genital warts], but the other STIs haai they fail. You go there and they give you pills, and then you find that it's still there it was just asleep, but when you go to the traditional healers, he gives you a 'bottle' and in few days you're sharp (Stout, married, 2013).

This, then, explains the high rate of participants who admitted that a majority of taxi drivers at the taxi rank do experience the signs of STIs. Surprisingly, all participants agreed that STIs, especially pubic lice, can only be cured by traditional healers. Furthermore, they admitted that they do visit a local traditional healer who is well known in Umbumbulu. The results suggest that among the participants, STIs are not viewed as a threat. There is also a strong belief that use of antibiotics does not treat STIs; traditional medicines are believed to cure STIs. Crucially, there was **no** recognition of the link between STIs and HIV. This raises questions about the perceived susceptibility to HIV and STIs, as a number of individuals do not see themselves as being personally vulnerable to contracting a disease from their partners. In as much as the taxi drivers understand that the disease is sexually transmitted. They believe the disease has its origins with some other traditional diseases. In this regard, some informants mentioned that traditional healers give their clients substances to use and once they have finished using them, they are instructed to throw them along the pathway, but then

these substances become harmful when absorbed by other people, thus they contract pubic lice. This is why taxi drivers consider traditional medicine effective compared to the doctors' treatment. Traditional healers are consulted in preference to conventional doctors (see also Epstein, 1997).

Although STIs are more openly spoken about, participants mentioned that they also find it more comfortable to talk about HIV only to their friends at the taxi rank. Thabo reports that almost all of taxi drivers at the taxi rank do engage in conversations, especially when waiting for passengers. However, they only talk to their friends:

I also talk about these issues to people who are in my group, it's easier that way. Otherwise, other people may misunderstand you, there are lots of diseases that people get here, i.e. cauliflower, pubic lice, (Thabo, 2013).

“Cauliflower” is a general term used by the participants meaning genital warts. Genital warts are caused by a virus which is transmitted directly from skin to skin during sexual intercourse with an infected person. STIs are more easily transmitted than HIV and further expose the infected person to HIV infection because of a compromised immune system. Thus consistent correct condom use can provide a barrier protecting the areas of exposure to genital secretions in both sexes (USAID, 2005). According to the SEM, the social, physical, and cultural aspects of an environment have a cumulative effect on one's health (Stokols, 1996). The environmental context may influence the health of individual people differently, depending on their unique beliefs and practices. The above statements clearly demonstrate that the information and the advice that taxi drivers provide to others may not necessarily be correct. The taxi rank environment encourages sharing some incorrect information about STIs and traditional healers, but not necessary about condom use.

Taxi drivers do discuss sexually related issues since they mention that they refer each other to traditional healers. In this study, friends have been demonstrated as people who provide information and advice. This in turn provides some evidence that peers provide social identity. It is important to note that peers can provide an individual with advice, and can also reinforce or destroy beliefs and encourage an individual to behave in a certain way (Glanz & Rimer, 2005). Perceived risk of contracting STIs/HIV may have important implications for

prevention programmes among taxi drivers. Therefore, there is a need to establish collaborative programmes involving, taxi drivers, traditional healers and other health organisations in Umbumbulu.

Male Attitudes towards Contraceptive Use by their Female Partners

“I try not to dictate when it comes to contraceptive use”

According to the HBM, perceived benefits are directly linked to perceived severity and susceptibility in that perception of these benefits may lower perceived susceptibility as well as perceived severity (Glanz & Rimer, 2005). Participants were asked about their influence over their female partners with respect to condom use and other contraceptive methods. Bra Darkie (non-cohabitating, 2013) who has finished paying ‘lobola’ explained:

Respondent: *I respect my partner very much, yes I’m a man, but I try not to dictate when it comes to contraceptive use; she’s on a pill and I use a condom.*

Researcher: Why do you use a condom because she’s on a pill?

Respondent: *They say these things [meaning pills and injectables] are not hundred percent safe, what if she gets pregnant? I’ve just finished paying ‘lobola’ for her, I want us to get married first.*

Due to gendered asymmetries in social and economic power, some females are taken advantage of by men (Mutinta, 2012). Men are usually expected to dictate to their partners. However the above statement suggests that there is a degree of mutual trust between sexual partner.

According to Berer (2006:163), “one of the benefits of making safer sex the social norm is that protection would be accepted for the sake of sexual health and seen as a good thing in itself, independent of a person’s past or present relationships.” Findings suggest that dual contraceptive use and consistent correct condom use was perceived as a benefit by a few participants. This also means that the participant is very clear that some contraceptive methods, for example, a pill, do not protect against unplanned pregnancy. It is interesting to note that the type of a relationship was associated with consistent condom use among taxi drivers. As one respondent stated:

With my stable partner I don't use it (condom) consistently; I trust her and I'm not too worried even if she can get pregnant, but then again I'm not sure if she uses the other methods of prevention, (Thabang, single, non-cohabitating, 2013).

When you trust each other it doesn't even cross your mind, because when I have sex, I only have it with you (Mkhize, married, 2013).

The above responses suggest that there is absence of dialogue about sexual matters between partners. Thabang's statement seems to suggest that proving his manhood precedes the need to protect himself from contracting the virus and from unplanned pregnancy. Although participants mentioned that they trust their "stable" partners, this study's data shows that there is no open communication about sexual issues. Lack of open communication about contraceptive methods has been observed to be a barrier which may hinder one partner from negotiating safe sex. The statement suggests that some couples do not communicate about contraceptive methods. The HBM construct suggests that awareness of partner's use of contraceptives may be associated with lower perceived risk. The findings in this study indicate that the degree of trust between sexual partners was a barrier to dual contraceptive use.

If she's my woman, why would she use the other form of contraceptive? I'll tell you why, because she'll be sleeping with another man, why use a pill or an injection without my knowledge if you know I'm the only man you're sleeping with, why? (Pro, cohabitating, 2013).

These kinds of responses again suggest that there is a lack of communication on sexual issues. This lack of communication leads men to immediately jump into conclusions of infidelity. The majority of participants in the FGD held negative attitudes towards the use of hormonal contraceptives by their partners. A number of views seemed to be affected by the knowledge of side effects and myths associated with contraceptive use. Hormonal contraceptives were blamed by the participants for reducing men's sexual pleasure. Participants' influence over their female partner's decisions with respect to other contraception methods was explored. Trust was perceived as a barrier to contraceptive use. Participants felt that if you use a condom with your 'straight' partner then she is more likely

to think that you have other sexual partners or that you do not trust her. *Trust is also associated with the sexual partner's commitment to a long term relationship*, said one participant, (Mkhize, married, 2013).

This suggests that a sexual partner could be trusted only when she is considered to be prepared for marriage in future.

If we really trust each other, we can only use one method, there's no need for a partner to use injectables because condom is there, and trust is very important, (Bra Darkie, 2013).

Trust for each other makes them find it easy to engage in unprotected sex (Mutinta, 2012).

Participants were also asked about their thoughts on the use of dual contraceptives (condom and pills or injections). In separate interviews both Kay kay (2013) Bra Darkie (2013) expressed that there was no need for dual contraceptive use.

There's no need to use both, I mean we trust each other (Kay kay, 2013).

Well, it's a good idea, but it's not practical. Why would I use a condom knowing very well that my partner is on a pill or injection? (Bra Darkie, 2012).

These statements suggest that they do not realise the importance of using two methods of contraception, thus Bra Darkie says it is not practical. Most participants knew very little about the benefits of dual contraceptive use. Although all knew about both condoms and hormonal contraceptives, they did not have in-depth knowledge of using both concurrently.

Such that the majority felt that it was better to use one, for instance either a condom or pill/injectables.

Negative Perceptions on Contraceptive Use

“Injectables and pills kill women's bodies”

There are many forms of contraceptives and these include hormonal contraception. Studies have shown that better communication by women with their partners has the potential to

increase contraceptive use while lack of communication results in the exact opposite (Wood & Jewkes, 2006). Participants were asked about their thoughts about women who use contraceptive methods such as injections and pills. The majority of participants considered pills and injections as disturbing from enjoying sex. It is worth noting that many taxi drivers were concerned about their partners gaining weight and losing shape when using injectables and pills. Pills and injectable contraceptives were thus identified as a barrier to dual contraceptive use.

Injectables and pills kill women's bodies, at times you find that the body gets too flabby, and they become like 'ivovo' at an early age, it's better to use condoms, (Thabang, non-cohabitating, 2013).

'Ivovo' is a Zulu sieve made up of grass used for separating coarser from finer particles especially when brewing Zulu beer. When asked to elaborate on this, participants mentioned that women's bodies decrease elasticity and firmness, and they start looking like 'gogos' (meaning 'grandmothers'). This suggests that there are attitudes and misconceptions about some side effects. The findings revealed that these attitudes and misconceptions were perceived as a barrier to dual contraceptive use. This kind of popular discourse and metaphorical imaging of the virus and its life-cycle, here manifested in characterisation of individuals taking injectables, has been discussed by Kunda and Tomaselli (2012). They argue that these kinds of metaphors make it very difficult for health and communication workers to devising effective education interventions as whatever conventional medical science proposes is discursively subverted by counter-discourses like these.

On the issue of side effects, Muzi (2013) and Ben (2013) stated: *I prefer to use a condom than my partner to use injection, because injections have a number of side effects, she gets rash and a discharge out of the blue.* Ben also explained that:

Some women get irregular periods, one minute she's on her days, you give her a break, the following weekend you ask her to visit you, she comes and then surprise, she's on her periods again, hhay, it's better to use a safe period, (Ben, 2013).

Another participant in the interview mentioned that his girlfriend used be very slim: *you*

should see her, she's gained a lot of weight, I told her to stop taking an injection and maybe try pills. No one in the above statements mentioned that they have made or they try and make efforts to initiate discussions around the use of contraceptive methods. In other words, their female partners do not have a voice in their relationships. Sadly the misconceptions about dual contraceptive methods may lead to limited use of other contraceptives, especially hormonal contraceptives. Unplanned pregnancy interventions that will provide taxi drivers with accurate information about dual contraceptive methods was lacking from my research site.

Negotiation of Contraceptive use in Relationships

“I’m the one who decides whether to use a condom or not, it depends on women’s characters”

The HBM states that before undertaking any health behaviour, individuals conduct a cost-benefit analysis (CBA) of their health behaviour and the choices that they make are driven by the cost-benefit analysis conducted. The research aimed to explore how participants perceived their role in preventing HIV infection and pregnancy. A number of the participants mentioned that it is important for men to take responsibility and also involve their female partners in the prevention of HIV infection and unwanted pregnancy. Most taxi drivers feel susceptible to HIV, but still continue to practice unsafe sex. Given the high rates of HIV infection in the area, the chances that they have been exposed to HIV or are HIV positive are high. In another statement in response to their role on condom negotiation, another participant said: *It happens that there's no time to think about condoms, HIV and other diseases, you just think about the money that you've spent on this person, you look at this sexy person in skinny jeans, and bang bang,* (Spha, 2013).

Data from the study shows that men avoid talking about their risk of acquiring STIs/HIV at the beginning of sexual relations. Woodsong & Koo (1999) observed that couples do not talk about STIs/HIV until they have reached that level of trust, usually and inappropriately **after** engaging in sexual activity (Woodsong & Koo, 1999).

“I have more than one girlfriend, and I tell you, they don’t even initiate sex ”

Although half of the participants indicated that decision making regarding the use of

contraceptive methods was an egalitarian process, findings indicate that the decision to use or not to use a condom was taken mostly by men. Some participants indicated that they want their female partners to also make the decisions. There are statements that appear to contradict each other. Some participants felt that they want their partners to make decisions, but other participants felt strongly that decision making when it comes to contraceptive use should be taken by men. Participants reported that they enjoyed greater power (as the man in the relationship) in the area of decision making. Their argument was that they provided for their partners' needs and so they were then entitled to be the decision makers. This was displayed in the FGD. When asked if women do negotiate safe sex, they said in most cases they do not.

You see suster [sister], I have more than one girlfriend, and I tell you, they don't even initiate sex, not even a single one of them has ever insisted on condom use. If I have it, I use it and if I don't have it... it's all the same suster, we have sex, (Professor, non-cohabitating, 2013).

Women may feel the need to adopt a submissive role, if they feel their relationship is characterized by a power imbalance. The above sentiment seems to show that men have more powers to make sexual decisions, both with regard to when sex happens, and to how it happens. Women's inability to negotiate safer sex due to socio-economical subordination and power inequity has been attributed to the increased vulnerability to HIV infection (Hope, 2001). This gender imbalance in decision making might be a barrier for men to practising a healthy lifestyle.

Other participants felt that their female partners should also take part in making decisions about contraceptive use. For Stout, *It's important to sit with our partners and talk about contraceptive use and types of contraception. We also need to allow them to make decisions because it's their bodies. If we want to have children, are we going to be able to support them? Mind you, we have to consider the fact that we have other children. (Stout, 2013).*

Stout's response seems to suggest that encouraging women to communicate about contraception methods remains an important factor. Participants were then asked about their opinions on women making decisions about contraceptives. Half of the participants felt that it was women's responsibility to avoid getting pregnant. This feeling contrasts with earlier

comments about hormonal contraceptives and how they are perceived to configure women's bodies. One participant argued saying: *I would be pleased because it will show that she cares about me and she understands the situation around. I won't get angry, no problem at all. The times we live in is not as before, I mean as long as it is the right thing to do, I don't have any problems with injectables and pills, as long as she trusts me.* (Zakhe, 2013).

Trust was used to justify participant's perception of safety. Taxi drivers' responses show that they do acknowledge the fact that women have a right to make decisions about choices of contraception. As one taxi driver put it: *Women do not need their partner's approval to use any method of contraceptive. It's their bodies, it's their right.* (Bra Darkie, 2013).

When asked about their views on the need to communicate with their partners about contraceptive use, participants responded overwhelmingly in support of such an approach. The reason, according to the participants, was that they understand that women are the ones who carry children and also look after them while they are at work. Dual method may occur without the knowledge of the male partner.

Data shows a contradiction where participants say women have a right to use any method of contraceptives since "it's their bodies", while another participant argues that women who carry condoms are 'loose'. As one male taxi driver says: *I don't care who says what, women who carry condoms are easy, I mean, why you would carry condoms and be on pills if you're a well behaved woman?* (Pro, non-cohabitating, 2013).

The perception that women who carry condoms are 'easy' was associated with taxi driver's attitudes which were related to perceived barriers. There is a lot of stigma associated with women who carry condoms; a man may perceive the request as an indication that their partner has other sex partners. This study also found that females are not expected to show any interest in sexual matters, lest they are considered promiscuous (Mutinta, 2012).

Participants raised concerns that hormonal contraceptives that are used by their partners can tempt them to have multiple sexual partners. One participant said, *it's so unfortunate that the woman that you trust most can have sex with another man without you knowing because they know they will not get pregnant.* The statement suggests that the participants do not really

trust their partners despite their claim of “when you love each other, it (condom use) doesn’t even cross your mind.” In the above statements, they mention that they do not use condoms consistently with the ones they trust. There seem to be a lot of contradictions. However, the structured interviews’ participants had different views. Almost all the interviewees agreed that their partners do use hormonal contraceptives. One participant (who has paid ‘lobola’) affirmed contraceptive use, but he had concerns about the side effects.

We discuss these things and my partner use an injection, but there’s one thing I don’t like about it, sometimes she bleeds for days and get ill. I think she’s going to have to change the injection she is using and maybe use pills. (Kay kay, cohabitating, 2013).

Women not making decisions might be barrier for women making decisions about contraceptive methods. Power inequalities in sexual relationships put women and men at risk of HIV as women in cases like this cannot insist on the use of dual contraceptives (Woodsong & Koo, 1999). This statement suggests that Kay kay decide for his partner and this leaves his partner with no choice. Both in the FGD and interviews, participants indicated that they want women to open up and communicate with their partners about contraceptives and sex. There were a lot of contradictions as far as decision making regarding contraceptive use was concerned. Participants explained that as much as they have information about pills and injections, it is not enough if their partners do not communicate. Taxi drivers’ partners could also stand as cues for action only if they make decisions jointly with their partners.

This brings to light one of the SEM community levels of influence. The model maintains that a community can have an influence on an individual’s health. In other words, the society dictates individuals’ lives. Power inequality becomes a significant barrier to women’s ability to adopt or negotiate contraceptive use. Community can act as a support system, but on the negative side, it can dictate to an individual. This suggests that society’s influence may be a very strong indicator of gender inequality. The Social Ecology Model also recognises individuals as embedded within larger social systems and describes the interactive characteristics of individuals and environments that underlie health outcomes (Sallis, Owen, & Fisher, 2008; Stokols, 1992).

Communication Strategies around contraceptive use in relationships

“It’s important to discuss stuff”

Interestingly, other participants perceived their role as well as their partner’s role in HIV and pregnancy prevention as an equal process. A majority of participants viewed decision making regarding the use of contraceptive methods as a couple’s responsibility. One respondent (who has paid the ‘bride price’) said:

We always discuss things like condom use and other prevention methods for example, we have children, we don’t want to have unplanned pregnancies, considering the fact that the money that I get here as a taxi driver is not much, it’s important to budget, (Kay kay, cohabitating, 2013).

The view is also supported by Thabo (who has paid the ‘bride price’), who claims the importance of negotiating the use of contraceptive methods as well as getting tested before a couple stop using condoms.

It’s important to discuss stuff (meaning contraception), if she doesn’t want to use condoms then she’s going to have to be prepared to go for HIV testing, nowadays it’s not easy to just trust someone without going for HIV testing, (Thabo, cohabitating, 2013).

What this seems to imply is that other participants acknowledge that they are susceptible to diseases, and practising healthy lifestyle was mentioned as significant. Participants acknowledge the importance of involving their partners in the matter of contraceptive use. Communication was viewed by Kay kay and Thabo (both interview participants) as an important factor.

Perceptions around HIV Testing

“I personally prefer not to know my status, it’s better that way, and we’re all going to die eventually”

The issue of HIV testing was generally perceived as a great benefit in the prevention of HIV and STIs. A few participants mentioned the importance of getting tested as they considered

themselves “too young to die”, Bra Darkie. But it was notable that participants did not put more emphasis on HIV testing although they knew about its availability. One could argue that the lack of HIV testing uptake has an association with some taxi drivers’ behaviour of failing to practise safe sex.

Bra Darkie’s statement suggests that some people still perceive HIV testing as a worthwhile move to take and they do not just talk about it, but they actually practice it. All male interview participants felt that getting tested should be the first thing to do before engaging in unprotected sex. However, other FGD participants did not indicate that they do it.

Interview participants also acknowledged the benefits of getting tested, as they felt that testing negative would encourage them to protect themselves when engaging in sex. While the extent of HIV Counselling and Testing (HCT) was not explored in this study, it must be noted that all participants acknowledge the fact that HCT plays an important role in the reduction of the HIV epidemic. In spite of these positive perceptions, when asked about their HIV status, almost half of the FGD group reported fear of knowing. One participant said:

I personally prefer not to know my status, it’s better that way, and we’re all going to die eventually, I mean what if I test positive, then what? Some people were saying it’s better to disclose, you’re just saying because you’re not in that situation, but think about it, how’re you going to leave knowing very well that everybody knows? (Ben, non-cohabitating, 2013)

The above statement suggests that some participants are scared of getting tested and yet they continue to practice unsafe sex. Also, not getting tested is a personal choice which lacks a sense of responsibility to one’s partner.

Religion and Contraceptive use

“My religion does not promote any use of contraceptive methods”

Religion was identified as a perceived barrier to condom use. The findings presented in this chapter reinforce Stokol’s (1996) theoretical argument that argues that the social, physical, and cultural aspects of an environment have a cumulative effect on health. Contraceptive use is influenced by diverse factors. One participant indicated that he doesn’t use a condom as it

is against his religion. Interestingly, another participant echoed the above statement saying his religion is too strict when it comes to many things including contraceptive use. He then explained:

My sister, in the area where I come from, a number of people are Shembe worshippers, but you have to know that men are different. I for instance, I like sex, yes I do have a 'straight' girlfriend that I'm living with, but if she's on her periods, she goes for ever, she takes too many days, my religion doesn't even allow me to sleep on the same bed with her, she's not even allowed to touch food, so what do I do when it's cold? I just go to my other girls and 'quench my thirst' there, after that wipe my mouth and go home, and we're all happy, (Kwethaba, cohabitating, 2013).

According to Sarkar (2008), condom use is influenced by religious ideology. She argues that religious behaviour is a predictor of sexual behaviour. Kwethaba's statement suggests that his partner has no decision making powers and this puts her at risk of being infected as it is clearly stated that there are other women involved.

In order to explore Umbumbulu male taxi driver's attitudes concerning condom use and dual contraceptive use by their female partners, the chapter presented the study's findings through discussion of the themes that emerged during the focus group discussion and structured interviews. Interviews and FGD were filled with open-ended questions that were designed to receive participants' HIV and AIDS-related knowledge, attitudes, beliefs, behaviours, and their interpersonal skills. The chapter also highlights theoretical constructs that shaped the process of data collection of the study.

Summary of findings in relation to the Health Belief Model

Concept	Definition	Participants main responses
PERCEIVED SUSCEPTIBILITY	<p>One's opinion of chances of getting a condition</p> <p>CAN THIS REALLY HAPPEN TO ME?</p>	<p>All 12 participants acknowledged that they were susceptible to contracting the virus. However, 11 of 12 participants did not see themselves as being personally vulnerable to contracting a disease from their partners.</p> <p>10 of the 12 participants demonstrated low perceived risk to HIV/AIDS.</p> <p>10 of the 12 participants demonstrated low perceived susceptibility to STIs.</p>
PERCEIVED SEVERITY	<p>One's opinion of how serious the condition and its consequences are.</p> <p>CAN THIS REALLY HURT ME?</p>	<p>All 12 participants made the same points demonstrating positive perceived severity and realised that HIV is not curable.</p> <p>11 of the 12 participants believed that there is no connection between STIs and HIV.</p> <p>1 of the 12 participants demonstrated the knowledge that STIs increase the risk of HIV infection.</p> <p>11 of the 12 participants did not realise that some STIs are incurable.</p> <p>All 10 participants admitted that they were involved in multiple sexual partnerships</p> <p>10 of 12 demonstrated low perception regarding severity to the outcomes associated with multiple sexual relationships and unprotected sex.</p>

One's belief that there is benefit in changing/adapting a new health behaviour

CAN DOING (X) ACTUALLY HELP ME

Contraceptive and condom use

All 12 participants acknowledged that consistent condom use is the best method of HIV/AIDS prevention as well as unplanned pregnancy.

2 of 12 participants indicated that they use condoms against HIV/AIDS, STIs and unwanted pregnancy consistently as a benefit.

10 of the 12 participants admitted that they did not use a condom consistently.

11 of the 12 participants knew very little about the benefits of dual contraceptive use and felt it was not important.

1 of 12 participants acknowledged that dual contraceptive use is the best contraceptive method against HIV/AIDS and STIs contraction.

2 of 12 participants showed the importance of negotiating the use of contraceptive methods as well as getting tested before a couple stop using condoms.

HIV, Counselling and Testing (HCT)

All 12 participants acknowledged the benefits of getting tested.

10 of the 12 participants reported fear of knowing their status.

PERCEIVED BARRIERS	<p>One's opinion of the tangible and psychological costs of the advised action.</p> <p>IT MIGHT BE DIFFICULT TO DO (X). CAN I ACTUALLY DO (X)?</p>	<p>The following points were identified as a barrier to condom/ dual contraceptive use.</p> <p>The degree of trust between sexual partners.</p> <p>Attitudes and misconceptions around condoms, pills and injectable contraceptives were perceived as a barrier to dual contraceptive use.</p> <p>Power and gender inequality.</p> <p>Alcohol abuse</p> <p>Lack of perceived risks of acquiring HIV/AIDS.</p> <p>Convenience (not having condom at hand).</p>
CUES TO ACTION	<p>Individual assessment of external forces promoting the desired change / activate readiness</p> <p>WHAT CAN I DO TO CHANGE</p>	<p>Provide how-to information, promote awareness, reminders.</p> <p>Taxi drivers receive reminder cues for action in the form of incentives (e.g. key rings with the printed message "no glove, no love") or reminder messages</p> <p>(Brothers for Life campaign).</p>

SELF EFFICACY	<p>Confidence in one's ability to take action and sustain it.</p> <p>I THINK I CAN DO I</p>	<p>At least 2 out of 12 participants showed confidence and knew what to do to protect themselves against HIV/AIDS and unplanned pregnancy.</p> <p>10 of the 12 participants knew what to do to protect themselves against HIV/AIDS, but they did not have confidence to engage in self- protective behaviour against HIV/AIDS.</p>
---------------	---	--

This study is also based on the Social Ecology Model (SEM) which recognises individuals as embedded within larger social systems and describes the interactive characteristics of individuals and environments that underlie health outcomes (Sallis, Owen, & Fisher, 2008; Stokols, 1992). The SEM addresses the complexities and interdependences between socioeconomic, cultural, political, environmental, organisational, psychological, and biological determinants of behaviour (Stokols, 1996). The SEM is divided into five levels of influence and these are (1) intrapersonal; (2) interpersonal; (3) organisational; (4) community and (5) public policy. However, the policy level was not explored in this study. These levels are diagrammatically described and explained by Glanz and Rimer (2005) as follows:

<i>Concept</i>	<i>Definition</i>
Intrapersonal Level	Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
Interpersonal Level	Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
Community Level	Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors
Institutional Factors	
Community Factors	Social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations
Public Policy	Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management

Intrapersonal Level

This is the most basic level of the model as it focuses on the individual and the individuals' beliefs, knowledge and attitudes. An individual is the most important unit of a group, thus an understanding of how an individual behaves is key in understanding how a group behaves. All participants demonstrated a high knowledge of HIV transmission and prevention and they believed that condoms were safer than other contraceptive methods such as injectables and pills. Yet inconsistent condom use was reported by more than half of the participants.

All participants knew that consistent condom use will protect them from contracting HIV infection as well as STIs. A majority of participants stated they were not aware that STIs increase chances of contracting HIV. Findings in this study also showed that the knowledge and information participants possess does not translate to healthy and safe behaviours as the majority of the participants specified that they are involved in multiple and sexual partnerships.

Interpersonal Level

Interpersonal level is the second level of Social Ecology Model and it involves friends and family. Friends and family are important sources of influence in health behaviours of individuals. This level provides social identity, support and role definition to an individual (Sallis, Owen & Fisher, 2008). In this study, social identity and support comes from participants' relations with their friends, colleagues at the taxi rank, and also their relations with their partners who may influence their behaviour and their decisions. These social relationships according to the SEM are important aspects of social identity as they provide emotional support and information.

Friends

All participants reported being comfortable talking about STIs and HIV only to their preferred friends at the taxi rank and they rely on each other for information and advice relating to HIV/AIDS and STI prevention. This finding suggest that friends' advice on HIV/AIDS and STI prevention can be both positive and negative, as the participants indicated that they have not received any formal education about HIV/AIDS at the taxi rank.

All participants indicated that they shared information with preferred friends. They reported that they prefer to consult traditional healers for treatment of STIs. The findings showed that taxi drivers' friends were the main sources of referral for those who visited traditional healers.

Partner

A lack of communication about contraceptive use as well as contraceptive methods between participants and their partners was also reported. Most of the participants admitted that they decide for their sexual partners whether to use protection or not. However, they seemed willing to communicate with their partners. On the contrary, very few participants indicated that they communicate with their partners. Very few participants indicated that they ask for

their partner's opinion regarding contraceptive methods. Others reported that they were not sure whether their partners use other contraceptive methods. Only one participant reported that he actively encourage contraceptive use.

Contraceptive use was also associated with trust in the partner. Most participants reported that they do not use condoms with their main partners and associated contraceptive use by their sexual partners with promiscuity.

Organisation Level

“Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviours, make up the institutional level” (Glanz & Rimer, 2005:11). Taxi driver's perceptions, attitudes as well as their knowledge are affected by the lifestyle at the taxi rank.

The majority of participants indicated that the nature of their work can be the cause of stress, this then may explain their sexual risk behaviour, which may have negative effects on health of taxi drivers. All participants mentioned lack of sleep as a mitigating factor, given their sexual and driving activities, possible ill-health, all of which place passengers at risk. Most participants reported that they (taxi drivers) work long hours. Hence taxi drivers who wish to visit the clinic finds it hard to access health services and also to participate in HIV /AIDS interventions targeting Umbumbulu community. More than half of the participants (married, cohabitating and single) indicated that it is hard for them to even communicate with their partners about sexual health issues as they finish work very late and also start very early in the morning. Most of the participants suggested that the taxi rank may be the best setting where they can be taught about sexual health and how best to protect themselves and their partners.

Community Level

This level includes institutional or organisational relationships (McLeroy et al, 1988) Socio economic characteristics of the environment, for example, taxi rank, influence health behaviours. According to Glanz and Rimer (2005) social networks and norms make up this level; so do groups and organisations. The community is viewed as a result of interconnected relationships that have an influence on an individual's health (McLeroy et al., 1988). The

interconnectedness of groups in the community level is ideal for improving and promoting health behaviour in society. This level takes into account the environment that taxi drivers come from and operate within. The taxi rank have substantial influence on health related behaviors of the taxi drivers.

The study found that concurrent multiple sexual partnerships are accepted as a common and normal behaviour at the taxi rank. The majority of participants admitted that they get involved in multiple sexual partnerships, and they do not use condoms consistently. Very few participants indicated that they do not want to be sexually involved with more than one partner. Also, many participants felt that having many sexual partners displayed a sign of real manhood.

Competition for sexual partners at the taxi rank was said to be very common. A majority of participants reported engaging into transactional and intergenerational sex with younger girls as it was mentioned that it is a norm at the taxi rank. More than half of the participants felt that having many sexual partners displayed a sign of real manhood.

Although almost all the participants believed that consistent correct condom use is important, it is interesting to note that more than half of the participants reported that they were not using condoms consistently as one of them said: *Condom is not nice, it's not really nice to have sex with a condom*. Very few participants reported that they were using condoms consistently. Also, very few participants indicated that their straight partners were using other hormonal contraceptives (either pills or injectables). The rest of the participants were not too sure if their partners were using other contraceptive methods.

Myths and misconceptions about dual contraceptive use were cited as a barrier. Gender inequality was cited as a barrier to condom and dual contraceptive use. The following chapter discusses and highlights the findings of this research study.

CONCLUSION

While there is a wealth of information around condom use and the knowledge, attitudes and perceptions that prevail thereof with women, little is known about this from a male perspective. This is mainly because men are most often the ‘other’ in the HIV and AIDS narrative. The study was informed by the Social Ecology Model (McLeroy et al., 1988) and the Health Belief Model (Rosenstock, 1974). This study used the Health Belief Model in order to understand influences and determinants of health behaviour, and how male taxi drivers are influenced with regard to their decisions to use condoms or other contraceptives. HBM is one of the oldest and most used theories in health communication. This study also used Social Ecology Model to understand how the environment affects and is in turn affected by male taxi drivers’ attitudes, particularly with regard to their partners’ use of dual contraception.

The overall aim of this research was to examine Umbumbulu male taxi driver’s attitudes towards condom use and dual protection use by their female partners. The study is located within the qualitative paradigm of research precisely because it aims to achieve a deep understanding of people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles. Qualitative research therefore enables the researcher to have a better understanding of the study population’s world view thus making research easier, especially in under researched areas. The study employed a descriptive case study because the information about the research problem was gathered from one area, Umbumbulu taxi rank, which is the only taxi association in Umbumbulu. Interview and FGD questions were used to collect data. They were designed based on the HBM and SEM constructs. This chapter therefore aims to summarise the findings of this research work and offer conclusions based on findings reached during the study. Recommendations for future research will be discussed, in terms of how to progress this research study.

A Summary: Findings, Recommendations and Conclusions

Men in this study demonstrated a high knowledge of HIV transmission and prevention. They were aware of the preventative actions to take that will be beneficial in reducing the threat of contracting the disease. Despite knowledge of STIs, HIV and AIDS transmission, an

investigation into taxi drivers' perceived susceptibility to HIV and AIDS revealed that many individuals do not feel personally vulnerable to contracting a disease from their sexual partners. Also, the information they possess does not translate to healthy and safe behaviours. According to the HBM, severity increased the possibility of desirable behaviour. Taxi drivers must feel threatened by their behaviour, for example, multiple sexual relationships and inconsistent condom use. The individual characteristics that influence behaviour within the individual level are well within the control of the individual, though they can be influenced by other factors. Taxi drivers' fear that they may have the disease may influence their behaviour.

Findings indicate that perceived susceptibility and perceived severity of HIV/ AIDS is an issue among the Umbumbulu taxi driver population. Taxi drivers in Umbumbulu engage in several risky sexual practices including unprotected sex, inconsistent condom use, transactional sex, age-disparate sex, multiple and concurrent sexual partnerships. Multiple factors were identified as barriers to condom use.

Perceived Barriers

Perceived barriers act as deterrents to practising healthy lifestyles, as individuals are more likely to focus on the barriers than on perceived benefits (Chew, et al., 2002). Multiple factors were identified as barriers to condom use. Most participants indicated that condom is not nice as it reduce sexual satisfaction; pills and injectables make women 'wet' and that also reduces sexual pleasure and trust was also considered a barrier to condom use. My findings are consistent with other studies. In one study on Barriers to condom use among Men Living with HIV (Fallahi et al., 2012) it was revealed that the reason for not complying with condom use included sexual gratification among other things.

The findings of the study also illustrate that a number of taxi drivers engage in high-risk sexual practices including unprotected sex, multiple and concurrent sexual partnerships, and intergenerational sex. Thus there is a need for health intervention that will aim to promote taxi driver's ability to succeed in changing behaviour and put more emphasis on the importance of using both methods.

Alcohol Abuse

The study finding was that participants' perceived alcohol as a risk factor to non- condom use. Taxi drivers indicated hay alcohol helps them to socialise better. Some of the taxi drivers believe that alcohol "help them to relax after a long day." Social Ecology Model posits, friends and peers provide social identity and play a major role in helping create and affirm identity and health behaviour (Sallis & Owen, 2000). The use of alcohol and other substances are of concern within the context of the high rates of HIV infection in southern Africa (Potgieter et al., 2012). A partner with high risk perceptions is likely to drink responsibly and practice safe sex.

Sexual Satisfaction

Sexual satisfaction was mentioned as the main barrier to condom use. Findings in this study are consistent with other studies. Findings show that gender imbalance in decision making about sex and contraceptive methods was identified as a barrier for men to practising healthy lifestyles. Communication between taxi drivers and their partners was noted to be poor and HIV was not a significant factor in sexual decision making. Friends (sexual partners) falls under the interpersonal level which seeks to provide support and social identity (Sallis, Owen & Fisher, 2008).

Power Relations

Gender imbalance in decision making was identified as a barrier for men to practising healthy lifestyles. Taxi drivers reported low, inconsistent condom usage with sexual partners. More than half of the participants admitted to having sexual intercourse without using condoms. Moreover, the decision to use or not to use a condom was left to the man. The study also found that power relations played a big role in non-condom use. Imbalances in power within sexual relationships often favour men. Such imbalances arise from social and cultural expectations around male and female .This put both men and women at risk of HIV as women do not have a say in sexual decisions (MacPhail & Campbell, 2001). This was also reported in a study that was conducted by Chimbindi et al., in 2010, that condoms were male-driven, and insistence on condom use by their partners was not mentioned. However, Hofferth (1987) posits that sexual partners who have better communication patterns are more likely to use effective contraceptives.

Trust

Trust was identified as a barrier in this study as many participants kept on saying they phase out condoms as they become associated with trust. My study confirms Sarkar (2008) finding that in established relationships, condoms become phased out as they become associated with trust. This is because partners believe that the significant other is also faithful, thus there is no need for protection (Varga, 1997).

Perceived barriers to condom use could prevent taxi drivers from using condoms consistently when they engage into sexual intercourse to prevent transmission of HIV and STI infections. This study suggests that health practitioners should not assume that when people have information and knowledge that they practise it. Thus, clearly, special efforts must be made to reach the taxi drivers in information health programmes that integrate family planning, HIV/AIDS as well as behaviour change.

Contraceptive Use

The study found that there were negative attitudes, misconceptions and myths around hormonal contraceptives. Findings in this study show that taxi drivers do not have in-depth knowledge of the importance of using dual contraceptive method. On the understanding of dual contraceptive use in sexual relationships, the investigation found that a large number of taxi drivers do not use dual contraceptive method. In addition, they felt that using both a condom and a pill or injection is not practical. Taxi drivers with a level of high level of perceived susceptibility will be more likely to use condoms consistently than those with low level of perceived severity.

If taxi drivers identify their personal barriers to accepting dual contraceptive use by their female partners, it becomes possible to find ways of breaking these barriers. Thus there is a need for well-designed interventions that can influence healthy behaviours at the individual and taxi population level. The findings about taxi drivers' understanding of dual contraceptive use and their perceived role, as well as their partner's role in HIV could inform men's intervention programmes on what to address, so as to reduce sexual risk-taking behaviour among taxi drivers. Encouraging taxi drivers to take responsibility and supporting their partners may promote HIV, STIs risk reduction.

Multiple and Concurrent Sexual Partnerships

In this study, multiple and sexual partnerships has been identified as one of the risky behaviours Umbumbulu male taxi drivers engage in. The study found that MCSPs are perceived as ordinary behaviour in spite of the knowledge about the risk taxi drivers still practice the risky behaviour. My study confirms Ncama et al. (2013) findings that multiple sexual partners are relatively common amongst the minibus taxi drivers, thus increasing the likelihood of transmitting HIV and other sexually-transmitted infections to their partners.

There is a need for taxi drivers to believe that the outcome of changing their behaviour will lead to an acceptable benefit. Reducing barriers could be one of the strategies to healthy lifestyle.

Social environment has the potential to influence individuals who exist within the same environment. Taxi drivers lack environmental support and they are more likely to rely on each other for information relating to HIV/AIDS and STIs. Although DramAidE have conducted several Brothers for Life workshops in Umbumbulu taxi rank, taxi drivers indicated that they need more programmes that will encourage them to practice healthy lifestyles. Contrary to findings that men are likely to have unprotected sex with their ‘established’ partners and test regularly, while having protected sex with their side partners. The study found that some participants are scared of getting tested, and yet they continue to practice unsafe sex with their partners.

In the light of findings of this study, it is recommended that a study focusing on both taxi drivers and their partners be conducted.

Recommendations

Findings suggest that dual contraceptive use as well as consistent and correct condom use were perceived as a benefit by a few participants. Taxi drivers would benefit from an intervention that addresses both individual and environmental determinants of the use of dual contraceptive methods. Interventions that will then target taxi drivers as well as involve other stakeholders i.e. community based organisations, the local clinic, their families, community leaders and traditional healers around Umbumbulu are needed. These interventions are more likely to be effective if they embrace an ecological perspective as an individual’s power is not only dependent on his or her behavioural skills, but also on whether his or her environment affords the behaviour to be enacted (Karen Glanz and Donald Bishop, 2010:400).

BIBLIOGRAPHY

- Adler, E., & Clarke, E. 2007. *How it's done: An invitation to social research*. Cengage Learning.
- Bandura, A. 1997. *Self-Efficacy: The Exercise of Control*, New York: Freeman.
- Barbour, R., & Kritzing, J. 1999. *Developing social group research: Politics, theory and practice*, London: Sage Publications.
- Barker, G., Ricardo, C., & Nascimento, M. 2007. *Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions*. World Health Organization.
- Barrett, J. 2003. *Organizing in the informal economy: A case study of the minibus taxi industry in South Africa* (No. 358158). International Labour Organization.
- Beauchair, R., Kassanjee, R., Temmerman, M., Welte, A., & Delva, W. 2012. Age-disparate relationships and implications for STI transmission among young adults in Cape Town, South Africa. *The European Journal of Contraception and Reproductive Health Care* 17(1):30-39.
- Becker, M. H. 1974. *The health belief model and personal health behaviour*, New Jersey: Slack.
- Berer, M. 2006. Dual Protection: More Needed than Practised or Understood. *Reproductive Health Matters* 14(28):162–170.
- Berg, L. 1995. *Qualitative Research Methods for the Social Sciences*, Boston: Allyn.
- Beksinska, M. E., Smit, J. A., & Mantell, J. E. 2012. Progress and challenges to male and female condom use in South Africa. *Sexual health* 9(1):51-58.

Bessette, G. 2004. *Involving the community: A guide to participatory development communication*. IDRC.

Boal, A. 1979. *Theatre of the Oppressed*. Translated by C.A. and M.O. Leal MacBrid. London. Pluto Press.

Botha, P. 2009. *The Application of Paolo Freire's Pedagogy in renegotiating HIV Stigmatised Identities: A study of DramAidE's Health Promotion Project (HPP) at the Durban University of Technology (DUT)*. University of KwaZulu- Natal.

Bogart, L. M., Skinner, D., Weinhardt, L. S., Glasman, L., Sitzler, C., Toefy, Y., & Kalichman, S. C. 2011. HIV/AIDS misconceptions may be associated with condom use among black South Africans: an exploratory analysis. *African Journal of AIDS Research* 10(2):181-187.

Boyatzis, R. 1998. *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Bourgault, L. 1995. *Mass Media in Sub-Saharan Africa*. Bloomington: Indiana University Press.

Braun, V., & Clarke, V. 2006. *Using thematic analysis in psychology, Qualitative Research in Psychology*, 3(9), 77-101. Edward Anorl (publishers) Ltd.

Braunstein, S., & Van de Wijgert, J. 2003. *Cultural Norms and Behaviour Regarding Vaginal Lubrication During Sex: Implications for the Acceptability of Vaginal Microbicides for the Prevention of HIV/STIs*. New York: Population Council.

Brown, L. K., DiClemente, R. J., & Reynolds, L. A. 1991. HIV prevention for adolescents: Utility of the Health Belief Model. *AIDS Education and Prevention*

Bryman, A., & Bell, E. 2003. *Business research methods*. Oxford University Press.

Burak, L., & Meyer, M. 1997. Using the Health Belief Model to examine and predict college

women's cervical cancer screening beliefs and behaviour. *Health Care for Women International* 18(3):251-262.

CADRE 2001. *Mobilising young Men to Care*. Pilot Project Report. Durban, South Africa: DramAidE Office, University of KwaZulu Natal.

Catania, J., Kegeles, S., & Coates, T. 1990. Towards an understanding of risk behavior: An AIDS risk reduction model (ARRM). *Health Education Quarterly* 17(1):53-72.

Champion, V., & Skinner, C. 2008. The Health Belief Model in: Glanz, K., Rimer, B., Viswanath, K. editors *Health Behaviour and Health Education: Theory, Research and Practice*. 4th edn. San Francisco, CA: Jossey-Bass; 2008. 45.

Chew, F., Palmer, S., Slonska, Z., & Subbiah, K. 2002.. Enhancing health knowledge, health beliefs, and health behavior in Poland through a health promoting television program series.

Chimbindi, N. Z., McGrath, N., Herbst, K., San Tint, K., & Newell, M.L. 2010. Socio demographic determinants of condom use among sexually active young adults in rural KwaZulu-Natal, South Africa. *The Open AIDS Journal*:? (4), 88-95.

Cleary, P. 1986. Methodology: Themes and approaches .In: McHugh, S. & Vash, T. M (Eds). *Illness behaviour: A multidisciplinary model* .New York. Plenum Press.

Creswell, J. W. 2003. *Research Design: Qualitative, Quantitative, and mixed methods approaches*. Second edition. Sage Publications.

Creswell, W. 1998. *Qualitative inquiry and research design: Choosing among five Traditions*, Thousand Oaks, California: Sage.

Crotty, M. 1998. *The foundations of social research: Meaning and perspective in the research process*, Sydney, New South Wales, Australia: Allen and Unwin.

Dalrymple, L. 1995. Researching the use of Drama for AIDS and lifestyle education in

KwaZulu-Natal. DramAidE, Durban. Dasgupta, A. K., and Peace, D. W. (1978). *Cost-Benefit analysis: Theory and Practice*. London: Macmillan.

Dawson, C. 2002. *Practical Research Methods: a user- friendly guide to mastering research techniques and projects*. How To Books Ltd.

Delva, W., Beauclair, R., Welte, A., Vansteelandt, S., Hens, N., Aerts, M., & Temmerman, M. 2011. Age-disparity, Sexual Connectedness and HIV Infection in Disadvantaged Communities around Cape Town, South Africa: a study protocol. *BMC public health* 11(1):616.

Denzin, N K. & Lincon, Y S 2003. *The landscape of qualitative research: theories and issues*. Thousand Oaks, Calif., Sage.

De Irala, J., Osorio, A., Carlos, S., & Lopez-del Burgo, C. 2011. Choice of birth control methods among European women and the role of partners and providers. *Contraception* 84(6):558-564.

Department of Health. 2007. *National Strategic Plan HIV and AIDS and STI Strategic Plan, 2007-2011*. Pretoria, Department of Health South Africa.

DramAidE 2008. *Annual report 2008*. DramAidE Office, University of KwaZulu Natal, Durban.

DramAidE 2010. *Annual Report 2010*. DramAidE Office, University of KwaZulu Natal, Durban.

Durden, E., 2010. *Staging Empowerment?: An Investigation into Participation and Development in HIV and AIDS Theatre Projects* Unpublished PhD thesis, University of KwaZulu Natal, Durban.

Durden, E., & Tomaselli, K. 2012. *Theory Meets Theatre Practice: Making a Difference to Public Health Programmes in Southern Africa*. Professor Lynn Dalrymple: South African

Scholar, Activist, Educator. *Curriculum Inquiry* 42(1):80-102.

Edensor, T. 2004. Automobility and national identity representation, geography and driving practice. *Theory, Culture & Society* 21(4):101-120.

Elder, J. P., & Stern, R. A. 2009. The ABCs of Adolescent Smoking Prevention: An a behavioral-ecological perspective *J Child Health Care* 13:46-62.

Ely, M., Vinz, R., Downing, M., & Anzul, M. 1997. *On writing qualitative research: living by words*, Routledge: Falmer Press.

Epstein, E. 1997. *Sex news:Aids education media development in South Africa*. University of KwaZulu-Natal, Durban.

Fallahi, H., Tavafian, S. S., Yaghmale,F., Hajizadeh, E., Rastegarpour, A., & Midwifery, N. 2012. Barriers to condom use among Men Living with HIV: A Qualitative study in Iran. *Life Science Journal* 9(3):2593-2599.

Farooqui, M., Hassali, M. A., Knight, A., Shafie, A.A., Farooqui, M.A., Saleem, F., & Aljadhey, H. 2013. A qualitative exploration of Malaysian cancer patients' perceptions of cancer screening. *BMC public health* 13(1): 48.

Figueroa, M. E., Kincaid, D. L, Rani, M., & Lewis, G. 2002. *Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes*. New York: The Rockefeller Foundation.

Fisher, A.A, Foreit, J.R., Laing, J., Stoeckel, J., & Townsend, J. 2002. *Designing HIV/AIDS Intervention Studies: An operation research handbook*. New York: Population Council.

Fisher, J., Fisher, W. 1992. Changing AIDS-risk behavior. *Psychological Bulletin* 111(3):455- 474.

Fobosi, S. 2013. The minibus taxi industry in South Africa: A servant for the urban poor? *Consultancy Africa Intelligence*, 2 May:1.

Fourie, L.J. 2005. Rethinking the formalisation of the mini-bus taxi industry in South Africa.

Fourie, P., & Schonteich, M. 2001. Africa's new security threat: HIV/AIDS and human security in southern Africa, *African Security Review*, 10(4):29- 57.

Freimuth, V. 1992. Theoretical foundations of AIDS: Edgar, M. & V. Freimuth (Eds.), *AIDS: A communication perspective* (91-110). Mahwah, N. J. :Erlbaum.

Freire, P. 1972. *Pedagogy of the Oppressed*. London: Penguin.

Gallo, M. F., Horris, A., & Turner, A. N. 2014. Female condoms: new choices, old questions. *Lancet Glob Health* 1(3):119-120.

Gazu, A.W., Mudenda, P.M., Govender, A. 2008. *An evaluation of health promoters' peer education programme administered at the Durban University of Technology, UKZN*. Mimeo.

Glanz, K., & Bishop, D.B. 2010. The role of behavioural science theory in development and implementation of public health interventions. *Annual review of public health* 31(1):399-418.

Glanz, K., Rimer, B. K., & Viswanath, K. 2008. *Health behaviour and health education theory, research, and practice*. 4th Edition. San Francisco: Jossey Bass.

Glanz, K., & Rimer, B. K. 2005. *Theory at a Glance: A Guide for Health Promotion Practice*, United States: National Cancer Institute.

Government Gazette (2 Dec.1998) Act No. 120, 1998. *Recognition of Customary Marriages Act*.

Green, L.W. 1984. Modifying and developing health behaviour. *Annual Review of public*

Health 5(1):215-236.

Gregson, J., & Kirkman, R. 1999. Double Dutch: looking at the usage of combined pill plus condom in girls under 25. *European J. of Contraception and Reproductive Healthcare* 4(1):45-48.

Gutin, S.A., Mlobeli, R., Moss, M., Buga, G., & Morroni, C. 2010. Survey of knowledge, attitudes and practices surrounding the intrauterine device in South Africa. *Contraception* 83(2):145-150.

Hallman, K. 2004. Socioeconomic Disadvantage and Unsafe Sexual Behaviours among Young Women and Men in South Africa. Population Council Policy Research Division Working Paper no 190, The Population Council, New York.

Hanan, M.A. 2009. Interpersonal and Mass Media Campaign for HIV/AIDS Prevention: An Integrated Approach *Journal of Development Communication* 20(1).
<https://www.questia.com/library/journal/1G1-214206139/interpersonal-and-mass-media-campaign-for-hiv-aids> (Accessed 03 October 2014).

Harling, G., Newell, M-L., Tanser, F. 2014. Do Age-disparate relationships drive HIV incidence in young women? Evidence from a population cohort in rural KwaZulu-Natal, South Africa. *Journal of Acquired Immune Deficiency Syndromes* 66(4):443-451.

Harrison, S. E., Watson, E. K., Ward, A. M., Khan, N. F., Turner, D., Adams, E., & Rose, P. W. 2011. Primary health and supportive care needs of long-term cancer survivors: a questionnaire survey. *Journal of Clinical oncology*, JCO-2010.

Hart, G. J., Pool, R., Green, G., Harrison, S., Nyanzi, S., & Whitworth, J. A. G. (1999) Women's attitudes to condoms and female-controlled means of protection against HIV and STDs in south-western Uganda. *AIDS Care* 11(6):687-698.

Hastings, G., & Donovan, R., 2002. International initiatives: Introduction and overview. *Social Marketing Quarterly* 8(1):2-4.

Hawkins, K., Price, N., Mussa, F. 2009. Milking the cow: Young women's construction of identity and risk. in age-disparate transactional sexual relationships in Maputo, Mozambique. *Global Public Health* 4(2):169-182.

Higgs, J. 2001. *Critical moments in qualitative research*, Oxford, England: Butterworth-Heinemann.

Hofferth, S. L1987. Influences on early sexual and fertility behaviour. In C. D. Hayes (Eds), *Risking the future: Adolescent sexuality, pregnancy, and childbearing*. (2)7- 35. Washington, DC: National Academy Press.

Hope, K.R. 2001. Population mobility and multi-partner sex in Botswana: implications for the spread of HIV/AIDS. *African journal of reproductive health* 5(3):73-83.

Hunter, M. 2010. *Love in the Time of AIDS: Inequality, Gender and Rights in South Africa*. Pietermaritzburg, University of KwaZulu-Natal Press.

International Organization for Migration. (IOM). 2003. Mobility and HIV/AIDS in Southern Africa: *a Field Study in South Africa, Zimbabwe and Mozambique*. Pretoria.

Jana, M., Nkambule, M., & Tumbo, D. 2008. *One Love: Multiple and Concurrent Sexual Partnerships in Southern Africa*. Johannesburg, South Africa: Soul City Institute for Health& Development Communications.

Janz, N. K., & Becker, M. H. 1984. The health belief model: A decade later. *Health Education & Behavior* 11(1):1-47.

Jensen, K. E. 2012. *Parallel discourses: Religious Identity and HIV Prevention in Botswana*. Cambridge Scholars Publishing.

Jewkes, R., Vundule, C., Maforah, F. & Jordaan, E. 2001. Relationship dynamics and

teenage pregnancy in South Africa. *Social Science and Medicine* 52(5):733-744.

Julinawati, S., Cawley, D., Domegan, C., Brenner, M., & Rowan, N.J. 2013. A review of the perceived barriers within the Health Belief Model on Pap smear screening as a cervical cancer prevention measure. *Journal of Asian Scientific Research* 3(6):677-692.

Karim, S. S., & Karim, Q. A. (eds.) 2010. *HIV/AIDS in South Africa*. 2nd edition. Cape Town: Cambridge University Press.

Kellner, D. 2009. *Toward a critical media cultural studies* in Rhonda Hammer and Douglas Kellner (eds), *Media and Cultural Studies: Critical Approaches*. 5-24. New York. Peter Lang.

Kelly, R.J., R.H. Gray, N.K. Sewankambo, D. Serwadda, F. Wabwire-Mangen, T. Lutalo, & M.J. Wawer. 2003. Age Differences in Sexual Partners and Risk of HIV-1 Infection in Rural Uganda. *Journal of Acquired Immune Deficiency Syndromes* 32(4):446-451.

Kelly, J. 2001. Evaluation report of the DramAidE intervention in the Ndwedwe Child Survival Project. South Africa: MCDI/DramAidE.

Kelly, J. 2002. Baseline report preceding the extension phase of the Ndwedwe Child Survival Project. South Africa: MCDI/DramAidE.

Kincaid, D.L., Parker, W., Schierhout, G., Connolly, C., & Pham, V.H.T. 2008. AIDS Communication Programmes, HIV Prevention, and Living with HIV and AIDS in South Africa, 2006. *Pretoria: JHHESA*.

Krueger, R. 1988. *Focus Groups: A Practical Guide for Applied Research*, SAGE Publications, Inc. Newbury Park: California, U.S.A.

Kulczycki, A., Kim, D. J., Duerr, A., Jamieson, D. J., & Macaluso, M. 2004. The acceptability of the female and male condom: a randomized crossover trial. *Perspectives on Sexual and Reproductive Health* 36(3):114-119.

Kumar, R. 2011. *Research Methodology: A Step-by-Step Guide for Beginners*. Sage Publications.

Kunda, J-E.L., & Tomaselli, K. 2012. Confusing Public Health with Militant Nationalism: South Africa's AIDS Policy under Thabo Mbeki. In Ige, S. and Quinlan, T. (eds.) *African Responses to HIV/AIDS: Between Speech and Action*. Scottsville, South Africa: University of KwaZulu-Natal Press, 109-123.

Kunda, L. J. 2008. *They have ears but they cannot hear. Listening and talking as HIV prevention: a New Approach to HIV and AIDS campaigns at three of the Universities in Kwazulu-Natal*. Unpublished PhD thesis. University of KwaZulu-Natal, South Africa.

Kun, K. 1998. Vaginal Drying Agents and HIV Transmission. *International Family Planning Perspectives* 24:93-94.

Lakew, Y., & Tamene, H. 2014. HIV related risk behaviours among taxi drivers and their assistants in Addis Ababa, Ethiopia: descriptive cross-sectional survey. *BMC public health* 14(1):330.

Larios, S. E., Lozada, R., Strathdee, S. A., Semple, S. J., Roesch, S., Staines, H., & Patterson, T. L. 2009. An exploration of contextual factors that influence HIV risk in female sex workers in Mexico: The Social Ecological Model applied to HIV risk behaviors. *AIDS care* 21(10):1335-1342.

Lary, H., Maman, S., Katebalila, M., & Mbwapbo, J. 2004. Exploring the association between HIV and violence: young people's experiences with infidelity, violence and forced sex in Dar es Salaam, Tanzania. *International Family Planning Perspectives* 30(4):200-206.

Leclerc-Madlala, S. 2009. Cultural scripts for multiple and concurrent partnerships in Southern Africa: why HIV prevention needs anthropology. *Sexual Health* 6(2):103-110.

Leclerc-Madlala, S. 2008. Age-disparate and intergenerational sex in southern Africa: the

dynamics of hyper-vulnerability, *AIDS care* 22(4):17-25.

Leclerc-Madlala, S. 2003. Transactional Sex and the Pursuit of Modernity. *Social Dynamics* 29(2):213-233.

Loewenstein, G., & Furstenberg, F. 1991. Is teenage sexual behaviour rational? *Journal of Applied Social Psychology* 21(12):957-986.

Lubombo, M. 2014. *Transcending GIPA: Towards an Ubuntu Framework for mainstreaming participation of South African people living with HIV in social change communication for HIV prevention*. Unpublished PhD thesis. University of KwaZulu- Natal, South Africa.

Lubombo, M. 2011. *Participatory Communication for Social Change: Normative Validity and Descriptive Accuracy of Stakeholder Theory*. Unpublished MA thesis. University of KwaZulu-Natal, South Africa.

Luke, N. 2005. Confronting the 'sugar daddy' stereotype: age and economic asymmetries and risky sexual behavior in urban Kenya. *International family planning perspectives* 31(1):6-14.

Luke, N., & Kurz, K. 2002. Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices. *Washington, DC: International Center for Research on Women (ICRW)*.

Lurie, M., & Rosenthal, S. 2007. Concurrent partnerships as a driver of HIV epidemics in the Sub-Saharan Africa: The evidence is limited: *AIDS and Behaviour* 14(1):17-24.

Macleod, C. 2011. *'Adolescence', pregnancy and abortion: Constructing a threat of degeneration*. London: Routledge.

MacPhail, C., Pettifor, A. E., Pascoe, S., & Rees, H. V. 2007. Contraception use and pregnancy among 15–24 year old South African women: a nationally representative cross-sectional survey. *BMC medicine* 5(1):31. <http://www.biomedcentral.com/1741-7015/5/31>. (Accessed 23 December 2013).

MacPhail C, & 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 & medicine* 52(11):1613-1627.

Mah, T., & Halperin, T. 2008. Concurrent sexual partnerships and the HIV epidemic in sub-Saharan Africa: The evidence to move forward. *AIDS and Behaviour*, Thousand Oaks, California: Sage.

Maharaj, P., & Cleland, J. 2005. Risk perception and condom use among married or cohabiting couples in KwaZulu-Natal, South Africa. *International family planning perspectives* 31(1):24-29.

Mantell, J.E., Beksinska, M., Scorgie, F., L., Milford, C., Balch, E., Mabude, Z., Smith, E., Adams-Skinner, J., Exner, T.M., Hoffman, S., & Stein, Z.A. 2011. Everywhere you go, everyone is saying condom, condom. But are they being used consistently? Reflections of South African male students about male and female condom use. *Health Education Research* 26(5):859-871.

Manzi, J. R. 2004. *The Socio-economic and political impact of the formalization and recapitalization process of the taxi industry: a Case Study of the Durban Greater North Taxi Region, Region 7*. Unpublished MA thesis. University of KwaZulu-Natal, Durban.

Manzini, N. 2001. Sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa. *Reproductive Health Matters: By and For Women and Men* 9(17):44–52.

Marshall, C., & Rossman, G.B. 2011. *Designing Qualitative Research* (5th ed.). Thousand Oaks, CA: Sage.

Mathew, W. 2012. *Cutting Into Perceptions: Investigating Men's Understanding of Protection-Through Medical Male Circumcision for HIV Prevention, in Durban, KwaZulu-Natal*. Unpublished MA thesis, University of KwaZulu-Natal, Durban.

Matthews, F.E., Arthur, A., Barnes, L. E., Bond, J., Jagger, C., Robinson, L., & Bryne, C. 2013. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study 1 and 11. *The Lancet*, 382 (9902), 1405-1412.

Mattson, M. 1999. Toward a reconceptualization of communication cues to action in Health Belief Model: HIV test counselling. *Communication Monographs* 66(3):240-265.

Mattson, J. 1991. *Better Business by the ABC of Values*. Studentlitteratur.

Mbonye, M., Nalukenge, W., Nakamanya, S., Nalusiba, B., King, R., Vandepitte, J., & Seeley, J. (2012) Gender inequity in the lives of women involved in sex work in Kampala, Uganda. *Journal of the international AIDS society*, 15(Suppl 1).

Mchunu, G., Ncama, B., Naidoo, J. R., Majeke, S., Myeza, T., Ndebele, T., & Pillay, P. (2012) Kwazulu-Natal minibus taxi drivers' perceptions on HIV and AIDS: Transmission, prevention, support and effects on the industry. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 9(4), 210-217

McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*. 15(4)351–377.

Melkote, S., & Steeves, H. 2001. *Communication for development in Third world*. New Delhi: SAGE.

Mogotlane, S., Hazell, E., & Mthembu, B. 2007. Women's Cultural Perspective on Reasons for HIV and AIDS Prevalence in Rural Area of KwaZulu Natal Province of South Africa (UKZN). *Africa Journal of Nursing and Midwifery* 10(1):35-43.

Moodley, E. 2007. *An assessment of students' perceptions of the ABC prevention strategy: Toward students' participation in HIV/AIDS message design at the University of KwaZulu-Natal*. Unpublished MA thesis. University of KwaZulu -Natal, Durban.

Morgan, D. L. 1988. *Focus groups as qualitative research*. Newbury Park, CA: Sage.

Morojele, N. K., Kachieng'a, M. A., Mokoko, E., Nkoko, M. A., Parry, C. D., Nkowane, A. M., ... & Saxena, S. 2006. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social science & medicine* 62(1):217-227.

Morrell, R., Jewkes, R., & Lindegger, G. 2012. *Hegemonic Masculinity/Masculinities in South Africa: Culture, Power, and Gender Politics*. Sage Publications.

Mulwo, A.K, Tomaselli, K.G. & Dalrymple, L. (2009) Condom brands, perceptions of condom efficacy and HIV prevention among university students in KwaZulu-Natal, South Africa. *African Journal of AIDS Research* 8(3):311–320.

Mulwo, A. 2008. *An Analysis of Students' Responses to ABC & VCT Messages at Three Universities in KwaZulu-Natal Province, South Africa*. Unpublished PhD thesis, University of KwaZulu-Natal, South Africa.

Mumtaz, Z., Slaymaker, E., & Salway, S. 2005. Condom use in Uganda and Zimbabwe: exploring the influence of gendered access to resources and couple-level dynamics. *A focus on gender: collected papers using DHS data*. Calverton: ORC Macro, 117-46.

Murima, P. 2013. *Assessing teenagers' knowledge, attitudes and perception toward teenage pregnancy. The case of a Durban high School*. Unpublished MA thesis, University of KwaZulu-Natal Province, South Africa.

Mutinta, G.C. 2012. *Investigating Students' Sexual Risk Behaviour, Risk and Protective Factors and Their Responses to the Scrutinize Campus Campaign at Universities in KwaZulu- Natal*. Unpublished PhD thesis. University of KwaZulu- Natal, South Africa.

Myer, L., Morroni, C., Mathews, C. & Little, F. 2002. Dual method use in South Africa. *International Family Planning Perspectives* 28(2):119-121.

Myers, L., Hajiyanis, H., Clarfelt, A., Bessenaar, T., Motuba, T., Mashale, R., Mkhwanazi, N., & Kelly K. 2013. Audience Reception Analysis of the National Brothers for Life Mass Media Campaign. CADRE.

National Department of Health. 2007. HIV & AIDS and STI STRATEGIC PLAN FOR SOUTH AFRICA 2007-2011

Ncama, B., Mchunu, G., Naidoo, J., Majeke, S., Pillay, P., Myeza, T. Ndebele, 2013. Minibus taxi drivers' sexual beliefs and practices associated with HIV infection and AIDS in KwaZulu-Natal, South Africa. *Curationis* 36(1):1-6.

Nduhura, D. 2004. *Freirean pedagogy as applied by DRAMAidE for HIV/AIDS education*. Unpublished thesis. University of KwaZulu-Natal, South Africa.

Nduhura, D. 2004. *Freirean pedagogy as applied by DRAMAidE for HIV/AIDS education*. Unpublished thesis. University of KwaZulu-Natal, South Africa.

Niehaus, I., & Jonsson, G. 2006. Dr Wouter Basson Americans, and wild Beasts: men's conspiracy theories of HIV/AIDS in the South African Lowveld. *Medical Anthropology* 24(2):179-208.

Nkosana, J., & Rosenthal, D. 2007. The dynamics of intergenerational sexual relationships: the experience of schoolgirls in Botswana. *Sexual Health* 4(3):181-187.

Noh, S., Gagné, J. P., & Kaspar, V. 1994. Models of health behaviors and compliance: Applications to audiological rehabilitation research. *Research in audiological rehabilitation: Current trends and future directions*, 27(2):375-389.

Nyathikazi, T. J. L., 2013. *Investigating the association between HIV and AIDS and polygamy among practising polygamists in KwaZulu-Natal, North Coast area*. Unpublished PhD thesis. Stellenbosch University.

Orisatoki, O., & Oguntibeju, O. 2010. The perception of taxi drivers in southern part of Saint

Lucia, West Indies towards HIV/AIDS and condom use. International Symposium on HIV and Emerging Infectious Diseases, Spartan Health Sciences University, School of Medicine, Vieux Fort, Saint Lucia.

Panday, S., Makiwane, M., Ranchod, C. and Letsoalo, T. 2009. Teenage pregnancy in South Africa with a specific focus on school-going learners. Pretoria: HSRC Press.

Parker, W., Makhubele, B., Ntlabathi, P. & Connolly, C. 2007. *Concurrent sexual partnerships amongst young adults in South Africa: Challenges for HIV prevention communication*, Pretoria: CADRE.

Parker, W. Nkosi, Z., Birdsall, K., & Hajiyanis, H. 2004. Breaking the Barriers: an analysis of condom-related calls to the national AIDS Helpline, Pretoria: CADRE.

Parker, W. 1994. *The development of community-based media for AIDS education and prevention in South Africa: Towards an action-based participatory research model*. Unpublished thesis. University of Natal. South Africa.

Peltzer K. 2002. Perceived treatment efficacy of the last experienced illness episode in a community sample in the Northern Province, South Africa. *Curationis* 23(1):57–60.

Peltzer, K. 2003. Depressive symptoms in relation to alcohol and tobacco use in South African university students, *Psychological Reports*, 92:1097-1098.
<http://www.hsrc.ac.za/en/research-data/view/1130> (Accessed 25 September 2014).

Peters, A., Jansen, W., & van Driel, F. 2010. The Female Condom: The International Denial of a Strong Potential.

Pinkerton, S. D., Chesson, H. W., Crosby, R. A., & Layde, P. M. 2011. Linearity and Nonlinearity in HIV/STI Transmission Implications for the Evaluation of Sexual Risk Reduction Interventions. *Evaluation review* 35(5):550-565.

Porter, G., Hampshire, K., Abane, A., Robson, E., Munthali, A., Mashiri, M., & Tanle, A.

2010. Moving young lives: Mobility, immobility, and inter-generational tensions in urban Africa. *Geoforum* 41(5):796-804.

Potgieter, C., Strebel, A., Shefer, T., & Wagner, C. 2012. Taxi 'sugar daddies' and taxi queens: Male taxi driver attitudes regarding transactional relationships in the Western Cape, South Africa. *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 9(4):192-199.

Pullum, T., Cleland, J., & Shah, I. 2005. Consensus, power and trust in the use of family planning and condoms by couples in Eastern and Southern Africa. In *IUSSP International Conference, Tours*, 18, 23.

Rauf, W., Hitchcock, S., Rauf, A. & Becker, P.J., 2010. Knowledge of and misconceptions about the spread and prevention of HIV infection among older urban women attending the Tshwane District Hospital, South Africa, *South African Family Practice* 52(2):142–148.

Ritchie, J. & Lewis, J. 2003. *Qualitative research practice: A guide for social science students and Researchers*, Sage Publications.

Rosenbaum, J., Zenilman, J., Rose, E., Wingood, G., & DiClemente, R. 2012. Cash, cars, and condoms: economic factors in disadvantaged adolescent women's condom use. *Journal of Adolescent Health* 51(3):233-241.

Rohleder, N., Marin, T. J., Ma, R., & Miller, G. E. 2009. Biologic cost of caring for a cancer patient: dysregulation of pro-and anti-inflammatory signaling pathways. *Journal of Clinical Oncology* 27(18):2909-2915.

Rosenstock, I.M. 1990. The health belief model: Explaining health behavior through expectancies. In: Glanz K, Lewis FM, Rimer BK, eds. *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, CA: Jossey-Bass, 39-62.

Rosenstock, I. M., Stretcher, V. J. & Becker, M. H. 1988. Social learning theory and the health belief model. *Health Ed Quar* 15(2):175-184.

Rosenstock, I. 1974. Historical Origins of the Health Belief Model. *Health Education Monographs* 2(4):324-473.

Ruark, A. 2013. Couple partnership dynamics and relationship satisfaction in Swaziland and implications for HIV prevention. *Presentation at 3rd Structural Drivers of HIV Conference*, Cape Town, South Africa. Johns Hopkins, Bloomberg, School of Public Health.

SAFAIDS. 2011. Multiple and concurrent partnerships: Driving Southern Africa's HIV Epidemic. *A Useful Resource in Advocacy*.

SA Government Gazette (1998) *Act No. 120, 1998 Recognition of Customary Marriage Act*.

Sallis, J.F., Owen, N., & Fisher, E.B. 2008. Ecological models of health behaviour. In: Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). *Health Behaviour and Health Education: Theory, Research, and Practice* (4th edition.). San Francisco: Jossey-Bass.

Sallis, J. F., & Owen, N. 2002. Ecological models of health behaviour. In: Glanz, K. Rimer,., & Lewis, F. M. (Eds.). *Health Behaviour and Health Education: Theory, Research, and Practice*. (3RD edition). San Francisco: Jossey-Bass.

Sarkar, N. N. (2008) Barriers to condom use. *European Journal of Contraception and Reproductive Healthcare* 13(2):114-122.

Schierhout, G., Delate, R., & Ridgard, N. 2008. *First HIV/AIDS National Communication Survey 2006: Summary of the Findings from the Provincial Analysis*. Pretoria: JHHESA.

Setswe, G. 2010. Socio-cultural drivers of the HIV/AIDS epidemic in sub-Saharan Africa. Powerpoint PPT Presentation. <http://www.powershow.com/view/3c7c94-NDU0O/> (Accessed 24 February 2013).

Sharma, M., & Romas, J. A. 2008. *Theoretical foundations of health education and health promotion*. (2nd Ed.). Jones & Barlett Publishers. Ontario Canada.

Shisana, O, Rehle, T, Simbayi, L.C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D. (2014) *South African national HIV prevalence, incidence and behaviour survey, 2012*.

Cape Town, HSRC Press.

Shisana, O. 2013. *Is NHI the NHI: The right solution for South Africa's inequitable health care system? State of the Nation 2013*. Pretoria: HSRC.

Shisana, O., Labadarios, D., Rehle, T., Simbayi, L., Zuma, K., Dhansay, A., Reddy, P., Parker, W., Hoosain, E., Naidoo, P., Hongoro, C., Mchiza, Z., Steyn, N.P., Dwane, N., Makoae, M., Maluleke, T., Ramlagan, S., Zungu, N., Evans, M.G., Jacobs, L., Faber, M., & SANHANES-1 Team. 2013. *South African National Health and Nutrition Examination Survey (SANHANES-1)*. Cape Town: HSRC Press.

Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., Pillay-van-Wyk, V., Mbelle, N., Van Zyl, J., Parker, W., Zungu, N.P., Pezi, S., & the SABSSM III Implementation Team. 2009. *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town, HSRC Press.

Skeen, E. 2007. *The Rape of a Trial: Jacob Zuma, AIDS, Conspiracy, and Tribalism in Neo-liberal Post-Apartheid South Africa*. Unpublished PhD thesis. Princeton University.

Smedley, B. D., & Syme, S. L. 2001. Promoting health: Intervention strategies from social and behavioral research. *American Journal of Health Promotion* 15(3):149-166.

Sondergaard, L. (2000) *Evaluation of the South African Memorial Quilt Project*. Durban: University of Natal.

Stern, E., & Buikema, R. 2013. The relational dynamics of hegemonic masculinity among South African men and women in the context of HIV. *Culture, Health & Sexuality* 15(9):1040-1054.

Stern, E. 2013. Women's Health Research Unit, *The relational dynamics of hegemonic masculinities in the context of HIV*: Women's Health Research Unit 3rd Structural Drivers of HIV Conference December 5, 2013, Cape Town.

Stokols, D. 1996. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion* 10(4):282-298.

Stokols, D. 1992. Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist* 47(1):6-22.

Strebel, A., Shefer, T., Potgieter, C., Wagner, C. & Shabalala, N. 2013. 'She's a slut ... and it's wrong': Youth constructions of taxi queens in the Western Cape. *South African Journal of Psychology* 43(1):71–80.

Talvitie, V. 2012. *The Foundations of Psychoanalytic Theories: Project for a Scientific Enough Psychoanalysis*. London: Karnac Books.

Tan, J. Y., Pratto, F., Operario, D., & Dworkin, S. L. 2013. Sexual positioning and race-based attraction by preferences for social dominance among gay Asian/Pacific Islander men in the United States. *Archives of sexual behavior* 42(7):1233-1239.

Tanser, F., Barnighausen, T., Hund, L., Garnett, G.P., McGrath, N., & Newell, M.L. 2011. Effect of concurrent sexual partnerships on rate of new HIV infections in a high-prevalence, rural South African population: a cohort study. *The Lancet*, 378(9787):247-255.

Terre Blanche, M., Durrheim, K., & Painter, D. (Eds.). 2006. *Research in practice. Applied methods for the Social Sciences*. Cape Town: UCT Press.

Tomaselli, K., Dyll, L., & Francis, M. 2008. "Self" and "other": Auto-reflexive and indigenous ethnography. In N. Denzin, Y. Lincoln, & L. Smith (Eds.), *Handbook of critical and indigenous methodologies*. (pp. 347-373). Thousand Oaks, CA: SAGE Publications.

Tomaselli, K., & Chasi, C. (Eds.) 2011. *Development and Public Health Communication*. Cape Town: Pearson.

UNAIDS.2014. The Gap Report

<http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport> (Accessed 12

June 2015).

UNAIDS. 2012. *Global Report: Report on the Global AIDS Epidemic*. UNAIDS

UNAIDS. 2011. How to get to zero: Faster. Smarter. Better. *UNAIDS World AIDS day report*.

UNAIDS 2009. *National AIDS Spending Assessment (NASA): classification and definitions*. Geneva.

UNAIDS (Joint UN Programme on HIV/AIDS). 1999. *Communications framework for HIV/AIDS: a New Direction*. Pennsylvania, State University.

UNAIDS (Joint UN Programme on HIV/AIDS). 2007. *Practical Guidelines for Intensifying HIV prevention : Towards Universal Access*. New York.

UNFPA; WHO & PATH. 2005. *Condom Programming for HIV Prevention: An Operations Manual for Programme Managers*.

USAID. 2005. ISSUE Brief USAD: HIV/STI Prevention and Condoms.

Van Manen, M. 1997. *Researching lived experience: Human science for an action sensitive pedagogy*. (2nd ed.). London: The Althouse Press.

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

Vijayakumar, G., Mabude, Z., Smit, J., Beksinska, M., & Lurie, M. 2006. A review of female-condom effectiveness: patterns of use and impact on protected sex acts and STI incidence. *International Journal of STD & AIDS* 17(10):652–659.

Williams, Jr. D., Perko, M., Belcher, D., Leaver-Dunn, D., Usdan, S., & Leeper, J. 2006. Use of social ecology model to address alcohol use among college athletes. *American Journal of*

Health Studies 21(4):228-237.

Women's Health Research Unit World Health Organisation. 2007. UNAIDS 2009 AIDS epidemic update. UNAIDS/09.36 E/JC1700E.

World Health Organization. 2012. *Trends in maternal mortality: 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank estimates.*

World Health Organization. 2007. *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions.* Geneva. (citing Connell, R. 1994. *Masculinities.* Berkeley, Univ. of Cal. Press).

World Health Organisation. 2006. Defining sexual health: *Report of a technical consultation on sexual health, 23-31 January 2002, Geneva.*

Wood, K., & Jewkes, R. 2006. Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters* 14(27):109-118.

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

Woodsong, C., & Koo, H. (1999) Two good reasons: women's and men's perspectives on dual contraceptive use. *Social Science and Medicine* 49(5):567-581.

Wright, H. 2009. Trusting the process: using an emergent design to study adult education. *Educate*~, 9(3):62-73.

Yin, R. 2003. *Case Study Research: Design and Methods*, 3rd Edition. Sage Publications.

INTERVIEW

DramAidE Director, Mr Gumede

November, 2014: personal interview.

APPENDIX 1: INFORMED CONSENT FORM

(To be read out by researcher before the beginning of the interview/Focus Group Discussion, and to be explained in isiZulu. One copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

I am doing research on a project entitled **Male Taxi Driver's attitudes concerning condom use and dual contraceptive use by their partners**. The aim of this project is to understand taxi driver's information and attitudes about this topic.

This project is supervised by Dr Emma Durden at the School of Culture, Communication and Media Studies, University of KwaZulu-Natal. Should you have any questions my contact details are:

DramAidE / CCMS

University of KwaZulu-Natal,

Howard College Campus

Durban, 4041.

Tel: 27 031 260 1564

Thank you for agreeing to take part in the project. I would like to emphasize that:

-your participation is entirely voluntary;

-you are free to refuse to answer any question;

-you are free to withdraw at any time.

The information you provide in the Interview/Focus Group Discussion (researcher to tick where necessary) will be kept strictly confidential and will be available only to members of the research team. Excerpts from the Interview/Focus group discussions may be made part of the final research report but your identity will not be reflected in the report.

If you give consent to participate in the study, please sign this form to show that you have read the contents

I..... (Full names) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time should I so desire.

Signature of the Participant.....Date.....

Thank you

Zamashandu Mbatha

APPENDIX 2: INTERVIEW AND FOCUS GROUP GUIDES

Interview Questions/ Imibuzo

Knowledge/ Ulwazi

1: Do you know how HIV is spread?

Uyazi ukuthi igciwane le sandulela ngculaza libhebhetheka kanjani?

2: Do you know how to prevent HIV infection?

Uyakwazi ukuvikela igciwane le sandulela ngculaza?

3: Do you know the link between HIV and other STIs?

Uyakwazi ukuxhumana phakathi kwe gciwane le sandulela ngculazakanye nezifo ezithathelana ngokocansi?

4: Do you know how to prevent pregnancy?

Uyakwazi ukuvikela ukukhulelwa?

Attitudes/ Isimo sengqondo

5: What is your opinion on condom use for the prevention of HIV infection / STIs?

Uthini umbono wakho mayelana nokusetshenziswa kwe jazi lomkhwenyana?

6: What is your opinion on the use of condoms to prevent pregnancy?

Uthini umbono wakho mayelana nokusetshenziswa kwe jazi lomkhwenyana ekuvimbeleni ukukhulelwa?

7: What is your opinion on the use of dual contraceptives?

Uthini umbono wakho mayelana nokusebenzisa izindlela ezimbili zokuvikela?

8: What is your opinion on women making decisions about contraceptives?

Uthini umbono wakho mayelana nokuzithathela izinqumo kwabesifazane ngezindlela zokuvikela?

9: What influence do you think you have over your female partner with respect to condom use?

Yimaphi amandla ocabanga ukuthi unawo kulowo wesimame ozwana naye ngokusetshenziswa kwe jazi lomkhwenyana?

10: What role do you think men should play in preventing HIV infection and pregnancy?

Yiliphi iqhaza obona ukuthi abantu besilisa kumele balibambe ekuvikeleni igciwane lesandulela ngculaza kanye nokukhulelwa?

Behaviour/ Ukuziphatha

1. What is your marital status? E.g. Married-Ushadile/divorced-wahlukanisa/unmarried-awushadile.

Sithini isimo sakho sokushada?

2. Are you sexually active?

Ingabe uyazibandakanye ngokwezocansi?

3. Do you have a permanent partner?

Unaye umaqondana eninaye okomphela?

4. Are you in a long term relationship?

Ingabe usebudlelwaneni obesikhathi eside?

5. What HIV prevention method do you use with your permanent female partner/other female partners?

Yiziphi izindlela zokuvikela igciwane lesandulela ngculaza enizisebenzisayo nowakwakho umaqondana
/nalaba abanye ophathina bakho?

6. What method of contraception (to prevent pregnancy) do you use?

Yiluphi uhlobo lokuvikela (ukukhulelwa) enilusebenzisa

APPENDIX 3: ETHICAL CLEARANCE LETTER



19 June 2012

Mrs Zamashandu J Mbambo (971162604)
School of Applied Human Sciences

Dear Mrs Mbambo

Protocol reference number: HSS/0391/012M
Project title: Male taxi driver's attitudes concerning condom use and dual contraceptive use by their female partners: An investigation into Umbumbulu District, KwaZulu-Natal

In response to your application dated 11 May 2012, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Science Research Ethics Committee
/ms

cc Supervisor: Dr Emma Durden
cc Academic Leader: Professor JH Buitendach
cc Ms Nondumiso Khanyile

Professor S Collings (Chair)
Humanities & Social SC Research Ethics Committee
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350 Facsimile: +27 (0)31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za
Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

Inspiring Greatness

